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Characteristics of SCHIP Eligibility and Enrollment Data Systems: Feasibility for Supporting Research on SCHIP

Final Report

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I. INTRODUCTION

More than 4.5 million children were enrolled in the State Children's Health Insurance Program (SCHIP) in fiscal year 2001. As enrollment in SCHIP increases and programs mature, research is focusing on such topics as enrollment and disenrollment rates, the impact of cost sharing on enrollment, the effectiveness of outreach, and barriers to enrollment and retention. As a result of congressional mandates to study these programs, national evaluations of SCHIP have been funded by the Centers for Medicare & Medicaid Services (CMS) and by the Office of the Assistant Secretary for Planning and Evaluation (ASPE). These studies are gathering information through a variety of data collection efforts, including surveys and focus groups and analysis of secondary administrative data files.

To determine the capabilities of state data systems to support primary data collection efforts and secondary data analysis, Mathematica Policy Research, Inc. (MPR) collected information on the characteristics of SCHIP and Medicaid eligibility and enrollment data systems from 23 states. Information was collected to determine whether state eligibility and enrollment data systems could support the construction of reliable sampling frames for beneficiary surveys and focus groups under the ASPE and CMS evaluations—for example, whether the data could identify specific subgroups, such as new enrollees, established enrollees with at least six to nine months of enrollment experience, and disenrollees. Information also was collected on whether the administrative data could support secondary data analysis of SCHIP enrollment patterns, retention and disenrollment rates, the impact of cost-sharing provisions on continuity of enrollment, and the reasons for denials and disenrollment from SCHIP.

This report presents information on the SCHIP and Medicaid eligibility and enrollment data systems from the 23 states that participated in a series of telephone interviews that occurred

between December 2000 and July 2001. The information collected in the interviews was used to develop state profiles, primarily to inform the ASPE and CMS evaluation teams in the selection of states for their respective studies.[1] While the profiles can provide useful background on the state data systems, there are some caveats that apply to their use. Specifically, the profiles reflect the characteristics of each state's data system(s) as of the time of the interview (or subsequent followup). Because SCHIP programs are evolving rapidly, the data systems may have changed since the time of the interview. In addition, the profiles reflect the knowledge of the particular state staff interviewed. Because different staff members use these systems for different purposes, knowledge and understanding are likely to differ across personnel.

Chapter II of this report discusses the methodology used to collect information on the state data systems, Chapter III provides a brief overview of the characteristics of the data systems, and Chapter IV contains the data system profiles for each of the 23 states.

[1] The 10 states included in the ASPE SCHIP evaluation are California, Colorado, Florida, Illinois, Louisiana, Missouri, New Jersey, New York, North Carolina, and Texas; the 8 states proposed for the CMS SCHIP evaluation are Georgia, Kansas, Kentucky, Maryland, Ohio, Oklahoma, Pennsylvania, and Utah.

II. METHODOLOGY

Information on state eligibility and enrollment data systems for SCHIP and Medicaid was collected through telephone conference calls with state policy and data systems staff between December 2000 and July 2001. Most interviews were conducted in late 2000 and early 2001. States were first contacted by mail and then by telephone, to elicit their participation. An advance letter, cosigned by ASPE and CMS, was sent to 25 states, addressed to the SCHIP contact listed in the American Public Human Services Association (APHSA) 2000 directory.[2] MPR staff then contacted the recipients of the letters by telephone and arranged for an interview with the appropriate staff. Twenty-three states participated in the interviews: Alabama, Arizona, California, Colorado, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Missouri, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Utah, and Virginia. Two states, Florida and Michigan, declined to participate in the interviews.[3] Of the 23 states interviewed, 4 have Medicaid expansion SCHIP programs (M-SCHIP), 9 have separate child health programs (S-SCHIP), and 10 have combination (COMBO) programs.

In 16 of the 23 states, MPR staff conducted one interview; the other 7 states involved multiple interviews to collect all the necessary information. The interviews followed a semi-structured interview guide and typically lasted between 60 and 90 minutes.

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[2] The 25 states were selected by ASPE; included were those with the largest absolute numbers of uninsured children. ASPE is mandated by Congress to base their evaluation on 10 states with a "significant portion of uncovered children."

[3] Michigan initially agreed to respond to a mail survey but later decided not to return the interview protocol.

The interviews collected information on the organization, structure, and content of SCHIP and Medicaid eligibility and enrollment data systems. Specifically, questions were designed to collect information on the structure of individual and family identification numbers, the availability of contact information, such as addresses and telephone numbers, historical enrollment information, reasons for denials and disenrollment at the individual level, and premium-payment histories. In addition, states were asked about recent and upcoming changes to their eligibility and enrollment data systems for SCHIP and Medicaid, current research using their SCHIP and Medicaid administrative files, and the availability and quality of encounter data from managed care plans that serve children in separate child heath programs.

The interviews focused on two types of data systems—those that determine initial eligibility for Medicaid and SCHIP, and those that store ongoing enrollment information. The system that determines eligibility for Medicaid passes information to a Medicaid enrollment data system, typically the state's Medicaid Management Information System (MMIS), which is used to pay providers. The two types of systems may contain different types of data. For example, information regarding the initial application and reasons for denials and disenrollment usually are stored only in the eligibility data system. And in some states, the MMIS is the only system in which historical enrollment information is available. Therefore, our discussion focuses on both types of systems.

Some SCHIP programs have adopted the existing systems used for Medicaid, while others have developed separate systems that determine eligibility and store enrollment history for SCHIP. To distinguish between systems for SCHIP versus Medicaid, the discussion often refers to the SCHIP eligibility system and the Medicaid/M-SCHIP eligibility system; frequently, a

reference to the Medicaid/M-SCHIP eligibility system refers to the larger statewide system used by other public assistance programs.[4]

MPR staff developed a profile of each state's eligibility and enrollment data systems based on information collected in the interviews. States were sent drafts of the data profile and were asked to provide comments or to clarify information discussed in the interviews.[5] The profiles were revised based on state comments. Most profiles were verified in early 2001; the last profile was verified in September 2001. The profiles are included as Chapter IV of this report.

[4] In many states, a single statewide eligibility system is used to determine eligibility for the Medicaid program (and M-SCHIP), as well as for other public assistance programs such as Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP).

[5] One state, Utah, did not respond with comments.

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III. OVERVIEW OF ELIGIBILITY AND ENROLLMENT DATA SYSTEMS FOR SCHIP AND MEDICAID

This chapter provides a brief overview of the data systems used to determine eligibility, and store historical enrollment data, for SCHIP and Medicaid in 23 states. The discussion focuses on selected characteristics of these data systems and the availability of certain types of data that may affect the ability to use the data to conduct research on SCHIP and Medicaid. Specifically, this chapter discusses the availability of:

- Identifying information, such as identification (ID) numbers, which allow the tracking of children when they transition between SCHIP and Medicaid or the linking of siblings within and across programs
- Enrollment histories, contact information, individual-level reasons for denials and disenrollments, and premium-payment histories
- Research-quality, individual-level managed care encounter data for children in separate child health programs

Tables 1 and 2 summarize the information collected. Table 1 presents counts of the number of state systems, overall and by program type, with each of the characteristics discussed in this chapter. Table 2 presents a state-by-state overview of these characteristics.

The counts in Table 1 represent all the state systems that have the specific characteristic or data element. In some cases, a state's data system may have the specific characteristic or data element, but only on a limited basis. For example, while most state systems contain core contact information—child's name, date of birth, name of parents, address, and phone number—some systems either do not include a phone number or do not update the phone number after the initial application. Because phone numbers can be critical to the fielding of beneficiary surveys and focus groups, data systems with this type of limitation are not included in the count for core contact data in Table 1 and the limitation is noted in Table 2.

TABLE 1

OVERVIEW OF CHARACTERISTICS OF SCHIP ELIGIBILITY AND ENROLLMENT DATA SYSTEMS IN 23 STATES, BY TYPE OF SCHIP PROGRAM

	Number of States with Characteristic			
		SCHIP Program Type		
Data characteristic	Total	M-SCHIP	S-SCHIP	Combination
Number of states interviewed	23	4	9	10
Single eligibility data system for SCHIP and Medicaid	13	4	5	4
System allows the:				
Tracking of individuals across SCHIP and Medicaid	17	4	7	7
Linking of siblings within programs	23	4	8	9
Linking of siblings across programs	15	4	7	4
System contains:				
Historical enrollment data	22	4	8	10
Core contact data	20	3	8	9
Individual-level reason for denial and disenrollment data	19	4	9	6
Premium payment data[a]	13 (out of 14)	1 (out of 1)	4 (out of 4)	8 (out of 9)
Individual-level managed care encounter data for S-SCHIP are available[b]	13 (out of 16)	n.a.	6 (out of 7)	7 (out of 9)

SOURCE: Interviews conducted by Mathematica Policy Research, Inc. with SCHIP and Medicaid representatives in late 2000 and early 2001.

NOTE: Core contact data include: name of child, date of birth, name of parents, address, and phone number.

M-SCHIP = Medicaid-expansion SCHIP
S-SCHIP = Separate child health program
Combination = Both M-SCHIP and S-SCHIP programs
n.a. = not applicable

[a]Total reflects number of states that charge premiums for SCHIP.

[b]Total reflects number of S-SCHIP states that have managed care delivery systems.

TABLE 2

CHARACTERISTICS OF 23 SCHIP ELIGIBILITY AND ENROLLMENT DATA SYSTEMS, BY STATE

State	Program Type	Single Eligibility Data System for SCHIP and Medicaid	Can Track Individuals Across SCHIP and Medicaid	Can Link Siblings Within Programs	Can Link Siblings Across Programs	Historical Enrollment Data	Core Contact Data	Individual-Level Data on Reasons for Denials and Disenrollment	Premium Payment Data	Individual-Level Managed Care Encounter Data for S-SCHIP
Alabama	COMBO	No	Limited[a]	Yes	No	Yes	Yes	Limited[b]	Yes	n.a.
Arizona	S-SCHIP	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
California	COMBO	No	Limited[a, c]	Yes[d]	No[c]	Yes	Yes	Limited[e]	Yes	No
Colorado	S-SCHIP	No[f]	Limited[a, f]	Yes[g]	No	Yes	Yes	Yes	Yes[h]	Yes[i]
Georgia	S-SCHIP	No[j]	Limited[a]	Yes[d]	No	Yes	Yes	Yes	Yes	n.a.
Illinois	COMBO	Yes	Yes	Yes	No	Yes[k]	Yes	Yes	Yes	Yes
Indiana	COMBO	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kansas	S-SCHIP	Yes	Yes	Yes	Yes	Yes[l]	Yes	Yes	Yes	Yes
Kentucky	COMBO	Yes	Yes	Yes[d]	Yes	Yes	Yes	Yes	n.a.	Yes
Louisiana	M-SCHIP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n.a.	n.a.
Maryland	COMBO	No	Yes	Yes	Yes	Yes	Yes	Yes[m]	Yes	Yes
Massachusetts	COMBO	Yes	Yes	Yes[d]	Yes	Yes	Yes	Yes	Yes	Yes
Missouri	M-SCHIP	Yes	Yes	Yes[d]	Yes	Yes	Limited[n]	Yes[o]	Yes[p]	n.a.
New Jersey	COMBO	No	Yes[a,q]	Yes	No	Yes	Limited[r]	Limited[s]	Yes	Yes
New York	COMBO	No	Limited[a]	Yes[t, d]	No	Yes	Yes	No	No	No
North Carolina	S-SCHIP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n.a.	n.a.
Ohio	M-SCHIP	Yes	Yes	Yes[d]	Yes	Yes	Yes	Yes	n.a.	n.a.
Oregon	S-SCHIP	Yes	Yes	Yes[d]	Yes	Yes	Yes	Yes	n.a.	Yes
Pennsylvania[u]	S-SCHIP	No	Yes	Yes	Yes	Limited[v]	Yes	Yes	n.a.	No
South Carolina	M-SCHIP	Yes	Yes	Yes	Yes	Yes	Yes[w]	Yes	n.a.	n.a.
Texas	COMBO	No	Limited[a]	Yes	No	Yes	Yes	Yes[o]	Yes	Yes
Utah	S-SCHIP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n.a.	Yes
Virginia	S-SCHIP	Yes	Yes	Yes[d]	Yes	Yes	Limited[x]	Yes	n.a.	Yes

SOURCE: Interviews conducted by Mathematica Policy Research, Inc. with SCHIP and Medicaid representatives in late 2000 and early 2001.

