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

Preamble

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

To assist States in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with States and CMS over the years to design and revise this Annual Report Template. Over time, the framework has been updated to reflect program maturation and corrected where difficulties with reporting have been identified.

The framework is designed to:

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

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

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

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

SCHIP Program Type:

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

Reporting Period: **2006** *Note: Federal Fiscal Year 2006 starts 10/1/05 and ends 9/30/06.*

Contact Person/Title: **Ruth Jacobs, Assistant Deputy Director, Benefits**

Address: **1000 G Street**

Suite 450

City: **Sacramento** State**:** **CA** Zip**:** **95814**

Phone: **916-445-2107** Fax: **916-327-9661**

Email: **rjacobs@mrmib.ca.gov**

Submission Date: **2/8/2007**

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. You are encouraged to complete this table for the different SCHIP programs within your state, e.g., if you have two types of separate child health programs within your state with different eligibility rules. If you would like to make any comments on your responses, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
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 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? Beginning 7/1/03, children under 200% receiving services from a CHDP provider will be enrolled in no-cost Medicaid via the CHDP Gateway for two months. In addition, children (ages 0-1 under 200% of the FPL, ages 1-5 under 133% of the FPL, and ages 6-18 under 100% of the FPL) who are screened to the no-cost Medi-Cal program (California's Medicaid Program) are granted presumptive eligibility into Medicaid until final eligibility determinations are made.	☒	Yes, for whom and how long? Children under 200% of the FPL receiving services from a CHDP provider will be enrolled in SCHIP via the CHDP Gateway for two months. In Addition, children who are screened to the no-cost Medi-Cal Program are granted presumptive eligibility into Medicaid until final eligibility determinations are made by Medi-Cal.
	☐	N/A	☐	N/A

Is retroactive eligibility available?	☐	No	☒	No
	☒	Yes, for whom and how long? For children up to 3 months.	☐	Yes, for whom and how long?
	☐	N/A	☐	N/A

Does your State Plan contain authority to	Not applicable	☒	No
		☐	Yes

implement a waiting list?			☐	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
	☐	N/A	☐	N/A

Does your program provide period of continuous coverage <u>regardless of income changes?</u>	☐	No	☐	No
	☒	Yes	☒	Yes
	Specify number of months	12	Specify number of months	12
	Explain circumstances when a child would lose eligibility during the time period in the box below		Explain circumstances when a child would lose eligibility during the time period in the box below	

	Death of the child, no longer a California resident, or the applicant requests to disenroll the child from the program.		Turning age 19, non-payment of premiums, death of the child, no longer a California resident, or the applicant requests to disenroll the child 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	15
	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. Applicant may pay three months in advance and receive the fourth month free. If the applicant uses Electronic Funds Transfer, he/she 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 appllicant is still required to make monthly premium payments.	
	☐	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	☐	No	☐	No

require income disregards?	☒	Yes	☒	Yes
	If Yes, please describe below		If Yes, please describe below	
	For infants under one year of age with imcome between 185% and 200% of the FPL.		Income greater than 200% through 300% of the 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.

Currently, 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 may access to the on-line electronic application process. The on-line application process for public use is underdevelopment and will be available in 2008.

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

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

	Medicaid Expansion SCHIP Program			Separate Child Health Program		
	Yes	No Change	N/A	Yes	No Change	N/A
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	☐	☒	☐	☐	☒	☐

b)	Application	☐	☒	☐	☐	☒	☐
c)	Application documentation requirements	☐	☒	☐	☐	☒	☐
d)	Benefit structure	☐	☒	☐	☐	☒	☐
e)	Cost sharing (including amounts, populations, & collection process)	☐	☒	☐	☐	☒	☐
f)	Crowd out policies	☐	☒	☐	☐	☒	☐
g)	Delivery system	☐	☒	☐	☐	☒	☐
h)	Eligibility determination process (including implementing a waiting lists or open enrollment periods)	☐	☒	☐	☐	☒	☐
i)	Eligibility levels / target population	☐	☒	☐	☐	☒	☐
j)	Assets test in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
k)	Income disregards in Medicaid and/or SCHIP	☐	☒	☐	☐	☒	☐
l)	Eligibility redetermination process	☐	☒	☐	☐	☒	☐
m)	Enrollment process for health plan selection	☐	☒	☐	☐	☒	☐
n)	Family coverage	☐	☒	☐	☐	☒	☐
o)	Outreach (e.g., decrease funds, target outreach)	☒	☐	☐	☒	☐	☐
p)	Premium assistance	☐	☒	☐	☐	☒	☐
q)	Prenatal Eligibility expansion	☒	☐	☐	☒	☐	☐
r)	Waiver populations (funded under title XXI)						
	Parents	☐	☒	☐	☐	☒	☐
	Pregnant women	☐	☒	☐	☐	☒	☐
	Childless adults	☐	☒	☐	☐	☒	☐

s) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	☐	☒	☐	☐	☐	☐
t) Other – please specify						
a. _____	☐	☐	☐	☐	☐	☐
b. _____	☐	☐	☐	☐	☐	☐
c. _____	☐	☐	☐	☐	☐	☐

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

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Application documentation requirements	
d) Benefit structure	
e) Cost sharing (including amounts, populations, & collection process)	
f) Crowd out policies	
g) Delivery system	
h) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	
i) Eligibility levels / target population	
j) Assets test in Medicaid and/or SCHIP	
k) Income disregards in Medicaid and/or SCHIP	

l) Eligibility redetermination process	
m) Enrollment process for health plan selection	
n) Family coverage	
o) Outreach	Effective July 1, 2006, the Enrollment Entity/Certified Application Assistant (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 where a child is granted presumptive Medicaid eligibility), the amount increased from $50 to $60.
p) Premium assistance	
q) Prenatal Eligibility Expansion	On March 28, 2006 CMS approved the pre-natal SPA, where the Access for Infants & Mothers (AIM) program will be drawing down federal funds for pregnant women who are enrolled in AIM. Those infants born to AIM enrolled mothers are automatically eligible for the SCHIP program.

r) Waiver populations (funded under title XXI)

Parents	
Pregnant women	
Childless adults	

s) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse	

t) Other – please specify

a.	
b.	
c.	

Enter any Narrative text below.
Effective July 1, 2006, the Enrollment Entity/Certified Application Assistant (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 where a child is granted presumptive Medicaid eligibility), the amount increased from $50 to $60. In

addition, for each successful Annual Eligibility Review form where a child(ren) continues to be eligible for SCHIP, the EE receives $50 instead of $25. During the last quarter of this reporting period, outreach funding was recently restored to promote public awareness about the SCHIP and Medicaid programs. The $22 million funding allocation will occur on a county level to those counties where the highest number of eligible (but not enrolled) children reside and to counties that have the highest number of SCHIP and Medicaid enrollment in order to promote program retention. The county allocations will be built on existing local structures, experience and knowledge gained by counties. County outreach will utilize 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.

SECTION II: PROGRAM'S PERFORMANCE MEASUREMENT AND PROGRESS

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

SECTION IIA: REPORTING OF CORE PERFORMANCE MEASURES

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

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

These measures are based on specifications provided by the Health Plan Employer Data and Information Set (HEDIS®). HEDIS® provides a useful framework for defining and measuring performance. However, use of HEDIS® methodology is <u>not</u> 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, report data from the previous two years' annual reports (FFY 2004 and FFY 2005). 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 2006). 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:

- <u>Population not covered</u>: Check this box if your program does not cover the population included in the measure.
- <u>Data not available</u>: 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.
- <u>Small sample size</u>: 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.
- <u>Other</u>: 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:

- <u>Provisional</u>: 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 2006.
- <u>Final</u>: Check this box if the data you are reporting are considered final for FFY 2006.

- 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® 2006). 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), hybrid data (claims and medical records), survey data, or 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 2007, 2008, and 2009. Based on your recent performance on the measure (from FFY 2004 through 2006), 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 2004	FFY 2005	FFY 2006
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*: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this information when it was first requested by CMS. Data is currently being collected and should be reported in the 2007 report	**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*: The Managed Risk Medical Insurance Board's contract with participating health plans did not requie the plans to collect his information when it was first requested by CMS. Health Plans participating in the Healthy Families program for the 2005-2008 contract period, which began on July 1, 2005, will be required to report this measurement.	**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*: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect his information when it was first requested by CMS. Data is currently being collected and should be reported in the 2007 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*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ 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:** 2006

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

FFY 2004	FFY 2005	FFY 2006
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: 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:
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:

Annual Performance Objective for FFY 2007: We will report our first year of data in 2007 to be used as a benchmark for future year comparison and improvements;l we willuse this data to establish a benchmark

Annual Performance Objective for FFY 2008: Monitor data;Work with plans to improve scores if they do not meet Benchmarks 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: Monitor data;Work with plans to improve scores if they do not meet Benchmarks 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:

Other Comments on Measure:

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

FFY 2004	FFY 2005	FFY 2006
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*:	**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*:	**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 2003	**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
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ 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 of HFP members who were three, four, five, or six years old during the measurement year who were continuously enrolled in the plan during the measurement year and who received one or more well-child visit(s) with a primary care provider during the measurement year. MRMIB calculates percentages and compares the results with those submitted by the health plans.	**Definition of 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 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: 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 compares the results with those submitted by the hlth plans.
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with 1+ visits Numerator: 10711 Denominator: 16980 Rate: 63.1 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: 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.

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

FFY 2004	FFY 2005	FFY 2006
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:

Annual Performance Objective for FFY 2007: Working with plans to improve scores via Quality Performance Improvement Project Wherein participating health plans with higher scores 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 Wherein participating health plans with higher scores 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 Wherein participating health plans with higher scores share best practices and lower scoring plans submit a corrective action plan to improve these scores

Explain how these objectives were set:

Other Comments on Measure: For 2006: based upon the random sample submitted by the plans, it can be imputed that 65% of all applicable HFP enrollees had a well-child visit in the measurement year.

MEASURE: Use of Appropriate Medications for Children with Asthma

FFY 2004	FFY 2005	FFY 2006
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*: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this information when it was first requested by CMS. Health plans participating in 2006-2007 will be required to report this measurement	**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*: The Managed Risk Medical Insurance Board's contract with participating health plans did not require the plans to collect this information when it was first requested by CMS. Health plans participating in the Healthy Families Program for the 2005-2008 contract period, which began on July 1, 2005, will be required to report this measurement.	**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*: 2006
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ 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:** 2006

Use of Appropriate Medications for Children with Asthma (continued)

FFY 2004	FFY 2005	FFY 2006
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: 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:
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: Percent receiving appropriate medications	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of 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:

Other Comments on Measure: : This is our first year of data to be used as a benchmark for future year comparison and improvements. We will use this data for benchmarking

MEASURE: Children's Access to Primary Care Practitioners

FFY 2004	FFY 2005	FFY 2006
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*:	**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*:	**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 2003	**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
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating HFP health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating 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: HFP members, ages 12 months through 18 years.	**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.
Year of Data: 2004	**Year of Data:** 2005	**Year of Data:** 2006

FFY 2004	FFY 2005	FFY 2006
HEDIS Performance Measurement Data: *(If reporting with HEDIS/HEDIS-like methodology)* Percent with a PCP visit 12-24 months Numerator: 6827 Denominator: 7306 Rate: 93.4 7-11 years Numerator: 75948 Denominator: 92391 Rate: 82.2 25 months-6 years Numerator: 78001 Denominator: 93509 Rate: 83.4 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: 8129 Denominator: 8904 Rate: 91.3 7-11 years Numerator: 79199 Denominator: 97579 Rate: 81.2 25 months-6 years Numerator: 92350 Denominator: 113441 Rate: 81.4 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 7-11 years Numerator: Denominator: Rate: 25 months-6 years Numerator: 102489 Denominator: 117196 Rate: 87.5 12-19 years 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:	**Other Performance Measurement Data:** *(If reporting with another methodology)* Numerator: Denominator: Rate: Additional notes on measure:

Explanation of Progress:

Annual Performance Objective for FFY 2007: Working with plans to improve scores via Quality Performance Improvement Project Wherein participating health plans with higher scores 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 Wherein participating health plans with higher scores 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 Wherein participating health plans with higher scores share best practices and lower scoring plans submit a corrective action plan to improve these scores

Explain how these objectives were set:

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.