NOTE: Core contact data include: name of child, date of birth, name of parents, address, and phone number.

M-SCHIP = Medicaid-expansion SCHIP
S-SCHIP = Separate child health program
COMBO = M-SCHIP and S-SCHIP programs

TABLE 2 *(continued)*

n.a. = not applicable

[a]The S-SCHIP and Medicaid/M-SCHIP eligibility systems data can be linked by SSN, but only for S-SCHIP children who voluntarily report SSN.

[b]Reasons for denials for S-SCHIP are maintained in a free-text notes field.

[c]The state planned to implement a common ID system between Medicaid and SCHIP systems in 2001.

[d]Family members can be linked in the Medicaid system (and M-SCHIP, if applicable) only if they have the same case number.

[e]The Medicaid system does not have denial codes for all denied applicants, and only limited disenrollment codes for Medicaid.

[f]The state planned to introduce a common eligibility system, with a common ID system, in 2001; however, it will not be fully implemented for three years.

[g]Family members can be linked within the S-SCHIP eligibility system but not within the Medicaid system.

[h]Colorado stopped requiring premiums (and implemented an enrollment fee) in January 2001.

[i]Health plans began reporting individual-level encounter data in January 2001.

[j]S-SCHIP and Medicaid have separate eligibility systems, but the S-SCHIP system began maintaining eligibility data for mail-in Medicaid applicants in August 2000. The state hopes to introduce a new, joint eligibility system for S-SCHIP and Medicaid in late 2002.

[k]The eligibility system only stores current eligibility; however, the MMIS contains historical enrollment data.

[l]The eligibility system is a point-in-time system. Enrollment history is available in an enrollment system for S-SCHIP and in MMIS for Medicaid, these two systems can be linked by common ID.

[m]Reasons for denial and disenrollment data for S-SCHIP are stored at the case, not individual, level.

[n]The phone number on the system cannot be updated after the initial application.

[o]Reasons for disenrollment for Medicaid are at the case, not individual, level.

[p]Premium payment data for M-SCHIP enrollees with income from 225 to 300 percent of the federal poverty level are maintained by the managed care contractor, whose data can be linked to eligibility data by case number.

[q]The state combines records from these two systems (merging by SSN and other factors such as name and date of birth) in the MMIS.

TABLE 2 *(continued)*

[r]Phone number is available only for S-SCHIP children and M-SCHIP children who apply by mail.

[s]Reasons for denials and disenrollment are available for S-SCHIP and mail-in M-SCHIP applicants but are not available for Medicaid or M-SCHIP applications made in local offices.

[t]Siblings can be linked within S-SCHIP if they are enrolled in the same HMO.

[u]Pennsylvania implemented a new eligibility and enrollment data system for S-SCHIP in August 2001. Data in this table reflect the new system.

[v]Enrollment history data for S-SCHIP are available only back to the beginning of the new data system in August 2001.

[w]Phone number does not include the area code.

[x]The eligibility system does not maintain phone number.

The classification of a state's data system as limited in any particular characteristic or data element was based on whether: (1) the design of the system or data element would limit any effort to conduct a survey or focus group of SCHIP and Medicaid enrollees or conduct analyses of enrollment patterns, or (2) the information was not stored in a statewide system that is considered accessible to researchers. One limitation, for example, is the absence of common identification numbers (IDs) that can be used to identify children who transition between the S-SCHIP and Medicaid programs. In such cases, sampling frames or enrollment data drawn from both programs may contain more than one record for children who recently experienced a transition between programs and research studies could not easily track the number and characteristics of children who transfer between programs.

In order for data elements to be considered available and capable of supporting research on SCHIP and Medicaid enrollees, data had to be available at the state level. In a few states, while all the data elements represented in Tables 1 and 2 may be collected on all enrollees, they may not be maintained at the state level. In some cases, the data are maintained either by the counties or the health plans. Because obtaining data from counties and health plans is logistically difficult, requiring considerable resources, Tables 1 and 2 report these data as unavailable for research purposes.

A. STRUCTURE OF DATA SYSTEMS

Many studies may require data from both the SCHIP and the Medicaid program, in order to develop sampling frames for surveys or to conduct analyses of enrollment patterns in public insurance programs. Obviously, a single eligibility data system for SCHIP and Medicaid would facilitate this type of research. As shown in Table 1, 13 of the 23 states included in this study have a single eligibility data system for SCHIP and Medicaid. All four of the states with a Medicaid expansion SCHIP program have adopted the existing system used for Medicaid

eligibility—often part of a larger statewide public assistance eligibility system—to process SCHIP eligibility. Of the 19 states with separate child health programs (either S-SCHIP alone or in combination with an S-SCHIP program) 9 use the same eligibility system for SCHIP and Medicaid.[6]

Among the 10 states that use more than one eligibility data system, information for M-SCHIP applicants and enrollees is typically recorded in the system used for Medicaid, while S-SCHIP eligibility data are maintained in a separate system developed for the program. In a few states, however, the location of eligibility data depends on how or where a child applies for program coverage. For example, in New Jersey, eligibility data for children enrolled in M-SCHIP is stored in a contractor's data system, if the application was by mail, or in the system used for Medicaid eligibility, if application was made at a county human services office. Similarly, in Georgia, data for Medicaid enrollees are maintained on the S-SCHIP eligibility system, if application was made through the mail, rather than at a county welfare office. The state profiles in Chapter IV describe in greater detail the organization of the data systems and eligibility processes for SCHIP and Medicaid.

B. CONTENT OF DATA SYSTEMS

In order to develop sampling frames and examine enrollment and disenrollment over time, researchers may require certain key data elements from state data systems. This section discusses the availability of identifying information, historical enrollment data, contact data, denial and disenrollment data, and premium-payment data.

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[6] Two states, Colorado and Georgia, reported plans to develop a unified system for S-SCHIP and Medicaid. Colorado's will not be implemented until 2004, while Georgia expected its new single eligibility data system to be fully implemented by late 2002.

1. Identifying Information

a. Ability to Track Children Across SCHIP and Medicaid

Researchers studying enrollment patterns in SCHIP may want to track children who transition between SCHIP and Medicaid programs, to determine how many children disenrolling from one program gain coverage from another. In the 10 states with separate eligibility data systems for SCHIP and Medicaid, tracking children across programs will be facilitated by systems that share common, unique, and permanent ID numbers. In the 13 states that use the same eligibility system for SCHIP and Medicaid, tracking children between SCHIP and Medicaid will require a data element that identifies the eligibility group or program for each period of enrollment.

Three of the 10 states with separate eligibility systems for SCHIP and Medicaid (Arizona, Maryland, and Pennsylvania) have a common, unique ID that can be used to link children across these systems. In seven other states with separate systems (Alabama, California, Colorado, Georgia, New Jersey, New York, and Texas), the social security number (SSN) could be used to link SCHIP and Medicaid records. However, this approach is limited because the S-SCHIP programs in these states do not require parents to report the child's SSN.[7] Otherwise, records linkage would require matching records by other criteria, such as name, address, and date of birth. In New Jersey, the state combines records from the separate eligibility systems in the state's Medicaid Management Information System (MMIS), merging by SSN and other factors; thus, it should be possible to track children across programs using the MMIS.

[7] As of August 24, 2001, federal law allows states to require S-SCHIP enrollees to report SSN. Our interviews were conducted prior to this ruling.

In each of the 13 states with a single data system for SCHIP and Medicaid, children can be tracked across the programs according to "eligibility group" or "program of eligibility." Some state systems have separate records for each child for each period of enrollment in a specific eligibility group; other systems have a single record per child, which is made up of separate eligibility segments, each with a distinct eligibility group code. The layout of enrollment records is discussed in more detail in the section on historical enrollment data.

b. Ability to Link Siblings Within and Across Programs

Researchers conducting surveys of children enrolled in SCHIP (or Medicaid) may want to identify children who are in the same household (for example, to sample only one child per household). Alternatively, they may want to investigate whether there are differences in outcomes between families whose children are enrolled in one program, compared to families with children in multiple programs. Both types of research agendas require the identification and linkage of siblings, both within a program and across multiple programs.

As Tables 1 and 2 indicate, eligibility systems in all 23 states contain family-level, or case-level, IDs that can be used to identify family members within programs. However, a few caveats apply to using family IDs to link siblings within a program. Nine states reported that family members can be linked within Medicaid/M-SCHIP data systems only if they are on the same case number (see Table 2); in some systems, children in certain Medicaid eligibility categories—such as SSI—have their own case number which differs from the case number for other family members covered under other eligibility groups. In Colorado, only siblings enrolled in Colorado's S-SCHIP program, not Medicaid, can be linked, while in New York's S-SCHIP program siblings can be linked only if they are enrolled in the same health plan.

It is more difficult to link siblings across SCHIP and Medicaid programs than it is to link siblings within the programs. Siblings can be linked across S-SCHIP and Medicaid/M-SCHIP

using a common case ID in 15 of the 23 states. The inability to link siblings across programs is primarily due to differing case IDs used by S-SCHIP and Medicaid eligibility systems.

2. Historical Enrollment Data

To develop sampling frames of new enrollees, ongoing enrollees (such as those with six or more months of enrollment), and disenrollees, researchers will require information on a child's enrollment history. Similarly, secondary data analysis that examines enrollment patterns will require historical data that can be used to construct separate spells of enrollment within and across programs.

All but 1 of the 23 states included in this study have eligibility and enrollment data systems that contain historical enrollment data. The one state with a limited ability to provide historical data is Pennsylvania. Prior to August 2001, SCHIP data were maintained by health plans and were not available at a statewide level. The state implemented a centralized S-SCHIP data system in August 2001, that contains historical enrollment data from that point forward.

In Illinois and Kansas, historical enrollment data are available only in the state's MMIS, because the eligibility systems contain only current data. Most state data systems store data for at least three years. A few states archive eligibility records after a certain period of inactivity (such as three years), but this was not considered a limitation when the state reported that archived data were readily available.

States differ in the way their data systems store enrollment histories. As mentioned earlier, in some state systems, each child has a separate record for each period of enrollment in a specific eligibility group; determining a child's enrollment history will require combining multiple records. Other systems have a single eligibility record per child that contains a separate eligibility segment for each enrollment period. In addition, enrollment records vary in their construction: some records might have dates that define the beginning and end of each eligibility

period, while others might have a data element for each consecutive month that indicates whether a child was enrolled that month. The state profiles in Chapter IV provide more detail on the organization of historical enrollment data.

3. Contact Data

To conduct surveys and focus groups of SCHIP and Medicaid enrollees and disenrollees, researchers may rely on state data systems to provide core contact data for sample members. We define "core" contact data as the child's name and date of birth, and parents' names, address, and phone number.

Core contact data elements are available for SCHIP and Medicaid enrollees in 20 of the 23 states interviewed. The main limitation of the contact data among the remaining three states is the availability of phone numbers. For example, Virginia's eligibility system for SCHIP and Medicaid does not record phone numbers for enrollees. In New Jersey, the phone number for S-SCHIP enrollees and M-SCHIP enrollees who apply by mail is recorded on a contractor's system; but no phone number is recorded for enrollees who apply at a county Medicaid office. Missouri's single eligibility system does not allow phone numbers entered during the initial application process to be updated.

About half the states collect additional contact information beyond the core information that may be required for fielding a beneficiary survey or focus groups. Most states could give a general sense of the quality of the contact data, but few states were able to report more specific information, such as the percentage of records with a phone number or the percentage of enrollees that could be located for a previous survey effort. In general, states that updated contact information relatively frequently—such as those whose eligibility systems are shared with other programs with more frequent redeterminations (for example, the FSP and TANF) and those that mail out monthly eligibility cards—felt that their contact data were fairly accurate.

The state profiles in Chapter IV also include information on the availability of additional contact data, such as alternate phone numbers, the process of updating contact data, and the perceived quality of the contact data.

4. Denial and Disenrollment Data

Studies of enrollment patterns in SCHIP and Medicaid can be enriched by analyses of the reasons for disenrollment or denial. For example, researchers may want to distinguish between disenrollment due to: loss of eligibility; procedural requirements, such as failure to return a renewal form or inadequate documentation; and voluntary withdrawals from the program.

Of the 23 states interviewed, 19 have data systems that store reasons for denials and disenrollment at the individual level. All S-SCHIP-only and M-SCHIP-only states have systems that store these data. Only 6 of the 10 combination states have this capacity for both their M-SCHIP and S-SCHIP components. In 3 of the 19 states (Maryland, Missouri, and Texas), eligibility data systems record reasons for denials and disenrollment at the case level only, not at the individual level.

The types of limitations among these data elements vary. Reasons for denials and disenrollments in California and New Jersey are available only for S-SCHIP enrollees, because the county systems that process Medicaid and M-SCHIP eligibility do not report this information to the state. In Alabama, reasons for denial are stored only in a free-text case notes field for S-SCHIP enrollees, a format that typically is difficult to use for research purposes. In New York, these data are not available, because the health plans do not report them to a statewide system.

Most of the 19 state systems that contain reasons for denial and disenrollment have fairly comprehensive reason codes for denials and disenrollment. Almost all states have reason codes that can differentiate between denial or disenrollment due to loss of eligibility versus other

factors; however, some systems have one broad reason code (for example, "failure to comply") that does not differentiate between procedural reasons for denial or disenrollment and voluntary withdrawal. The state profiles identify the data systems that store denial and disenrollment data, list the reason codes recorded, and discuss any limitations reported by the state.

5. Premium Payment Data

In order to analyze how cost-sharing affects enrollment and retention in publicly financed insurance programs, researchers will require data on the amount and frequency of premium payments during enrollment in SCHIP. The information collected indicates that SCHIP programs in 14 of the 23 states charged premiums; 13 of these are S-SCHIP programs, and 1 is an M-SCHIP program (Missouri) that obtained a waiver to charge premiums to families with gross income above 225 percent of poverty.

Among the 14 SCHIP programs with premiums, 13 have data systems that store data on premium-payment history.[8] New York does not have premium-payment history data because these data are maintained by the individual health plans and are not submitted to a statewide system.

[8] One state, Colorado, eliminated premiums for its S-SCHIP program in September 2000, and instead began charging enrollment fees in January 2001; the system stores premium payment data prior to September 2000.

C. MANAGED CARE ENCOUNTER DATA FOR SEPARATE CHILD HEALTH PROGRAMS

Administrative claims and managed care encounter data may provide an important source of data for research studies pertaining to access and quality in SCHIP programs. However, the design of these studies will depend on the availability and quality of encounter data for Medicaid and SCHIP programs with managed care delivery systems. All health plans participating in Medicaid, including M-SCHIP, are required to submit encounter data to the CMS Medicaid Statistical Information System (MSIS), and CMS has been determining the completeness and quality of these data. Little is known, though, about whether states require health plans participating in S-SCHIP programs to also submit encounter data. The interviews offered the opportunity to ask states whether they require health plans to submit encounter data to a statewide system, and if so, the frequency with which plans report, the storage location of the data collected, and the perceived quality of the data submitted.

Of the 16 states in our sample that have S-SCHIP programs which use a managed care delivery system, 13 require participating health plans to submit encounter data records to a statewide system.[9] Seven of these states have combination programs; the other six implemented only a S-SCHIP program. The three states that provide care to S-SCHIP enrollees through managed care systems, but do not require health plans to report encounter data, are California, New York, and Pennsylvania.

Encounter data are reported to states at varying frequencies, ranging from daily to annually; but monthly is the most common reporting frequency. Most of the 13 states that require plans to

[9] SCHIP programs that delivered care through a Primary Care Case Management (PCCM) delivery system were considered fee-for-service delivery systems and information on the claims records collected from PCCM providers was not obtained.

report encounter data store the data in the state's MMIS. Only three states were able to comment on the quality of the managed care encounter data received from their health plans; two generally found the encounter data to be of good quality (Oregon and Indiana), while one found the data to be of poor quality (Utah).[10]

[10] Utah reported that it hoped that the implementation of a new MMIS would improve the quality of encounter data.

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IV. PROFILES OF STATE ELIGIBILITY AND ENROLLMENT DATA SYSTEMS FOR SCHIP AND MEDICAID

This chapter presents the individual profiles of the eligibility and enrollment data systems used for SCHIP and Medicaid for 23 states. Each profile is organized into five sections:

1. An overview of the structure of eligibility and enrollment data systems for SCHIP and Medicaid, as well as any recent or upcoming changes
2. A description of specific data elements stored in the systems, including identification numbers, data from the initial application, historical enrollment data, premium payment data, denials and disenrollment data, contact data, and managed care encounter data for S-SCHIP
3. A synopsis of state research based on eligibility and enrollment data, including external research and internal research and reports
4. A summary of the eligibility and enrollment data systems for SCHIP and Medicaid
5. The contact person for evaluation and/or data inquiries.

The profiles also include information on a number of related data issues that may aid researchers in designing studies—such as how to identify children who initially applied to a different program (for instance, children who applied to SCHIP but were screened and enrolled in Medicaid) and how to identify retroactive eligibility and presumptive eligibility. In addition, the profiles report how eligibility-redetermination dates are recorded and maintained, and whether the state's eligibility and enrollment data system automatically disenrolls children from a program and the conditions under which automatic disenrollment occurs. Where available, staff comments on the quality of data elements, and the ease with which states could generate files with enrollment and contact data from their data systems, are included as well.

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ALABAMA

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Alabama has a combination SCHIP program called ALL Kids. The M-SCHIP program (Phase I—Medicaid Expansion) covers children up to age 19 with incomes up to 100 percent of the federal poverty level (FPL) and who are not otherwise eligible for traditional Medicaid. The S-SCHIP program (Phase II—ALL Kids) covers children up to age 19 with incomes between 100 and 200 percent FPL. Medicaid and M-SCHIP are administered by the Alabama Medicaid Agency (AMA). The Alabama Department of Public Health (ADPH) oversees S-SCHIP and contracts with the State Employees Insurance Board (SEIB) to handle the eligibility determination component of the S-SCHIP.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

There is a joint application in Alabama for ALL Kids, poverty-related Medicaid, and the Alabama Child Caring Foundation, a charitable foundation of Blue Cross/Blue Shield (BC/BS) of Alabama. Applications can be mailed to any of the three programs.

For S-SCHIP, the SEIB uses three data systems to maintain data on eligibility and enrollment in ALL Kids: (1) a mainframe system, (2) an Application Tracking (AT) database (MS Access), and (3) a Pediatric Health History (PHH) database (MS Access). When an application is received at SEIB, information is entered into the AT database; however, eligibility determination for the S-SCHIP program is done manually by the enrollment worker. The worker first determines whether a child is eligible for Medicaid or M-SCHIP. If so, that application is delivered to the Medicaid office. Before finalizing eligibility for ALL Kids, the worker will also check to make sure that the child is not: enrolled in Medicaid, the child of a state employee, or covered by BC/BS. Workers access the Medicaid data system to check Medicaid eligibility.

Once an applicant is found eligible for ALL Kids, the case information is keyed into the SEIB mainframe system and into the PHH database (about 90 percent of enrollees have a completed health history in this database). At the time of enrollment, information on ALL Kids enrollees is transferred from the SEIB central processing unit to BC/BS, the administrative vendor for S-SCHIP, who then sends out an insurance card, along with benefit and provider information. The SEIB transmits enrollment data to BC/BS nightly.

For applications to M-SCHIP and Medicaid made in local offices, caseworkers enter the application information into a statewide online eligibility system called the Alabama Medicaid Application and Eligibility System (AMAES). If a child has applied to Medicaid/M-SCHIP, but appears eligible for S-SCHIP, the application is sent to the SEIB by

a caseworker, and the SEIB does an eligibility determination for S-SCHIP. The applicant will then receive a notice that his or her application has been forwarded.

AMAES is a mainframe VSAM system. It is separate from the Department of Human Resources (DHR) system, which determines eligibility for other Medicaid eligibility groups such as Section 1931, and for Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP). AMAES, however, maintains enrollment information for all Medicaid eligibility groups; the system receives nightly batches from DHR. AMAES sends nightly transmissions on eligibility in all Medicaid programs to the state's Medicaid Management Information System (MMIS). All fields necessary for claims payment are passed from AMAES to MMIS. AMAES also passes information about Medicaid disenrollees to the MMIS. The structures of the AMAES and the MMIS are similar. MMIS is maintained by EDS, the fiscal agent for Alabama Medicaid.

ADPH occasionally links S-SCHIP data from SEIB with M-SCHIP/Medicaid from AMAES for special projects, but this is not done regularly. Both systems maintain an SSN, although the SSN is not required for S-SCHIP enrollees in the SEIB. If the SSN is missing, a pseudo-number is assigned and the linking of data between the two systems is done by name and address. In addition, S-SCHIP staff at the SEIB collect M-SCHIP enrollment data from MMIS, in order for them to look at the SCHIP program overall.