SECTION IIB: ENROLLMENT AND UNINSURED DATA

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

Program	FFY 2005	FFY 2006	Percent change FFY 2005-2006
SCHIP Medicaid Expansion Program	181017	214216	18.34
Separate Child Health Program	1042458	1177189	12.92

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

The One Month Bridge caseload across the state continues to grows. Los Angeles which began reporting One Month Bridge in March 2005 continues to report increasing numbers of 7X eligibles which accounts for about 1/4 of the growth from 2005 to 2006.

2. The table below shows trends in the three-year averages for the number and rate of uninsured children in your State based on the Current Population Survey (CPS), along with the percent change between 1996-1998 and 2003-2005. 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 2006 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
Percent change	-33.6*%*	NA	-36.6**%**	NA

1996-1998 vs. 2003-2005				

* Significant at the .01 level, 2-tailed test

** Significantly different than zero at the .01 level, 2-tailed test

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

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

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

☒ 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. 2005: UCLA has issued a fact sheet on coverage, but the full report which explains the methodology will not be issued until the end of January 2007.
Population (Please include ages and income levels)	CHIS is a general population survey that examines health insurance coverage, as well as numerous other issues. It surveys households through random selection and does so in five languages.
Sample sizes	2001 Survey: 55,000 households with over samples of Asian Pacific Islanders and American Indian/Alaska Natives. This sample included 5,000-6,000 adolescents and 14,000 children by proxy.
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%.
Statistical significance of results	Results are statistically valid. More than 1.1 million children under age 19 were uninsured for all or part of the year in 2005. The same number was identified in 2003. 2003 was a significant drop

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

California uses the California Health Interview Survey (CHIS) as its primary source of data for the number of uninsured. This data has a significantly larger sample size than CPS and also estimates whether children would have been eligible for SCHIP or Medi-Cal.

B. 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.)
California considers the estimate to be reliable. California plans to continue utilizing CHIS to measure changes in the number of uninsured children. Collection of new data for the 2005-07 CHIS survey began in July 2005 and is complete. Data from the 2005 survey is contained in "preview documents" with the full report released later this winter.

C. What are the limitations of the data or estimation methodology?
WAITING FOR INFORMATION FROM PETER HARBAGE AND RICK BROWN (LESLEY HAS REQUESTED THIS INFORMATION)

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

While the State does not actively collect data estimating the impact of outreach and enrollment simplification, the State believes outreach and enrollment simplification played a major role in SCHIP's and Medicaid's continuing increase in enrollment. The State funding for statewide media outreach campaigns stopped on July 1, 2003. However, the State continued to work closely with the David and Lucille Packard Foundation and Public Health Institute to sponsor the Connecting Kids to Healthcare Through Schools Project. This Project focuses on statewide school-based outreach and enrollment for the SCHIP, Medicaid and Children's Expansion Programs (e.g. Healthy Kids Programs). As a result of the school based outreach, during this reporting period, over 1,082,000 outreach materials were distributed to schools. The schools disseminated the materials to parents with their Back-to-School packets, at Back-to-School Nights, Parent/Teacher Conferences, and with school lunch menus. The dissemination of outreach materials resulted in over 24,790 parents requesting for applications to be mailed to them.

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

During this reporting period, outreach funding was recently restored to promote public awareness on the SCHIP and Medicaid programs. Funding allocation will occur on a county level to those counties where the highest number of eligible (but not enrolled) children reside and to counties that have the highest number of SCHIP and Medicaid enrollment in order to promote retention. The county allocations will 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 this reporting period, funding has not been distributed to the counties. Next year's report will provide more detailed information on the overall impact of outreach funding.

Effective July 1, 2005, the EE/CAA reimbursement process was restored for each successful application where a child(ren) is enrolled. As of September 2006, 17,015 CAAs assisted families in applying for the SCHIP and Medicaid programs. This is over a 1,400% increase in CAA participation compared to the previous reporting period. The number of applications assisted by CAAs increased from approximately 17.2% to 26.54%. The number of complete applications received significantly increased from approximately 19% to 47.10%. During the initial application process, 61.85% eligible children who were enrolled in SCHIP obtained assistance from CAAs. During the Annual Eligibility

Review process, 12.67% of children continued to be eligible for SCHIP through the assistance of CAAs.

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. The format of this section has been revised for FFY 2006 to provide 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, please enter the data you reported for each objective in the previous two years' annual reports (FFY 2004 and FFY 2005). In the third column, please report the most recent data available at the time you are submitting the annual report.

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.

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 2006.
- Final: Check this box if the data you are reporting are considered final for FFY 2006.
- 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® 2006). 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. For the objectives related to access to care and use of preventative care, please indicate whether you used administrative data (claims), hybrid data (claims and medical records), survey data (specify the survey used), or 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 2007, 2008, and 2009. Based on your recent performance on the measure (from FFY 2004 through 2006), 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 2004	FFY 2005	FFY 2006
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*: California Department of Health Services.	**Data Source:** ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: Department of Health Services.	**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: Eligible children in Medicaid in FFY 2004-2005 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: Analyze changes in number of eligible children in Medicaid in FFY 2003 and 2004. Numerator: Denominator: Rate: Additional notes on measure: 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.	**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 Denominator: 301000	**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:

FFY 2004	FFY 2005	FFY 2006
	Rate: 74.4 Additional notes on measure:	

Explanation of 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.

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

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 2004	FFY 2005	FFY 2006
Goal #2 (Describe) Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.	**Goal #2 (Describe)** Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal	**Goal #2 (Describe)** Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☐ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☐ Final. ☒ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:* 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:*
Data Source: ☐ Eligibility/Enrollment data ☐ Survey data. *Specify*: ☒ Other. *Specify*: "The State of Health Insurance in California: Findings from the 2001 and 2003 California Health Interview Survey" (Brown, et.al, UCLA 2004)	**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.
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: 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:

FFY 2004	FFY 2005	FFY 2006
Numerator: 224000 Denominator: 301000 Rate: 74.4 Additional notes on measure:	Numerator: 224000 Denominator: 301000 Rate: 74.4 Additional notes on measure:	
Explanation of 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:*		
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 2004	FFY 2005	FFY 2006
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)** Reduce the percentage of children using the emergency room as their usual source of primary care.
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*: Program does not currently encounter data; therefore, cannot determine if EF utilization is excessive.
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:

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:

FFY 2004	FFY 2005	FFY 2006
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.		