C. CHANGES TO SYSTEMS

ADPH is in the process of developing a new, unified data system for S-SCHIP, to replace the three systems they now use (SEIB mainframe, PHH, and AT database). S-SCHIP was implemented in such a short time that the SEIB was picked to handle eligibility and enrollment because of their experience with state employees' information, and their experience authorizing and transmitting information to carriers and negotiating with carriers. It quickly became apparent, however, that the S-SCHIP program needed information not provided by the SEIB mainframe. In response, program staff developed two MS Access databases—the AT and the PHH—to supplement the information in the SEIB system. The AT database was originally designed to store data for another program administered by SEIB; over time, the database has evolved primarily through the use of the memo field to record more information on applicants.

ADPH has hired a consultant to look at all three S-SCHIP systems and plans to move them to one integrated system for the S-SCHIP program (an MS Sequel server database), by the end of 2001. The new unified S-SCHIP eligibility system will contain denial codes at the individual level, and will have the ability to link family members—features that the current systems lack. The new system will be maintained by ADPH.

AMA has made significant changes to the Medicaid data systems in recent years. Recent changes to MMIS include further definition of eligibility categories, the development of an M-SCHIP indicator, updates that allow for family planning waivers and continuous eligibility, and the storage of more data, such as third-party insurance information.

As a result of changes to MMIS, AMAES was enlarged and new fields were added. The AMAES now transmits information differently to MMIS. In the past, it sent the entire file of information to MMIS; now it sends an extract. AMAES was enhanced with the addition of an indicator for M-SCHIP and was updated to allow for continuous eligibility for children and a waiver for family planning.

Currently, DHR performs eligibility and enrollment for such Medicaid groups as 1931 and foster care, then transfers the information to the AMAES nightly. AMA would like to develop a system in which all SCHIP and Medicaid programs can use the same statewide online eligibility system that would support different application processes. The AMA would like to convert the AMAES system to a relational database.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

The three S-SCHIP systems (SEIB mainframe, PHH, and AT database) use the SSN as the individual identifier. For children without an SSN, they assign a pseudo ID number, but most applications have the child's SSN.

The AMAES assigns a unique permanent ID that is based on the SSN. The AMAES also assigns a Medicaid number to each new enrollee; but the Medicaid number could change over time, if the child has discontinuous enrollment.

2. Family-Level IDs

The PHH database is the only system in which it is possible to link family members within S-SCHIP. There is no family-level ID in the SEIB mainframe system. In the PHH database, there is a record for the head of the household with a unique ID that can be used to link family members.

It is possible to link siblings enrolled in Medicaid and M-SCHIP within AMAES. There is a family-level ID in AMAES, the "payee number," which is based on the SSN of the parent (or sponsor).

It is not possible to link family members between Medicaid/M-SCHIP and S-SCHIP. Siblings not enrolled in Medicaid/M-SCHIP might be listed in a family profile on the AMAES, but it is not possible to tell whether the siblings are enrolled in S-SCHIP, since there is no common ID across both systems.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Information from applications to S-SCHIP is maintained in three separate systems: the SEIB mainframe system, the AT database, and the PHH database. (However, the AT database is the only database that stores information on denied applications.) The table below indicates the relevant database(s) in which S-SCHIP information is stored.

Selected Data Elements—S-SCHIP	Comments
Date of application	Yes, in the AT (date application received)
Place of application	Yes, in the PHH (where family obtained the application and where they heard of the program)
Mode of application	n.a., all mail-in
Race/ethnicity	Yes, in PHH
Family composition	No
Family income	Yes, in the AT (type of income is also maintained in the AT, but in a memo, free-text field)
Assets	n.a.
Current/prior third party insurance	No (would only be noted as reason for denial)

n.a. = not applicable

In the new system for S-SCHIP, one data system will contain all the above information.

The following table refers to the AMAES eligibility system for Medicaid and M-SCHIP. Where data are also maintained in the MMIS, this is noted.

Selected Data Elements—M-SCHIP/Medicaid	Comments
Date of application	Yes (MMIS also)
Place of application	Yes[a]
Mode of application	Yes[a]
Race/ethnicity	Yes (MMIS also)
Family composition	Yes
Family income	Yes, gross income, type of income, and frequency
Assets	n.a.
Current/prior third party insurance	Yes, but not type of insurance

[a]The AMAES does not have a code that identifies the specific place of application, but it does have a code indicating whether the application was filed by mail or at DHR, ADPH, or an outstation location, such as a hospital. There are also codes showing the county of residence, the worker, and the worker's county.

n.a. = not applicable

2. Reason Codes for Denied Applications

All information on denied applications to S-SCHIP is stored in the AT database. However, reason codes for denials are stored in the memo field, which is a running narrative of application history at the individual level. Thus, it is not possible to summarize the reasons for denials for ALL Kids. Since this information is in narrative form, the staff at SEIB are not sure how consistent or reliable it is. (The planned new S-SCHIP system will store reason for denial as a data element.)

The table below refers only to the AMAES system for reasons for Medicaid denial; the MMIS system does not include the reasons for denial.

Selected Reasons for Denial—M-SCHIP/Medicaid	**Comments**
Income too high	Yes
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	n.a. for children
Current insurance	n.a.
Prior insurance within waiting period	n.a.
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes, categorized as "failure to provide information"
Withdrew application	Yes
Unknown	Yes, categorized as "unable to complete"

n.a. = not applicable

The AMA believes that the quality of the denial data in the AMAES is good. However, one code, "failure to provide information," is broad and does not distinguish between incomplete or missing information and failure to complete the application process.

3. Ability to Determine Initial Program of Application

The AMAES system can identify Medicaid/M-SCHIP enrollees who originally sent their application to S-SCHIP through the mail. However, the S-SCHIP systems (SEIB mainframe and AT database) cannot identify S-SCHIP enrollees whose applications were referred from Medicaid.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

The AMAES contains a data element that differentiates between M-SCHIP and other Medicaid eligibility groups. Otherwise, one distinguishes between M-SCHIP/Medicaid and S-SCHIP enrollment according to the database from which the child's record comes.

2. Historical Enrollment Data

The SEIB mainframe system can be used to track enrollment history in S-SCHIP. The information in the PHH file, however, is never updated once it has been entered from the initial application, and it cannot be used to track enrollment history. Similarly, once a child is enrolled, the AT system is not updated until renewal occurs, and the data in the system cannot be used to track enrollment history during the year.

The SEIB mainframe system uses begin and end dates to record eligibility in S-SCHIP. Children with discontinuous enrollment will have a begin date and a cancellation date, as well as a second begin date. There is no limit on the number of eligibility segments stored in the SEIB mainframe. If a child moves off and on the program, this information also is entered in the "change history file," a subsystem of the SEIB mainframe.

The SSN can be used to identify children over time within S-SCHIP. In addition to the current enrollment date, the SEIB system keeps an original enrollment date, which can be used to identify return enrollees to S-SCHIP.

The AMAES stores Medicaid/M-SCHIP enrollment data in monthly segments and keeps data up to 36 months. For each month a child is eligible, an "X" is placed in the segment for that month. M-SCHIP children are counted for the entire month of enrollment, even if enrollment starts on the 31st of the month. The date enrollment began (which is based on the date of application) is also specified. Data for new enrollees enter the AMAES in real time, since it is an online system. If a child disenrolls from M-SCHIP/Medicaid after the 20th of the month, the child will be recorded in AMAES as enrolled for the following month also (since the state must provide a 10-day notice before terminating enrollment). The AMAES records a date of termination.

The unique ID on the AMAES system (based on the SSN) can be used to identify return Medicaid enrollees. The Medicaid number on the system would not identify return enrollees, since individuals receive a new Medicaid number when they disenroll and then reenroll.

3. Identifying Retroactive Eligibility

The S-SCHIP program does not have retroactive eligibility. In the case of newborns, however, if application is made within 60 days of birth, the ALL Kids effective date will be the date of birth.

Medicaid/M-SCHIP enrollees can have up to three months of retroactive eligibility. Those who have retroactive coverage have monthly segments in the AMAES labeled as "retroactive." The period of retroactive coverage is also indicated in the system.

4. Premium Payment Information

The SEIB mainframe stores the amount and dates of premium payments. It is possible to identify late payments with these data. (The premium is $50 per year, and most enrollees have income low enough that they are not required to pay the premium.)

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

SCHIP and Medicaid provide 12 months of continuous eligibility. A joint renewal form was developed, starting with renewals due in June 2001.

The SEIB system does not contain a data element for renewal date for S-SCHIP. The system identifies children two months before their renewal date, based on the date of enrollment, and generates a file that is then sent to an outside vendor (Action in Mailing), which sends out a renewal form (to be mailed back to the SEIB). The new joint renewal form is not preprinted. (The old S-SCHIP renewal form was preprinted with such basic information as name, address, and contract number.) A letter accompanies the form which contains basic identifying information, instructions on completing the form, and the balance of any unpaid premium. ADPH is in the process of redesigning the ALL Kids computer system which will give the ability to preprint renewal forms with all pertinent information.

For M-SCHIP and Medicaid, there is an indicator on AMAES for continuous eligibility and a "review date" that shows the date of redetermination. The month of redetermination is entered by the caseworker at the time of initial eligibility determination. AMAES automatically identifies children ready for review and sends this information to the caseworker. The caseworker enters a new date into AMAES when redetermination is successfully completed.

2. Reasons for Disenrollment or Case Closure

Reasons for disenrollment from S-SCHIP are maintained in the SEIB mainframe system. The following table refers only to this system.

Selected Reasons for Disenrollment—S-SCHIP	**Comments**
Income too high	Yes
Income too low	Yes
Private insurance	Yes
Aged out	Yes
Failure to pay premium	Yes
Incomplete information on redetermination form	Yes, coded as a general "process" code
Failure to return redetermination form/did not reapply	Yes, coded as a general "process" code
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes, coded as a general "process" code
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes, coded as a general "process" code
Unknown	No

n.a. = not applicable

Staff reported that about 20 percent of denied cases were coded as the general "process" code.

The table below refers only to the AMAES system; reasons for disenrollment are not maintained in the MMIS.

Selected Reasons for Disenrollment—M-SCHIP/Medicaid	**Comments**
Income too high	Yes
Income too low	n.a.
Private insurance	n.a.
Aged out	n.a.
Failure to pay premium	n.a.
Incomplete information on redetermination form	Yes, coded as "failure to complete review"
Failure to return redetermination form/did not reapply	Yes, coded as "failure to complete review"
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes, coded as "failure to complete review"
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes, coded as "terminated at request"

n.a. = not applicable

AMA staff report that denial codes in the AMAES tend to be more specific than disenrollment codes, since the "failure to complete review' is such a broad category.

3. Identifying Transfers Between Medicaid and SCHIP

Children who transfer from S-SCHIP to Medicaid/M-SCHIP are not identified in the program's data systems. There is a disenrollment code of "income too low", but the system does not record any information about whether the case was referred to and enrolled in S-SCHIP. Definitively identifying transfers would require linking S-SCHIP records with Medicaid/M-SCHIP records in AMAES; however, linking is only possible for S-SCHIP enrollees who report their SSN.