Objectives Related to SCHIP Enrollment

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) Provide an application and enrollment process which is easy to understand and use.	**Goal #1 (Describe)** Provide an application and enrollment process which is easy to understand and use.	**Goal #1 (Describe)** Provide an application and enrollment process which is easy to understand and use.
Type of Goal: ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:	**Type of Goal:** ☐ New/revised. *Explain*: ☒ Continuing. ☐ Discontinued. *Explain*:
Status of Data Reported: ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*	**Status of Data Reported:** ☐ Provisional. ☒ Final. ☐ Same data as reported in a previous year's annual report. *Specify year of annual report in which data previously reported:*
Data Source: ☒ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☒ Eligibility/Enrollment data. ☐ Survey data. ☐ 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: N/A Definition of numerator: N/A
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 2004	FFY 2005	FFY 2006

Explanation of Progress:

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.

Other Comments on Measure:

Objectives Related to SCHIP Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
Goal #2 (Describe) Ensure the participation of community-based organizations in outreach/education activities.	**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..
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. ☒ Other. *Specify*: Enrollment Entity Agreements and HFP Enrollment Data.	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☒ Other. *Specify*: Enrollment Entity Agreements and HFP Enrollment Data..	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*: Enrollment Entity Agreements and HFP Enrollment Data.
Definition of Population Included in the Measure: Definition of denominator: Definition of numerator:	**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
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: Increased number of EE/CAAs providing application assistance to families. Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006

Explanation of 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 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:

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.

Objectives Related to SCHIP Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
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. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ 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:

FFY 2004	FFY 2005	FFY 2006

Explanation of Progress:

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.

Other Comments on Measure:

Objectives Related to Medicaid Enrollment

FFY 2004	FFY 2005	FFY 2006
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. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ 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: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		

FFY 2004	FFY 2005	FFY 2006
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
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. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ 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: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		

FFY 2004	FFY 2005	FFY 2006
Other Comments on Measure:		

Objectives Related to Medicaid Enrollment (Continued)

FFY 2004	FFY 2005	FFY 2006
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. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Eligibility/Enrollment data. ☐ Survey data. ☐ 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: **Annual Performance Objective for FFY 2007:** **Annual Performance Objective for FFY 2008:** **Annual Performance Objective for FFY 2009:** *Explain how these objectives were set:*		
Other Comments on Measure:		

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

FFY 2004	FFY 2005	FFY 2006
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*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Enrollment data from the HFP Administrative Vendor – Electronic Data Systems (EDS)	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Enrollment data from the HFP Administrative Vendor MAXIMUS.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ 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:
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: 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 2004	FFY 2005	FFY 2006
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:

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:

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.

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

FFY 2004	FFY 2005	FFY 2006
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*:
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ 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: 2004	**Year of Data:** 2005	**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: 62 Additional notes on measure:	**HEDIS Performance Measurement Data:** *(If reporting with HEDIS/HEDIS-like methodology)* Numerator: Denominator: Rate: Additional notes on measure:

FFY 2004	FFY 2005	FFY 2006
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:

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:

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.

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

FFY 2004	FFY 2005	FFY 2006
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:*
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. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ Other. *Specify*:	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ 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:	**Year of Data:**	**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 2004	FFY 2005	FFY 2006
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:
Explanation of 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:*		
Other Comments on Measure:		

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

FFY 2004	FFY 2005	FFY 2006
Goal #1 (Describe) Maintain or improve the percentage of children receiving CCS and mental health (SED) specialized services.	**Goal #1 (Describe)** Maintain or improve the percentage of children receiving CCS and mental health (SED) specialized services.	**Goal #1 (Describe)** Maintain or improve the percentage of children receiving CCS and mental health (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*:
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*: HFP enrollment, CCS, and County mental health data.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: HFP enrollment, CCS and County mental health data.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: HFP enrollment, CCS, and County mental health data.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ 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:** 2005
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 2004	FFY 2005	FFY 2006
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: 2.5%, SED 0.7%	**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.

Explanation of 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:

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).

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

FFY 2004	FFY 2005	FFY 2006
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)** Ensure no break in coverage for children who access CCS and 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*:
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. ☒ Other. *Specify*: HFP enrollment, CCS and County mental health data.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: HFP enrollment, CCS and County mental health data.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☐ 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: 2002	**Year of Data:** 2003	**Year of Data:** 2004
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 2004	FFY 2005	FFY 2006
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:

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:

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.

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

FFY 2004	FFY 2005	FFY 2006
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)** Achieve year to year improvements in the number of children that have had a visit to a primary care physician during the year.
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*: 2003 Measure for 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*: 2005 measure of access.
Data Source: ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ Other. *Specify*: Participating Healthy Families Program (HFP) health plans.	**Data Source:** ☐ Administrative (claims data). ☐ Hybrid (claims and medical record data). ☐ Survey data. ☒ 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: 2003	**Year of Data:** 2004	**Year of Data:** 2005
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 2004	FFY 2005	FFY 2006
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:

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:

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.

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 HFP. The questions that are included in the Fact Sheet request information about the organization of the plans and the provision of health, dental and vision care services. Specific areas addressed include:

- Access to providers,
- Obesity screening and education,
- Mental health and substance abuse services; and
- Process each plan uses to notify MRMIB of contractual arrangements that will impact the plan's provider network.

Annual Quality of Care Reports: Health and dental plans submit quality of care reports each year, as required in their HFP contracts. The Quality Improvement Work Group selects measures included in the reports for relevancy to the HFP population. Measures focus on preventative care and access because these areas are vital to young children and the cornerstone of the Program. The HEDIS® (Health Employer Data Information Set) is used as a basis for the current measures. The measures currently collected are:

- Childhood Immunization Status
- Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Adolescent Well-Care Visits
- Children's and Adolescent's Access to Primary Care Practitioners
- Follow-up After Hospitalization for Mental Illness
- Identification of Alcohol and Other Drug Services
- Use of Appropriate Medications for People with Asthma

The HEDIS® Mental Health Utilization Measure and Well-Child Visits during the First 15 Months of Life Measure have been added to the 2006-2007 Health Plan data reporting requirements. The HEDIS® Chlamydia Screening Measure has been added to the 2007-2008 Health Plan data reporting requirements.