Similarly, children who transfer from Medicaid/M-SCHIP to S-SCHIP cannot be identified in the AMAES, but there is a disenrollment code for too much income and a data element indicating the case was referred to S-SCHIP. The AMA receives a monthly report from the AMAES of children moving between Medicaid eligibility categories, including M-SCHIP, so children transferring between M-SCHIP and other Medicaid eligibility categories can be identified.

4. Identifying Disenrollment Prior to Redetermination

There is no redetermination date for S-SCHIP in the SEIB system. This date is determined by the enrollment date or the date of birth (for a child turning 19 years of age prior to the end of the 12 months of eligibility). There is a separate termination date in the system, that

can be compared with the expected redetermination date, based on the date of enrollment or age.

In the AMAES, the review date is overwritten when someone terminates from the program. To identify disenrollment from M-SCHIP/Medicaid at a time other than the scheduled redetermination date, the termination date could be compared to the expected redetermination date, based on the date of enrollment.

5. Automatic Disenrollment

The SEIB system automatically disenrolls children from S-SCHIP when they reach the age limit (19) or do not provide renewal information. The AMAES automatically disenrolls a child if the child reaches the age limit, does not complete a review, or moves to another Medicaid program. AMAES will also automatically terminate an enrollee who maintains a "failure to complete review" status for more than 90 days.

E. CONTACT DATA

1. Contact Information Collected in System

Contact information on S-SCHIP enrollees is maintained in three separate systems: the SEIB mainframe system, the AT database, and the PHH database. The table below indicates the relevant database(s) in which the information is stored.

Selected Contact Data—S-SCHIP	Comments
Name of parent/guardian(s)	AT (name of person who applied for child) and PHH
Phone number	AT and PHH
Zip code	SEIB, AT, and PHH
Alternate address or phone	AT (one extra phone number)
SSN	SEIB, AT, and PHH (if reported)[a]
Case identifiers other than SSN	PHH – head of household ID
SSNs of parents/adults in HH	AT, PHH, if reported
Primary language	No

[a]A pseudo number is assigned in the SEIB system if an SSN is not reported.

Contact data for M-SCHIP and Medicaid are stored in the AMAES and sometimes in the MMIS. The following table refers to the AMAES system, and the MMIS system when applicable.

Selected Contact Data—M-SCHIP/Medicaid	**Comments**
Name of parent/guardian(s)	Yes (also in MMIS)
Phone number	Yes
Zip code	Yes (also in MMIS)
Alternate address and phone	Yes
SSN	Yes (also in MMIS)
Case identifiers other than SSN	Yes (also in MMIS)
SSNs of parents/adults in HH	Yes (also in MMIS)[a]
Primary language	No

[a]The SSN is that of the primary parent. Typically this is the mother.

AMA is working to get all this contact information into the MMIS system as well. The next upgrade to AMAES will also include a language indicator.

2. Processes for Updating Contact Information

For S-SCHIP enrollees, contact information is updated at renewal or when SEIB receives information from the family or from BC/BS. If an enrollee loses their S-SCHIP (BC/BS) card and calls SEIB, the enrollment worker will also verify address information. (SEIB would then notify BC/BS of any changes.) Also, researchers at the University of Alabama at Birmingham (UAB) School of Public Health are conducting surveys of disenrollees; they provide any updated contact information to ADPH who then sends it to SEIB. (Staff noted that this does not happen often.)

SEIB does not currently track all S-SCHIP disenrollees, but they hope to do this in the future. They would like to have a disenrollment file. In a separate effort, ADPH has begun tracking S-SCHIP disenrollees whose renewal forms were returned by the postal service and those who did not respond at renewal.

Caseworkers make changes to contact information for Medicaid/M-SCHIP in the AMAES. Contact information is typically updated at renewal, when enrollees are sent forms and asked to re-supply all contact information. In addition, the AMAES system receives nightly batch updates from DHR and Social Security. Any new contact information is collected during follow-up for a child who has disenrolled from Medicaid/M-SCHIP, that would be noted by the caseworker in a hard copy case file, but would not be entered into the AMAES.

3. Quality of Contact Information

S-SCHIP staff did not know how many letters are returned as undeliverable at redetermination or how many cases are missing phone numbers in the AT or PHH.

4. Ability to Produce Files with Contact Information and Eligibility History

S-SCHIP staff reported that it would not be hard to produce a file with enrollment history and contact data for S-SCHIP enrollees. They already send a monthly file to UAB researchers (described below).

Staff reported that it would be very easy to produce a file with eligibility history and contact information on Medicaid/M-SCHIP enrollees from the AMAES.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Not applicable. The delivery system in Alabama S-SCHIP is all fee-for-service, and BC/BS maintains all claims data.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILTITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

The School of Public Health at the University of Alabama Birmingham (UAB) is surveying parents of disenrollees, new enrollees, and continuous enrollees (those with at least one successful renewal) in ALL Kids. The New Enrollee and Disenrollee Surveys have not included M-SCHIP enrollees up to this point. The Continuous Enrollee Survey includes an adolescent supplement for households with an adolescent enrolled in ALL Kids. A similar adolescent supplement is sent to M-SCHIP enrollees who have been on the program for more than one year (all M-SCHIP enrollees are adolescents).

UAB survey researchers receive address data for S-SCHIP children from SEIB. The disenrollee sample is extracted by SEIB 30 days after the cancellation date and sent to UAB. (For example, a report on February 1st will reflect children that canceled January 1st). Since it may be eight weeks before the family actually receives the survey and the child may have reenrolled by the time the survey arrives, UAB has started matching the list of disenrollees from SEIB against the BC/BS current enrollment file before the surveys are mailed. (For example, they will match a February 1st SEIB disenrollment report against an April 1st BC/BS current enrollment list.) This process helps them to avoid surveying children who reenroll shortly after disenrolling, because they have not completed the redetermination process on time. UAB reports that of the 6,200 surveys mailed, 83 were returned with undeliverable addresses.

UAB School of Public Health is conducting an analysis with Medicaid claims data, and has AMA permission to retrieve the contact information on M-SCHIP enrollees. This contact data is also used to administer the ALL Kids surveys. Other research using Alabama SCHIP data includes an Agency for Healthcare Research and Quality (AHRQ) grant to study access to care in S-SCHIP versus M-SCHIP programs in Alabama and Georgia.

AMA is working on the Serving Alabama Families Effectively (SAFE) program, funded by the Robert Wood Johnson Foundation (RWJF) as part of the RWJ Supporting Families After Welfare Reform grant project. Through the project, AMA is using denial and termination data to track enrollment and disenrollment problems.

B. INTERNAL REPORTS

As part of the National Academy for State Health Policy Enrollment/Retention SWAT Team, made up of representatives from seven states—Alabama, Arizona, California, Georgia, Iowa, New Jersey, and Utah—ADPH is analyzing renewal and retention issues. Activities include mapping each state's renewal processes, conducting focus groups in four states, and fielding telephone surveys in all states involved in the project. The goal of the project is to better understand renewal/retention rates in SCHIP programs and to develop strategies on how to retain all eligible children in SCHIP.

Staff report that the state has not done much analysis of M-SCHIP using the AMAES file. The MMIS M-SCHIP data are sent to the SEIB for analysis.

IV. DISCUSSION

Alabama uses different eligibility and enrollment data systems for S-SCHIP and M-SCHIP/Medicaid. The systems can be linked by SSN; however, the SSN is optional for S-SCHIP enrollees. S-SCHIP data are currently stored in three systems: one mainframe system, a database of application history, and a database for health history. The Pediatric Health History database is the only data source that links family members in S-SCHIP. Core contact data are maintained across these three systems; for example, the two separate databases record phone number, but only the mainframe eligibility system contains zip code. Individual-level data on reasons for denials from S-SCHIP are not available (these reasons are recorded in a running text field), but data on reasons for disenrollment from S-SCHIP are available.

The mainframe eligibility system for M-SCHIP/Medicaid, known as AMAES, contains individual-level data on denials and disenrollment, and contains core contact data that may also be updated as a result of contacts with other public assistance programs, such as TANF. The AMAES stores three years of eligibility data, and it is possible to link family members in the system. The eligibility system passes address data, but not phone number, to the state's MMIS.

Alabama is in the process of developing a unified eligibility data system for S-SCHIP, M-SCHIP, and traditional Medicaid. In this new system, it will be possible to link children and families across Medicaid and SCHIP programs, and the system will contain individual-level data on denials and disenrollment.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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ARIZONA

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Arizona has a separate child health program (S-SCHIP), called KidsCare, which covers children up to 200 percent of the federal poverty level (FPL). (Eligibility was raised from 150 percent FPL in September 1999.) S-SCHIP and Medicaid are administered by the Arizona Health Care Cost Containment System (AHCCCS).

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Arizona uses a number of statewide and state-operated automated eligibility and enrollment systems to determine eligibility for health coverage. Arizona's Department of Economic Security (DES) is responsible for determining Medicaid eligibility through a statewide system known as AZTECS. AZTECS is an automated eligibility system for Medicaid, the Food Stamp Program (FSP), Temporary Assistance for Needy Families (TANF), and a variety of state-run programs.

Eligibility for KidsCare, Arizona's S-SCHIP program, is processed in the KidsCare Eligibility Determination System (KEDS), a subsystem of the AHCCCS data system.

While the two systems are maintained separately, AZTECS and KEDS have a host-to-host link with the state's Medicaid Management Information System (MMIS), called the Prepaid Medical Management Information System (PMMIS), which allows them to interface nightly, updating information between the systems. There is a client ID number on AZTECS that is used to link Medicaid records to an AHCCCS ID and records on KEDS.

All data are stored in mainframe flat files.

C. CHANGES TO SYSTEMS

In the past few years, the most significant change to Arizona's eligibility and enrollment data systems was the implementation of the KEDS system in November 1998. Another important change took place in 1996, when DES implemented an automated eligibility system for the Medicaid program.

AHCCCS and DES are in the process of adopting a more interactive application system, similar to that used in California. They were to begin testing the system in late 2001, and the system will become operational in late 2003.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

Since the KEDS and the AZTECS system interface through the PMMIS, individuals in both S-SCHIP and Medicaid receive a unique, permanent AHCCCS ID. Once eligibility is established for Medicaid by AZTECS or for S-SCHIP by KEDS, this ID is assigned. The state also uses social security numbers (SSN) and the DES Client ID as alternate IDs.

2. Family-Level IDs

KEDS and AZTECS use a common case number. Each member of a family shares a case number that is unique across all programs. By using this case number, it is possible to link family members within and across programs.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

The following table refers to both S-SCHIP (KEDS) and Medicaid (AZTECS), unless otherwise noted.

Selected Data Elements	Comments
Date of application	Yes
Place of application	Yes, all applications are mail-in, but KEDS has a code for the place where the application was picked up
Mode of application	n.a. for S-SCHIP, all mail-in
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes, gross income and disregards
Assets	n.a. for S-SCHIP; Yes for Medicaid[a]
Current/prior third-party insurance	Yes

[a]Medicaid removed its asset test for children as of October 1, 2000. AZTECS stores information on assets required by DES for Medicaid eligibility prior to October 1, 2000.

n.a. = not applicable

2. Reason Codes for Denied Applications

The following table refers to both S-SCHIP (KEDS) and Medicaid (AZTECS), unless otherwise indicated.