HFP scores have remained better than Medicaid and comparable commercial plans for several years. The current mental illness measure will be replaced next year by the Mental Health Utilization (Inpatient, Intermediate, and Ambulatory Services) HEDIS® measure.

California Children's Services (CCS) and Mental Health Referral Reports: The CCS and Mental Health Referral Reports were implemented in FFY 2000 to monitor the access that eligible children have to CCS and county mental health services. Plans are required to report the number of children referred to these services on a quarterly basis. The numbers reported by plans are compared with the estimates of

children expected to require CCS and county mental health services to determine whether there is adequate access to these services.

Cultural and Linguistics Services Report: This report allows staff to monitor how HFP subscribers' special needs related to language access and culturally appropriate services are being met. The Cultural and Linguistic Services Report outlines how plans provide culturally and linguistically appropriate services to subscribers. Specific information obtained for the report included:

- How the Plan identifies the language preference of its members.
- The type of consideration taken by the Plan when using physician auto assignment or assigning culturally and linguistically appropriate providers, when a member has not selected a primary care physician.
- How the Plan informs its members of the availability of no cost interpretive services and how they provide this service to their subscribers and monitor their program.
- Methods that are used by the Plan to ensure language access at various points of contact.
- How Plans make available materials in non-English languages and the languages that are used in printing each document.
- How Plans ensure a sixth grade readability level for member documents (including translated documents).
- How Plans provide initial and continuing training on cultural competency to Plan staff and Plan network providers.

MRMIB staff developed and provided training for a new checklist in 2006 that provides consistency and clarity to the plans regarding their contractual Cultural and Linguistics requirements. MRMIB staff provided training to the Plans on how to use the checklist. The responses to the new checklist were received by MRMIB in early December 2006 and are currently being reviewed and tabulated.

Group Needs Assessment: The 2005-2008 HFP contract requires HFP plans to conduct a Group Needs Assessment (GNA) in 2007 to identify the health risks, beliefs, and develop work plans with timelines in order to address any needs that are identified. MRMIB will review the GNAs and work plans to determine the following:

- Subscriber identified needs
- Work plans and timelines ability to address identified subscriber needs

Plans, as part of their GNA, will assess the needs of their HFP subscribers in the following areas:

- Health related behaviors and practices
- Risk for disease, health problems, and conditions
- Knowledge, attitudes, beliefs, and practices related to access and use of preventive care
- Knowledge, attitudes, beliefs, and practices related to health risk
- Perceived health care and health education needs and expectations
- Cultural beliefs and practices related to alternative medicine
- Perceived language needs and preferred methods of learning

- Language needs and literacy level
- Community resources and capability to provide health education and cultural and linguistic services

Member Surveys: MRMIB uses two types of member surveys to monitor quality and service. All subscribers are given a plan disenrollment survey during open enrollment. The survey requests information on why members decided to switch plans during open enrollment. Questions on the survey address plan quality, cost, adequacy of the provider network, and access to primary care providers. For further information, please see Attachment A, Open Enrollment 2006 Survey Report.

Consumer satisfaction surveys for both health and dental plans were conducted each year prior to 2004. MRMIB has presented the findings of these surveys in prior year Federal Annual Reports.

Funds were not allocated for these surveys in 2004 and 2005. Funds have recently been allocated and MRMIB has contracted with DataStat to conduct both the Health and Dental Consumer Assessment of Health Plans Surveys (CAHPS® 3.0H) and the Young Adult Health Care Survey (YAHCS). YAHCS is a survey given to 14 to 18 year olds to assess how well the health care system is providing recommended preventive care. The survey is administered by mail with an on-line response option and contains 57 questions related to aspects of care. The data obtained from YAHCS will be used for comparisons among plans, other programs and against data from the CAHPS.

Data collection for both surveys began in March 2006. DataStat will prepare a report in 2007 based on that data. Information from the report will be provided in the 2007 Federal Annual Report.

Subscriber Complaints: MRMIB receives direct inquiries and complaints regarding HFP benefits from subscribers. Approximately 90 percent of the inquiries are received via correspondence and ten percent through phone calls.

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 performance measures to the 2005-2008 health and dental plan contracts. These performance measures include the following HEDIS® Measures:

- Mental Health Utilization (data will be available in 2007);
- Well Child Visits In The First 15 Months Of Life (data will be available in 2007); and
- Chlamydia Screening (data will be available in 2008)

Encounter/Claims Data: MRMIB is developing a process to collect encounter/claims 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, including the Quality Performance Improvement Project discussed below. MRMIB's goal is that the data will be available in 2007.

Quality Performance Improvement Project: MRMIB applied a qualitative analysis of HEDIS scores in 2006 to review individual plan quality outcomes. MRMIB compared HEDIS 2004 scores with the HEDIS 2003 scores in the following four areas:

- Childhood Immunizations;
- Well Child Visits;
- Adolescent Well Care Visits; and
- Access to Primary Care Physicians.

MRMIB aggregated scores for these measures, adjusted scores for improvements or declines and established a total plan score. Plans identified as “high performing plans” were contacted to discuss strategies and best practices which allowed them to achieve higher scores. Plans identified as “low performing plans” were provided theses strategies and best practices. The “low performing plans” are required to develop a corrective action plan to improve program scores. The Quality Performance Improvement Project will continue on an annual basis. Other quality measurements may be added at a later date to the review process.

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?

MRMIB has added performance measures to the 2005-2008 health and dental plan contracts. These performance measures include the following HEDIS® Measures:

- Mental Health Utilization (data will be available in 2007);
- Well Child Visits In The First 15 Months Of Life (data will be available in 2007); and
- Chlamydia Screening (data will be available in 2008)

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Improvement Project will continue on an annual basis. Other quality measurements may be added at a later date to the review process.

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.

Attachments:

Open Enrollment 2006 Survey Report

2006 Annual Retention Report

Phase I Mental Health/Substance Abuse Study

2005 CHIS Preview Documents: "More than Half of California's Uninsured Children Eligible for Public Programs But not Enrolled" and "One in Five Californians Were Uninsured in 2005 Despite Modest Gains in Coverage"

2003 Health Status Assessment Project (PEDS QL)

Enter any Narrative text below.

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

Please reference and summarize attachments that are relevant to specific questions

OUTREACH

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

   During the last quarter of this reporting period, outreach funding was recently restored to promote public awareness of the SCHIP and Medicaid programs. The $22 million funding allocation will occur on a county level to those counties where the highest number of eligible (but not enrolled) children reside and to counties that have the highest number of SCHIP and Medicaid enrollment in order to promote retention. The county allocations will 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 this reporting period, funding has not been distributed to the counties.

   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. In addition, for each successful Annual Eligibility Review form where a child(ren) continues to be eligible for SCHIP, the EE receives $50 instead of $25.

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

   The State determined that outreach through local community based organizations (i.e. EEs/CAAs) is important to reach the uninsured children and to promote program retention. These organizations (i.e. schools, faith-based organizations, social services agencies, health care provider communities, community clinics, etc.) create and establish relationships with families, promoting program awareness and providing assistance in applying for the programs. Past outreach efforts resulted in increased enrollment in the programs. After restoring the EE/CAA reimbursement process, the number of completed applications submitted significantly increased from 19% to 47.10% during the period of October 1, 2005 through July 31, 2006. As a result of EE/CAA assistance, 61.85% children who were enrolled in SCHIP (during the initial application process) obtained assistance from CAAs. In addition, the during the Annual Eligibility Review process, 12.67% of children continued to be eligible for SCHIP through the assistance of CAAs.

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

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

SUBSTITUTION OF COVERAGE (CROWD-OUT)

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

1. Does your state cover children between 200 and 250 percent of the FPL or does it identify a trigger mechanism or point at which a substitution prevention policy is instituted?

   ☒ Yes
   ☐ No
   ☐ N/A

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

   SCHIP does not maintain any trigger mechanisms. SCHIP precludes enrollment within 3 months of a child having employer-sponsored insurance (ESI).

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

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

   ☒ Yes
   ☐ No
   ☐ N/A

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

Under the provisions of the AB 495 SPA, Section 1.1, four counties are authorized to serve otherwise eligible children with incomes between 250-300% FPL, through their Healthy Kids Programs. These counties comply with the 3-month substitution coverage provision for ESI coverage. In addition, infants born to mothers who are enrolled in the California State AIM Program are automatically enrolled in SCHIP with coverage beginning on the infants' date of birth and may continue through age 2. These infants fall between 200% through 300% of the FPL. The infants are not subjected to any waiting period, since coverage begins on their date of birth.

All States must complete the following 3 questions

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

   The manner in which the State monitors and measures substitution of coverage has not changed since the inception of the program in 1998. Coverage substitution is monitored through the eligibility determination process and the collection of 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 coverage within the last 3 months. If the State receives this information, a formal ESI investigation is conducted.

   Children who received employer-based health coverage 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.

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

   During the period of October 1, 2005 through September 30, 2006, over 5.9% of the children were determined to be ineligible at the time of initial application, as a result of having other insurance coverage. Of the 5.9% that had other insurance coverage, 0.3% had employer-sponsored insurance and over 5.6% were receiving health coverage through the no-cost Medi-Cal programs. For those children who were disenrolled during the Annual Eligibility Review (AER) process, over 5% of the children were determined to be ineligible because they had other insurance coverage. Of the 5% who were disenrolled during the AER process, .02% obtained employer-sponsored insurance, while over 5.05% were disenrolled because they were enrolled in the no-cost Medi-Cal programs.

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

   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.

COORDINATION BETWEEN SCHIP AND MEDICAID

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

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

   The re-determination processes are similar; however, the re-determination process for Medicaid is separate from SCHIP. For Medicaid, each county welfare department mails a re-determination form to the applicant one month prior to the child's anniversary date. The form must be returned before the end of the annual re-determination month. If the child is found to be eligible for Medi-Cal, the child will continue to be enrolled in Medi-Cal for an additional twelve months. If the child is not eligible for Medi-Cal, 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 re-determination 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 resides in the home but is 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, offer 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 applicant is sent the appropriate disenrollment letter. All denial and disenrollment letters include a Program Review form to return to the program if the applicant disagrees with the adverse action.

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

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

   In the HFP, if a subscriber is determined ineligible due to income (being too low) at AER and the applicant has provided consent to forward to Medi-Cal, 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 HFP contacts the applicant to encourage him/her to re-consider Medi-Cal and to submit authorization to forward the AER application to the CWD. In these cases, coordination between the two programs and continuity of care are ensured by the State granting two additional months of HFP "bridge coverage" while the application is being processed for Medi-Cal eligibility or where the HFP is obtaining the applicant's consent to forward the AER application to the CWD.

   As part of the HFP bridge coverage, 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 HFP and Medi-Cal 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 Medi-Cal and may be eligible for the HFP, the transmittal sheet is returned to SCHIP. The

transmittal sheet is accompanied with the application and all documentation for a HFP determination.

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

   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.

ELIGIBILITY REDETERMINATION AND RETENTION

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

☒ Conducts follow-up with clients through caseworkers/outreach workers

☒ Sends renewal reminder notices to all families

- How many notices are sent to the family prior to disenrolling the child from the program? At least 3 notifications are sent to the 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?)
  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 30 days prior to due date, and a pending disenrollment letter is sent 15 days prior to the disenrollment date. The pending disenrollment letter includes a Continued Enrollment (CE) form that can be used to appeal the decision. If the CE form is received prior to the prospective disenrollment, coverage continues for an additional month or until the appeal is adjudicat

☐ Sends targeted mailings to selected populations

- Please specify population(s) (e.g., lower income eligibility groups)

☐ Holds information campaigns

☒ Provides a simplified reenrollment process,

Please describe efforts (e.g., reducing the length of the application, creating combined Medicaid/SCHIP application)

Customized, pre-printed re-enrollment forms are available in 10 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 languages.

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

Thirty days after children are disenrolled, telephone surveys are made to the families to learn

more about the specific reason why the coverage ended. If the families cannot be reached by telephone, then, disenrollment surveys are mailed to them.

☒ Other, *please explain*:

Effective July 1, 2006, the EE/CAA reimbursement increased the amount for each successful Annual Eligibility Review form where a child(ren) continues to be eligible for SCHIP. The EE receives $50 instead of $25.

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

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

3. 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?

   September 2006

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.