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	Yes for S-SCHIP[a]; n.a. for Medicaid
Age	Yes
Immigration status	Yes
Assets	n.a. for S-SCHIP; Yes for Medicaid prior to 10/1/00
Current insurance	Yes
Prior insurance within waiting period	Yes, for S-SCHIP; n.a. for Medicaid
Did not complete face-to-face interview	n.a. for S-SCHIP; Yes for Medicaid
Did not pay enrollment fee	Yes, refers to premium for S-SCHIP; n.a. for Medicaid
Missing data/inadequate information on the application	n.a. (an eligibility worker would contact the family to obtain this information, rather than denying them)
Withdrew application	Yes
Other	No
Unknown	No

[a]This reason code is stored in KEDS, but the referral to Medicaid would be automatic.

n.a. = not applicable

3. Ability to Determine Initial Program of Application

More than 50 percent of the children who apply for S-SCHIP are immediately transferred to Medicaid for a Medicaid eligibility determination. After application, the KEDS system first enrolls the children in S-SCHIP. If, however, DES determines that the child is eligible for Medicaid during the nightly interface, AZTEC updates the KEDS system, overriding S-SCHIP enrollment with Medicaid enrollment. Conversely, if a child is denied Medicaid eligibility by DES because of income, the child is automatically enrolled in KidsCare if no premium is required (family income not exceeding 150 percent FPL). If income is 150 percent FPL or above, children are not approved for S-SCHIP until the family indicates they are willing to pay premiums. There is a data element on each system indicating which program the family first applied to.

This process is seamless for the family, although they receive a letter that informs them of the change in eligibility status, or about the premiums requirement under S-SCHIP. (The state reported that a few families who have been transferred automatically to Medicaid have chosen not to enroll.)

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

S-SCHIP and Medicaid have separate data systems. Program eligibility can be determined according to which data system the child's record is from.

2. Historical Enrollment Data

AZTECS has Medicaid records that date back to 1991; the S-SCHIP data in KEDS date back to the program's inception in 1998. Eligibility segments in KEDS have begin and end dates; eligibility segments remain open-ended for the duration of an individual's eligibility. Eligibility data are updated in the MMIS (PMMIS) as part of the nightly interface of KEDS and AZTECS with the system. The unique, permanent AHCCCS ID, used in both KEDS for S-SCHIP enrollees and in AZTECS for Medicaid enrollees, makes it possible to distinguish new enrollees from return enrollees.

3. Identifying Retroactive Eligibility

Not applicable for S-SCHIP. Medicaid retroactive coverage of 3 months is identified in AZTECS.

4. Premium Payment Information

A finance subsystem of KEDS, designed for KidsCare billing and collections, records monthly premium payment information for S-SCHIP, including the amount of the premium, date of the premium, and whether the premium is late or missed. Information on premiums dates back in the system to October 1999. Individuals can be in arrears for up to two months, at which time eligibility is automatically terminated.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

S-SCHIP uses a 12-month redetermination period; however, children who enter S-SCHIP via prior Medicaid enrollment have a 6-month redetermination period. Children in Medicaid have eligibility redetermined every 12 months, except for children in families that also receive food stamps or TANF, whose eligibility is redetermined every 6 months.

Once S-SCHIP eligibility is determined, workers build a "redetermination month" field into KEDS, 6 or 12 months from the date of eligibility. At the time of redetermination, the system produces mailing labels, so notices can be sent to recipients. The AZTECS system stores all data related to redetermination for Medicaid clients.

2. Reasons for Disenrollment or Case Closure

Entries in the following table refer to both S-SCHIP (KEDS) and Medicaid (AZTECS), except where noted.

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	Yes for S-SCHIP[a]; n.a. for Medicaid
Private insurance	Yes for S-SCHIP; n.a. for Medicaid
Aged out	Yes
Failure to pay premium	Yes for S-SCHIP; n.a. for Medicaid
Incomplete information on redetermination form	Yes
Failure to return redetermination form/did not reapply	Yes
Did not complete face-to-face interview	n.a. for S-SCHIP; Yes for Medicaid
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes
Unknown	No

[a]These children will be enrolled automatically in Medicaid.

n.a. = not applicable

AHCCCS staff reported that the denial data are of very good quality.

3. Identifying Transfers Between Medicaid and SCHIP

There is a reason code in KEDS indicating that an individual became ineligible for S-SCHIP and transferred to Medicaid, as well as a reason code in AZTECS indicating that a child transferred from Medicaid to S-SCHIP.

4. Identifying Disenrollment Prior to Redetermination

It is possible to identify individuals who disenroll from Medicaid and S-SCHIP before it is time for their redetermination, by comparing the date of disenrollment to the redetermination date in each system.

5. Automatic Disenrollment

The KEDS system does not automatically terminate children who reach the age limit of S-SCHIP, however, it will automatically terminate families who fail to pay premiums.

In AZTECS, there is an automatic termination process for Medicaid enrollees who do not keep appointments for applications or redeterminations, and for those who become ineligible due to age.

E. CONTACT DATA

1. Contact Information Collected in System

The following table refers to both S-SCHIP (KEDS) and Medicaid (AZTECS).

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes
Zip code	Yes
Alternate address or phone	Yes, there is a field for a second phone number
SSN	Yes
Case identifiers other than SSN	Yes
SSNs of parents/adults in HH	Yes, if reported
Primary language	Yes, English/Spanish/other

2. Processes for Updating Contact Information

Arizona has several methods for updating contact information. First, contact information is updated as a part of the redetermination process. Second, it can be updated by the child's family. Third, because AZTECS also handles the Food Stamp and TANF programs, it is possible to update the contact information through contacts for these programs. KEDS can access updated information in AZTECS as a part of the nightly interface. Finally, updated information can be gathered manually from the health plans. (AHCCCS staff reported that health plans forward this information on an ad hoc basis.)

3. Quality of Contact Information

The state tracks the quality of contact information, but it had no recent statistics. Nonetheless, the state believes that the contact information is of high quality.

4. Ability to Produce Files with Contact Information and Eligibility History

Staff reported that it would not be difficult to produce a file with contact information and eligibility history from either KEDS or AZTECS.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Encounter data for KidsCare are stored in an AHCCCS subsystem that holds encounter and claims data gathered from the health plans. Encounter data are not reported in a timely fashion. Because the health plans have a year in which to submit the data, there is often a lag. Despite the lag time, the state feels that the data are fairly good, since they are used to set rates in future time periods.

The AHCCCS is working on incorporating encounter data for the S-SCHIP program into a Quality Improvement Initiative.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

AHCCCS has a committee to study the Medicaid and S-SCHIP populations. The committee used data from the state's systems to conduct focus groups and surveys of enrollees, disenrollees, and reenrollees, looking at what causes people to stay or leave. The state also interviewed individuals who left Medicaid because their TANF benefits ran out. (A report is available from Vince Wood at DES, 602-542-3596.)

B. INTERNAL REPORTS

AHCCCS produces simple ad hoc reports from KEDS. For example, reports examine the number of applications and number of enrollees, broken out by characteristics such as age, ethnicity, and county. The reports also assess the percent of applications denied, premium billing rates, and enrollment by health plan. Finally, AHCCCS looks at the success of outreach organizations in enrolling individuals.

In addition, many reports are generated by the AZTECS system including reports on demographics, new approvals, denials, and terminations.

IV. DISCUSSION

Arizona maintains eligibility and enrollment data for Medicaid and S-SCHIP in two systems, KEDS for S-SCHIP and AZTECS for Medicaid. These systems are highly compatible, however, and share information through the state's MMIS system (PMMIS) in a nightly interface; they have a common ID, which can be used to link individuals and siblings across programs. The systems maintain individual-level data on reasons for denied applications and for disenrollment, and maintain data on enrollment history. Contact information is available from both systems. Contact data can be updated in several ways, including through contact with families for programs such as TANF and the FSP.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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CALIFORNIA

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

California has a combination SCHIP program consisting of the Healthy Families Program (S-SCHIP) and Medi-Cal (M-SCHIP). California's M-SCHIP program covers children ages 14 through 18 with family incomes up to 100 percent of the federal poverty level (FPL). The S-SCHIP program covers children up to age 19 with incomes up to 250 percent of FPL. Title XXI funds also are used to cover infants between 200 and 250 percent FPL in the Access to Infants and Mothers (AIM) Program.[1]

The Managed Risk Medical Insurance Board (MRMIB) oversees the Healthy Families Program (HFP). MRMIB is an independent government board that reports to a Governor-appointed executive board. In addition to HFP, MRMIB administers the AIM program and the Major Risk Medical Insurance Program (MRMIP). HFP is administered by a Healthy Families administrative vendor (HFAV) that is selected through a competitive procurement process. The Department of Health Services (DHS) administers Medi-Cal through welfare departments in 58 counties.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

California uses a joint application for HFP and Medi-Cal and allows applicants to mail in the application. All mail-in applications are scanned and key entered by the HFAV. The HFAV then does a primary income screen to determine if an applicant is eligible for "no cost" Medi-Cal or HFP. This is referred to as Single Point of Entry (SPE) logic. If an applicant appears to be eligible for Medi-Cal rather than HFP, the application is manually pulled and sent to the appropriate county. Prior to enrolling a child in HFP, HFAV workers reference the statewide Medi-Cal Eligibility Determination System (MEDS) to determine whether HFP applicant is enrolled Medi-Cal. The HFAV sends weekly eligibility and enrollment data for S-SCHIP enrollees to MRMIB. MRMIB maintains a statewide HFP database.

In California, the counties determine Medi-Cal eligibility using county-specific data systems. Counties submit daily eligibility updates to MEDS via "MEDS update transactions." (Counties have 45 days to complete eligibility determinations and most do not send information to MEDS until the determinations are complete.) DHS maintains MEDS, which is a subsystem of the state's Medicaid Management Information System

[1] AIM is for pregnant women and infants at 200 to 300 percent of FPL. A child must be born into AIM to qualify.

(MMIS) and is also used to maintain data for other programs, such as the Food Stamp Program (FSP) and Temporary Assistance for Needy Families (TANF).

S-SCHIP enrollment information is also reported to, and available on, the MEDS, through data exchanges between the HFP database and MEDS that occur nightly. Other public programs also use information on HFP enrollment in the MEDS to determine if children in their programs are eligible for Title XXI coverage.

One group of children may have dual-eligibility for HFP and Medi-Cal. As a child's family income increases above 133 percent FPL for children under 6 and 100 percent for children ages 6 to 18, the child is eligible for the "share of cost" (SOC) Medi-Cal program, in which families pay the share of cost difference between their income level and the maintenance need level of 86 percent FPL (for the parents) in months that they incur medical costs. (In 2000, this was approximately $200 per month.) California allows dual eligibility for children in the SOC Medi-Cal program and S-SCHIP. In such cases, Healthy Families is the primary payer, and Medi-Cal is the secondary payer, and the family is not subject to any cost-sharing requirements.