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
258,428	7,837	3			21,445	8				

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

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

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

California continues to use 2 surveys to assess the main reason why children disenroll from the HFP due to non-payment of premiums. The first survey is a post card that is mailed to every family after their child(ren)are disenrolled from the Program for non-payment of premiums. This survey includes questions about premiums and the cost of the Program. 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 the Program 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 Program. If the family indicates they will not be making the payment, the Program 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 HFP 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 Program because they cannot afford the cost of the monthly premium.

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

   The State has not conducted an assessment of the effect of cost sharing on utilization of health services. However, many services provided in the HFP 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 provide to children through the California Children's Services Program and the county mental health departments for children who are Seriously Emotionally Disturbed (SED).

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

   On July 1, 2005, the state increased monthly premiums up to $15 per child, with a maximum of $45 a month for families. Families who were subjected to the higher premium amount were those whose income was over 200% of the FPL. When the premium increase occurred, at that time, approximately 25% of existing families who had children enrolled in SCHIP were impacted by the higher premium. Families who were affected by the premium increase were sent notification about this change and given the opportunity to lower their premiums. The process to give families opportunities to lower their premiums continues to exist. When comparing the number of children who were disenrolled from SCHIP for non-payment of premiums before the premium increase with those children who were disenrolled after the premium increase, there was no significant impact on the number of children disenrolled because of the premium change. The percentage of children disenrolled for non-payment of premiums before the premium increase

was 24.39%. Whereas, during this reporting period, 23.44% of children were disenrolled from SCHIP as a result of non-payment after the premium increase went into effect. The State has not performed any assessments on the impacts of the premium change on the application and enrollment processes, as well as the utilization if SCHIP health services.

PREMIUM ASSISTANCE PROGRAM(S) UNDER SCHIP STATE PLAN

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

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

Children

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

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

Adults

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

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

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

   ☐ Parents and Caretaker Relatives
   ☐ Childless Adults

3. Briefly describe your program (including current status, progress, difficulties, etc.)

4. What benefit package does the program use?

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

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

_____ Number of adults ever-enrolled during the reporting period

_____ Number of children ever-enrolled during the reporting period

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

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

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

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

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

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

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

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

1. Does your state have a written plan that has safeguards and establishes methods and procedures for prevention, investigation and referral of cases of fraud and abuse? Please explain.
The State handles and reviews all issues related to fraud and abuse. The State does not rely on contractors to perform the fraud or abuse 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 an absent parent indicates that the child resides with the absent parent. 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.

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

a) Provider credentialing

Number of cases investigated 0

Number of cases referred to appropriate law enforcement officials 0

b) Provider billing

Number of cases investigated 0

Number of cases referred to appropriate law enforcement officials 0

c) Beneficiary eligibility

Number of cases investigated 8

Number of cases referred to appropriate law enforcement officials 8

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

Enter any Narrative text below.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

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

COST OF APPROVED SCHIP PLAN

Benefit Costs	**2006**	**2007**	**2008**
Insurance payments			
Managed Care	1,060,844,172	1,112,340,597	1242699074
per member/per month rate @ # of eligibles	90	88	93
Fee for Service	738,326,262	508,484,351	504,161,908
Total Benefit Costs	1,799,170,434	1,620,824,948	1,746,860,982
(Offsetting beneficiary cost sharing payments)	(67,369,084)	(70,836,053)	(75,682,720)
Net Benefit Costs	$ 1,731,801,350	$ 1,549,988,895	$ 1,671,178,262

Administration Costs			
Personnel			
General Administration	74,777,271	10,229,032	95,845,725
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	625,222	15,190,472	19,844,277
Other			
Health Services Initiatives			
Total Administration Costs	75,402,493	25,419,504	115,690,002
10% Administrative Cap (net benefit costs ÷ 9)	192,422,372	172,220,988	185,686,474

Federal Title XXI Share	1,174,682,498	1,024,015,459	1,161,464,372
State Share	632,521,345	551,392,940	625,403,892

TOTAL COSTS OF APPROVED SCHIP PLAN	1,807,203,843	1,575,408,399	1,786,868,264

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)

Enter any Narrative text below.

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

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

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

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

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

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

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

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

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**2006**	**2007**	**2008**	**2009**	**2010**
Benefit Costs for Demonstration Population #1 (e.g., children)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					
Fee for Service					
Total Benefit Costs for Waiver Population #1					
Benefit Costs for Demonstration Population #2 (e.g., parents)					
Insurance Payments					
Managed care					
per member/per month rate @ # of eligibles					

Fee for Service					
Total Benefit Costs for Waiver Population #2					

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

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

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

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

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

Administration Costs

Personnel					
General Administration					
Contractors/Brokers *(e.g., enrollment contractors)*					
Claims Processing					
Outreach/Marketing costs					
Other *(specify)*					
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)?

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

Other notes relevant to the budget:

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

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

   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 in the coming legislative year is ensuring Californians have access to affordable health care with particular emphasis on children.

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

   Having enrolled approximately 90% of the eligible population, MRMIB must work harder to reach the remaining uninsured population through further outreach efforts and streamlining of enrollment.

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

   ENROLLMENT

   The HFP is the largest SCHIP program in the country with 760,000 children enrolled, which is approximately 90% of the eligible children in California.

   Prenatal SPA: California received approval from CMS for the Prenatal SPA on March 28, 2006. The SPA allowed California to draw down Title XXI funds for Medi-Cal and the AIM programs for certain prenatal services as of July 1, 2004.

   HFP Administrative Vendor Quality Standards: California has enacted the highest quality performance standards in the nation on its administrative vendor, at a 98% accuracy level. Along with the existing administrative performance standards that require timely processing, the new quality standards assure the accuracy of the administrative services provided by the vendor.

   HFP Retention Increase: The HFP retention report for 2004 that was conducted in 2006 indicated increased retention rate for the HFP. The retention rate was 77% for the period of January-December 2004 which was about a 7% increase from the previous years (2001-69%; 2002-71%, and 2003-70%). This may be attributable to enhanced telephone follow-up requirements that were part of the new administrative vendor contract that was enacted in January 2004 and the outreach efforts by HFP plans and local community based organizations.

Enrollment Entity reimbursement incentive increase: On July 1, 2006 application assistance reimbursements were increased for successful Annual Eligibility Review Processes from $25 to $50 and successful electronic initial joint applications from $50 to $60.