County caseworkers screen for S-SCHIP enrollment on MEDS to learn if an applicant for SOC Medi-Cal has S-SCHIP. For those who are dually-eligible, HFP is reported as "other health coverage" on the MEDS. There is a unique code that informs county staff and Medi-Cal providers that Healthy Families is the primary payer and Medi-Cal is the secondary payer.

The HFP database uses a mini-computer platform with a Sybase Data Base engine. MEDS is a mainframe system that uses VSAM and DB2 files.

C. CHANGES TO SYSTEMS

With the implementation of S-SCHIP in 1998, Medi-Cal developed an interface between MEDS and HFP. They also developed the "single point of entry" logic for screening for Healthy Families and Medi-Cal eligibility. California also developed an Integrated Voice Response (IVR) system in October 2000 for applicants and enrollees to check the status of their case.

HFP began a bidding process for an administrative vendor contract (the HFAV) in March 2001; as a result, their system may change dramatically. They would like to make processing more automated and improve the integration of the systems.

At the time of the interview, California was also pilot-testing an internet-based application, Health-E-App, for Healthy Families and Medi-Cal in San Diego County. The state planned to implement Health-E-App statewide in the Fall of 2001.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

Once a child is enrolled in Medi-Cal or HFP, the child receives a unique, permanent identifier called the Client Index Number (CIN). The CIN follows a child through periods of discontinuous enrollment and across programs. The HFP database and MEDS also record SSN when reported.

Future enhancements to MEDS will allow the single point of entry system to assign CINs to persons applying for both HFP and Medi-Cal. These CINs will link to the same family ID number used by HFP. The state hoped to have this feature in place by the end of 2001.

2. Family-Level IDs

The HFP database assigns a family ID that it is unique to HFP enrollees. MEDS assigns a case ID to all family members within a case and on Medi-Cal. However, family members do not always have the same case number in Medi-Cal. For example, if one family member is covered through the Supplemental Security Income (SSI) program, this individual would have a different case number than other family members. As a result, it is not possible to definitively link family members through case IDs. Currently, it is not possible to link family members across the MEDS and HFP systems; future enhancements to the MEDS may make this possible.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

The application information gathered by HFP for S-SCHIP is very different than that kept on MEDS for Medi-Cal.

Selected Data Elements—S-SCHIP	Comments
Date of application	Yes
Place of application	No
Mode of application	n.a., all HFP applications are mail-in[a]
Race/ethnicity	Yes
Family composition	Yes, relationship and number of people in household
Family income	Yes, gross income (earned and unearned income) and disregards
Assets	n.a.
Current/prior third party insurance	Yes, employer-sponsored insurance or 'other' health insurance

[a]If an applicant receives help from a Certified Applicant Assistant (CAA), HFP can identify which organization the CAA works for and trace the location of assistance.

n.a. = not applicable

HFP also collects application data on: citizenship, entry date into the US, if a child resides in a different home than the person filing the application, names of both parents and whether they are in the home, any children less than 21 in the household, anyone in the house needing Medi-Cal, and pregnant women in the household.

For Medi-Cal (Medicaid and M-SCHIP), most of the application information is kept at the county-level, and is not passed on to MEDS:

Selected Data Elements—Medicaid/M-SCHIP	Comments
Date of application	Yes[a]
Place of application	Yes, identifies county
Mode of application	No, kept at county level
Race/ethnicity	Yes
Family composition	No, kept at county level
Family income	No, kept at county level
Assets	n.a.
Current/prior third party insurance	Yes, on the Health Insurance System database, which is part of MEDS

[a]Date of application is currently captured for over 40 percent of Medi-Cal clients. By the end of 2001, this information should be maintained for all clients.

n.a. = not applicable

2. Reason Codes for Denied Applications

Denied applications to Healthy Families are maintained on the HFP system for 90 days and are then archived. There are a low percentage of unknown/other reasons for denial in the HFP data. HFP is refining denial codes to provide further detail on denials coded as "incomplete." If the missing data/inadequate information code is used, it means that follow-up happened, although the information remains inadequate.

Selected Reasons for Denial—S-SCHIP	**Comments**
Income too high	Yes
Income too low	Yes
Age	Yes
Immigration status	Yes, based on status after August 1996
Assets	n.a.
Current insurance	Yes
Prior insurance within waiting period	Yes
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes
Withdrew application	Yes
Unknown	Yes, but HFP tries to avoid use of this code

n.a. = not applicable

MEDS currently captures denial information for less than 50 percent of Medi-Cal applicants, because some counties do not report these data to the state. The state plans to have denial information on 100 percent of applicants by the end of 2001.

Selected Reasons for Denial—Medicaid/M-SCHIP	**Comments**
Income too high	Yes
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes, coded as "Failure to cooperate"
Withdrew application	Yes
Other	Yes

n.a. = not applicable

MEDS also contains denial information for the following reasons: death, individual moved out of state, living in a public non-medical institution, has Medicaid coverage from another state, and duplicate application.

3. Ability to Determine Initial Program of Application

Not applicable. Families make one application for all health coverage and do not apply to Medi-Cal or HFP specifically.

4. Identification of Presumptive Eligibility

Currently not applicable. Changes were underway to include presumptive eligibility based on the Single Point of Entry screening. These changes were planned for implementation by the end of 2001. Presumptive eligibility will be identified by a unique aid code on MEDS.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

Age and "aid" codes on MEDS are used to distinguish between M-SCHIP and traditional Medicaid. S-SCHIP enrollees are identified on MEDS by a unique eligibility code.

2. Historical Enrollment Data

The HFP database stores eligibility information from the beginning of the Healthy Families Program in July 1998. The database has a field showing the effective date of coverage that may be used to determine periods of enrollment. A child moving in and out of HFP will have multiple effective dates and disenrollment dates.

MEDS maintains online access to enrollment information for the current month and 15 prior months. Information beyond the 15 months is maintained in archived files. Individuals without enrollment in the past 16 months would still have a record on MEDS, indicating the date eligibility was terminated. Eligibility history is stored in monthly segments. A person enrolling in Medi-Cal, is given eligibility for the entire month and that is recorded as a monthly segment on the individual record. Children with continuous enrollment can be identified by aggregating monthly segments. DHS maintains the archived data.

The unique, permanent CIN makes it possible to identify returning enrollees in the HFP system and in MEDS. The CIN should follow children through periods of discontinuous enrollment.

Information on new enrollees in Healthy Families is available in the HFP data system the day after enrollment. The counties submit daily updates to MEDS either through an online entry system or through a file transfer protocol (FTP) from the county system. Depending on the method of submission, information will be available in MEDS the same day, the next day, or in two days.

3. Identifying Retroactive Eligibility

Healthy Families does not have retroactive eligibility. A monthly eligibility status code in MEDS indicates whether a particular month is covered through retroactive eligibility.

4. Premium Payment Information

The HFP database maintains detailed information on premiums: amount of premium, dates of payments, late payments, and missed payments.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

Healthy Families guarantees 12 months of continuous eligibility, and the system includes an element indicating the next redetermination date. When a child's coverage is renewed, the system automatically assigns a new date a year in the future.

Medi-Cal began 12-month continuous eligibility in January 2001. MEDS contains a redetermination month; however, the county offices handle redeterminations. Counties only tell MEDS when there is a change in status, so if a child is successfully redetermined, no information is sent to MEDS. MEDS continues individual monthly segments of eligibility until prompted to terminate a record.

2. Reasons for Disenrollment or Case Closure

In the HFP database, the disenrollment codes also make it possible to distinguish between disenrollment for procedural reasons (for example, incomplete information on form) from disenrollment due to ineligibility.

Selected Reasons for Disenrollment—S-SCHIP	**Comments**
Income too high	Yes
Income too low	Yes
Private insurance	Yes
Aged out	Yes
Failure to pay premium	Yes
Incomplete information on redetermination form	Yes
Failure to return redetermination form/did not reapply	Yes
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	No, coded as "other"
Decided not to reenroll	Coded as "failure to return form/did not reapply"
Unknown	Yes, "other"

n.a. = not applicable

Information on the reason for disenrollment from Medi-Cal is limited in the MEDS. The counties report reasons to MEDS, but the code values are used inconsistently across counties. Counties also sometimes use a general code "99".

Selected Reasons for Disenrollment—Medicaid/M-SCHIP	Comments
Income too high	No, coded as "does not meet eligibility requirements"
Income too low	n.a.
Private insurance	No, coded as, "does not meet eligibility requirements"
Aged out	No, coded as "does not meet eligibility requirements"
Failure to pay premium	n.a.
Incomplete information on redetermination form	Yes, "Failure to cooperate"
Failure to return redetermination form/did not reapply	Yes, "Failure to cooperate"
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes
Unknown	Yes

n.a. = not applicable

MEDS also contains disenrollment codes for the following reasons: alleged disability not substantiated, Medi-Cal eligibility reported under another ID, and resident of a public non-medical institution.

3. Identifying Transfers Between Medicaid and SCHIP

If children disenroll from HFP at redetermination due to low income and are potentially eligible for Medi-Cal, the disenrollment code on the HFP database will show that income was too low for HFP. The HFAV refers the case to the appropriate county but HFP does not track the outcome, so this code cannot be used to infer a transfer to Medi-Cal. (The state hoped to begin tracking these disenrollees by the end of 2001.)

It is possible to identify a transfer from Medi-Cal to Healthy Families, using the MEDS database. Children moving from Medi-Cal to HFP are eligible for a one month bridging program, which allows a child to continue on Medi-Cal until Healthy Families enrollment is in place. This bridging program is identifiable by an "aid" code in MEDS. (While there is no comparable bridging program for children who transfer from HFP to Medi-Cal, the state hoped to have one set up by the end of 2001.)

4. Identifying Disenrollment Prior to Redetermination

Both the HFP database and MEDS contain redetermination dates and termination dates. A difference between these two dates would indicate that a child disenrolled prior to redetermination.

5. Automatic Disenrollment

The HFP database will automatically disenroll children for aging out or failure to pay premiums. MEDS does not automatically disenroll children. The system sends the county worker a reevaluation alert when a child is aging out of an eligibility category such as poverty or M-SCHIP Medi-Cal.

E. CONTACT DATA

1. Contact Information Collected in System

Selected Contact Data—S-SCHIP	**Comments**
Name of parent/guardian(s)	Yes
Phone number	Yes
Zip code	Yes
Alternate address or phone	Yes, PO Box, street address, and the child's address if different from the guardian
SSN	Optional
Case identifiers other than SSN	Yes, CIN and Family ID
SSNs of parents/adults in HH	Optional
Primary language	Yes, language used for reading and speaking

Selected Contact Data—Medicaid/M-SCHIP	**Comments**
Name of parent/guardian(s)	Yes, only if the parent has also applied for Medi-Cal, cash assistance, or food stamps
Phone number	Yes, from some counties[a]
Zip code	Yes
Alternate address or phone	Yes, mailing and residence
SSN	Yes (an applicant has 60 days to obtain an SSN)
Case identifiers other than SSN	Yes, CIN and case ID
SSNs of parents/adults in HH	Yes, if parent also receives Medi-Cal, cash assistance, or food stamps
Primary language	Yes

[a]Counties are only recently required to report phone number data to the state.