QUALITY

Quality Performance Improvement Project: MRMIB applied a qualitative analysis of HEDIS scores in 2006 to review individual plan quality outcomes. MRMIB compared HEDIS 2004 scores with the HEDIS 2003 scores in the following four areas:

- Childhood Immunizations;
- Well Child Visits;
- Adolescent Well Care Visits; and
- Access to Primary Care Physicians,

MRMIB aggregated scores for these measures, adjusted scores for improvements or declines and established a total plan score. Plans identified as “high performing plans” were contacted to discuss strategies and best practices which allowed them to achieve higher scores. Plans identified as “low performing plans” were provided theses strategies and best practices. The “low performing plans” are required to develop a corrective action plan to improve program scores. The Quality Performance Improvement Project will continue on an annual basis. Other quality measurements may be added at a later date to the review process.

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 services and to assess the adequacy of coordination of services between health plans and counties.

Phase II and Phase III of the study will be conducted concurrently in 2007.

- 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.

Oral Health Demonstration Project (OHDP)-The OHDP is a 3 year project that ended December 2006. MRMIB implemented the OHDP through its existing network of dental and health plans. The Insurance-based OHDP created an opportunity to review, evaluate and improve policies and procedures affecting the delivery and accessibility of oral health services for young children. A total of twenty-one projects served as models for improving preventive oral health measures and treatment for children who historically have been underserved. The University of California, San Francisco (UCSF) was hired to evaluate the projects and has submitted a draft report that is currently being reviewed by MRMIB.

Six projects out of the original 21 projects were selected as models for improving preventive oral health measures and treatment for children who historically have been underserved. The projects agreed to provide best practices information including:

- Lessons learned by the project during its time of operation
- Work force issues
- Integration of medical and dental treatment
- Collaboration with partners
- Professional and consumer materials
- Methods of treatment including fluoride varnishes, sealants, xylitol
- Any policy issues identified by the projects
- Training in non- traditional settings and with special populations

- Methods used to deliver service to children with special needs

These best practices will be posted on the MRMIB website to communicate opportunities to improve preventive oral health measures and treatment for children.

Rural Health Demonstration Projects (RHDP): The Department of Health and Human Services approved a State Plan amendment for California in December 1999 that included RHDP. The RHDP was established to improve access to health care services for medically underserved and uninsured populations in rural areas and special populations who have rural occupations (farm workers, loggers, etc.) The projects are used to enhance services, extend clinic hours and hire additional providers. The projects provide a number of services, including:

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

OUTREACH

Certified Application Assistant (CAA) Online Web Based Training (WBT) (English/Spanish, Refresher WBT and # of CAAs trained): The existing online WBT for application assistance was expanded from English into Spanish on April 2006. In September 2006, MRMIB implemented a refresher WBT for CAAs that were interested in updating or reviewing their current program knowledge in both English and Spanish. To-date, MRMIB has trained approximately 1,500 CAAs statewide since the CAA WBT was implemented in February 2005.

COUNTIES

OERU County Allocation Grants: The July 2006 State Budget reinstated funding for the purpose of outreach, enrollment, retention and utilization. The funds are distributed through the California Department of Health Services to counties to support outreach activities by established community networks. The majority of funds are targeted towards the top twenty counties with eligible uninsured children and the smaller counties may apply for a set aside pool of funds from the larger counties.

AB 495 Counties: Under the provisions of the AB 495 SPA, Section 1.1, four counties are authorized to serve otherwise eligible children with incomes between 250 – 300% FPL. California began drawing down Title XXI funds for three of the AB 495 counties.

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

Enrollment Streamlining (alternate plan assignment and no initial premium requirement): California is streamlining the enrollment process by no longer requiring a premium payment with the initial application process and also is eliminating the requirement that the applicant select their plans at initial application. HFP will no longer deny application for being incomplete for these two reasons beginning in January 2007. If the child(ren) is eligible, HFP will bill the family the required subscriber contribution. If no plans are selected and HFP cannot get a selection from the applicant within twenty days, we will enroll the eligible child in the community provider health plan and alternately assign the dental and vision plan.

Health-e-App Public Access: California is partnering with two private philanthropic foundations to expand the access of the existing electronic application. Currently only approved county workers and 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 HFP/MC. Expanded access plus the system edits that prevent certain application errors is anticipated to improve the success rate for applications submitted electronically.

Presumptive Eligibility and Self-Certification: The State is scheduled to implement a SCHIP presumptive eligibility process to replace the Medi-Cal to HFP one-month bridge coverage. Currently, in the event a child who is enrolled in Medi-Cal no longer qualifies for the program, the child remains enrolled in Medi-Cal for one additional month until an SCHIP eligibility determination is made. The new process will replace the Medi-Cal one-month bridge coverage with SCHIP presumptive eligibility until the HFP conducts an eligibility determination. The new process will also establish self-certification of income during the SCHIP Annual Eligibility Review process, implement county pilot projects for Medi-Cal and establish an electronic gateway for the Women, Infants & Children (WIC) program.

HFP/MC Revised Joint Application: The long awaited revised joint application for HFP/MC will be implemented in the first quarter of 2007. 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 document for applicants.

HFP Open Enrollment (OE) Postcard Process: Less than 4% of HFP subscribers change plans during OE annually The HFP will be streamlining the open enrollment process in 2007 (April 15-May 31; with plan changes effective July 1). All subscribers will receive a postcard notification about OE and they can use that to request a customized OE packet to transfer plans.

QUALITY ENHANCEMENT

Quality Performance Improvement Project: MRMIB will continue, on an annual basis, to analyze HEDIS scores and monitor individual plan quality outcomes. The use of the high performing plans to provide strategies and best practices will also continue. The plans identified as “low performing plans” will be required to develop corrective action plans. Other quality measurements may be added at a later date to the review process.

Health Plan Contract Amendment: MRMIB amended the S-CHIP Health Plan contracts for the Budget Year beginning July 1, 2007 to reflect that MRMIB will evaluate each plan’s clinical quality measures annually. The amendment also states that MRMIB will take appropriate action if MRMIB determines that the contractor’s continued participation in the Healthy Families Program is not in the best interest of its subscribers.

OUTREACH

HFP Plan WBT: The online WBT for HFP plans that are approved to provide application assistance will be implemented in January 2007. While the training is similar to CAA training it is customized because of the statutory limitations on plan application assistance.

Enter any Narrative text below.