Updates of information in MEDS on S-SCHIP enrollees include: address, SSN, CIN, and date of birth. Currently, these updates do not include phone numbers, but the state plans to change this by the end of 2001.

2. Processes for Updating Contact Information

HFP workers at the HFAV may access the HFP internal eligibility system at any time to update contact information. Information is updated at renewal or if the family calls to report a change. HFP sends update reminders whenever mailing out billing statements and letters, and recently helped the health plans create a change of address form to be distributed to families. When receiving returned mail, HFP uses USPS software to track new addresses. They also call old phone numbers to try and get forwarding information. HFP will attempt to contact families of children disenrolled for failure to pay premiums. Sometimes these contacts result in new contact information, which is then updated in the HFP database.

There is no formal process for updating contact information in the MEDS, except at redetermination. If a benefits card is returned as undeliverable, county case workers will follow up to determine a new address. The counties will send new information on addresses to MEDS as they receive it. MEDS has information for other programs such as food stamps and TANF, so address changes initiated by client contact for these programs are stored in MEDS. With the implementation of 12 months of continuous eligibility for Medi-Cal, there are no regular mailings, other than yearly redetermination notices, that would identify when a client has moved. At the state level, no effort is made to follow up with Medi-Cal children who disenroll. Follow-up by county staff varies from county to county.

3. Quality of Contact Information

Staff reported that almost all enrollees in HFP provide a phone or message number at the time of enrollment. HFP attempts to find correct address information using a variety of methods, and as a result, believes that the contact information is reliable.

As an example of the quality of the address information, state staff reported that 7 percent of benefit cards (40,929 out of 562,454) mailed to clients in May 2001 were returned as undeliverable.

4. Ability to Produce Files with Contact Information and Eligibility History

Developing a list of contact information based on enrollment periods would require extensive programming for both HFP and Medi-Cal. Because of resource issues in both programs, it would take a long time to fulfill such a request.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Healthy Families does not require health plans to submit encounter records because the data tend to be incomplete or inaccurate. Rather, they receive annual HEDIS indicators from the managed care plans. NCQA auditors review the HEDIS indicators, so the staff with whom we spoke were confident in the quality of the aggregate information.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

The benefit unit of Healthy Families hired a company to do a survey on applicant satisfaction. The unit also did a study of those disenrolling due to non-payment of premiums. The sampling frame and contact data for these projects came directly from the HFP database.

Health Management Associates is conducting focus groups of Medi-Cal recipients, funded by the State Department of Health Services. A local contractor has been hired to select the participants for the focus groups. The contractors do not use MEDS data for recruitment, but rather find Medi-Cal recipients through churches, schools, and community-based organizations.

The Medi-Cal Policy Institute also has conducted satisfaction surveys and surveys of low-income families not covered by Medi-Cal (http://medi-cal.org/). Through an Education and Outreach Contract, DHS conducted a survey that examined public awareness of the Medi-Cal program. (The contact is Kennilee Gable, 916-657-3030.)

B. INTERNAL REPORTS

Healthy Families posts internal, automated enrollment reports to the MRMIB web page (http://www.mrmib.ca.gov/). These reports examine enrollment by race, gender, and age, among other variables. The goal is to increase the number of reports available to the counties. Healthy Families staff have been happy with the HFP database and have found that it meets their research needs.

Medi-Cal has a number of internal reports available at http://www.dhs.ca.gov/mcss/. Staff felt that the MEDS data limits analysis because it does not have individual-level information on reasons for denial and disenrollment for a large majority of Medi-Cal enrollees. As noted above, the state expects that most counties will start reporting these data by the end of 2001.

IV. DISCUSSION

California has separate data systems for eligibility and enrollment in their S-SCHIP (Healthy Families) and M-SCHIP/Medicaid (Medi-Cal) programs. However, the two systems interact for the purposes of eligibility determination and share a common identifier. Also, the Medi-Cal data system, known as MEDS, contains enrollment information on S-SCHIP enrollees.

Individual-level information on denied applications and disenrollment from S-SCHIP is available in the Healthy Families data system. For M-SCHIP and Medicaid, eligibility is determined at the county level; reasons for denial are passed on from the counties to the statewide system for less than half of all denied applicants. Counties also report reasons for

disenrollment, but reason codes may be used inconsistently across counties. The state hopes to have a revised system in place—in which all counties send application denial information to MEDS—by the end of 2001.

Contact information for enrollees is available in both systems. Family members can be linked within the two programs, as long as all family members have the same case number. Currently, families cannot be linked across the programs, but the state hopes to implement a common case ID system between SCHIP and Medicaid/M-SCHIP by the end of 2001.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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COLORADO

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Colorado has a separate child health program (S-SCHIP) known as Child Health Plan Plus (CHP+) that covers children ages 0 through 18 with family incomes up to 185 percent of the federal poverty level (FPL). The Medicaid program in Colorado is called BabyCare/KidsCare. S-SCHIP and Medicaid are administered by the Colorado Department of Health Care Policy and Financing.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Applications for S-SCHIP and Medicaid can be delivered in person or mailed in to county Medicaid offices. Colorado uses a joint application, but applicants are encouraged to direct the applications to the program of choice. For example, Medicaid applications are most often sent to county Medicaid offices, and clients tend to mail in applications to a central SCHIP office.

Colorado currently operates separate eligibility/enrollment systems for S-SCHIP and Medicaid. For its Medicaid program, the state operates the statewide Client-Oriented Information Network (COIN). COIN also handles eligibility determination for Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP). Eligibility and enrollment data for S-SCHIP are maintained in the Eligibility Determination System (EDS). A contractor, Child Health Advocates, maintains EDS. The two systems do not share a common ID other than SSN, which is voluntary in S-SCHIP.

Eligibility for S-SCHIP is determined electronically in EDS. Because COIN is an antiquated system, Medicaid eligibility is determined electronically for some applications and manually for others. The state is currently developing a new system (described below) that will automatically compare eligibility in the two programs through monthly reconciliations to make sure individuals are not enrolled in both S-SCHIP and Medicaid.

If S-SCHIP applicants are determined ineligible for S-SCHIP, the state sends them a denial letter, and their application is forwarded to the county-based Medicaid eligibility offices. Similarly, if a Medicaid applicant is determined ineligible for Medicaid, they receive a denial letter, and the application is passed along to S-SCHIP staff for review.

EDS is a relational database, run on a Legacy System. COIN's records are stored as flat files.

C. CHANGES TO SYSTEMS

Colorado has made no major systems changes in the past few years. The only changes that have taken place have been the addition of several eligibility groups.

Over the next few years, Colorado will be adopting a single system, the Client Beneficiary Management System (CBMS), which will combine the existing EDS and COIN systems. The state began to use CBMS in 2001, but full implementation will take three years. CBMS will be maintained on a relational database and run on an Oracle System.

There is also an information technology (IT) initiative to create a SCHIP online enrollment and automated eligibility determination system. See **www.cchp.org** for further information.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

COIN and EDS do not contain common individual-level IDs. Each system uses its own unique, permanent ID. The SSN is the ID number for S-SCHIP enrollees in EDS; people who did not give their SSN are assigned another ID.

The state was anticipating that, beginning in March 2001, it would start using a permanent, unique ID number across S-SCHIP and Medicaid, as part of the implementation of the CBMS data system.

2. Family-Level IDs

EDS has family-level IDs, which allow siblings to be linked within S-SCHIP. There is no family-level ID in COIN. Siblings cannot currently be linked across S-SCHIP and Medicaid, nor can they be linked within Medicaid. The new CBMS system will contain family-level IDs that will make it possible to link siblings within and across the two programs.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Unless otherwise specified, the information in the table below applies to both the S-SCHIP (EDS) and Medicaid (COIN) data systems.

Selected Data Elements	Comments
Date of application	Yes
Place of application	Yes
Mode of application	Yes
Race/ethnicity	Yes (optional)
Family composition	Yes
Family income	Yes, earned income and total income
Assets	n.a. for S-SCHIP; Yes for Medicaid
Current/prior third-party insurance	Yes (but not the type of private insurance)

n.a. = not applicable

Information is also recorded on the language spoken and the special needs of the applicant.

2. Reason Codes for Denied Applications

Unless otherwise specified, the information in the table below applies to both S-SCHIP (EDS) and Medicaid (COIN) data systems.

Selected Reasons for Denial	Comments
Income too high	Yes[a]
Income too low	Yes for S-SCHIP[b]; n.a. for Medicaid
Age	Yes
Immigration status	Yes
Assets	n.a. for S-SCHIP; Yes for Medicaid
Current insurance	Yes
Prior insurance within waiting period	Yes
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	Yes for S-SCHIP; n.a. for Medicaid
Missing data/inadequate information on the application	Yes
Withdrew application	Yes
Unknown	Yes, coded as "other"

[a]COIN contains a text field where a worker can indicate that the applicant was referred to S-SCHIP.

[b]EDS has denial codes for "Medicaid eligible" and "1931 eligible" (family Medicaid).

n.a. = not applicable

Staff reported that Colorado's denial data for S-SCHIP in EDS are of good quality. In a recent review of more than 1,700 denied applications, only six were classified as "other." In COIN, records for denied applications contain only the name of the head of household, the county case number, and the reason code for denial.

3. Ability to Determine Initial Program of Application

In COIN, there is a text field where a worker can note that a Medicaid applicant was referred to S-SCHIP, but there is no record of whether the child actually enrolled in S-SCHIP.

In EDS, there is a denial code for "Medicaid-Eligible." There will sometimes be a record in EDS of whether or not an applicant referred to Medicaid actually enrolled in Medicaid. S-SCHIP sends a letter to the county with the referral, along with a form regarding the outcome of Medicaid enrollment. If the county returns this form to S-SCHIP, then the result of Medicaid enrollment is entered into EDS.

In a study conducted in August 1999, there were 494 S-SCHIP records sent to Medicaid. Of the 494, 138 were recorded as enrolled in Medicaid, 71 were eventually determined eligible for S-SCHIP, and 285 were not able to be located because the county did not return the form indicating the outcome of enrollment in Medicaid.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

Since Medicaid and S-SCHIP data are maintained in separate systems, program eligibility is determined by which database a record is from.

2. Historical Enrollment Data

EDS records S-SCHIP eligibility in 12-month eligibility spans, using begin and end dates. An individual's enrollment history can be traced back to the inception of Child Health Plan Plus in Colorado. COIN maintains eligibility in monthly segments, and enrollment history dates back up to five years.

EDS uses a Web-based interface that allows enrollment data to be entered in real time. COIN enrollment data are entered in overnight batches from county offices.

3. Identifying Retroactive Eligibility

In EDS, S-SCHIP eligibility is retroactive to the date of completed application; retroactive eligibility can be identified by comparing the date of enrollment with the date of application.

In COIN, it is possible to distinguish between the date of application and the date of retroactive eligibility for Medicaid.

4. Premium Payment Information

Families in S-SCHIP with income greater than 100 percent FPL were required to pay a state-subsidized premium for covered benefits until January 2001. At that time, Colorado dropped the premium requirement and adopted an enrollment fee. Additionally, a grace period for premium payments was in effect from September 2000 to December 2000. During the period in which premiums were required, EDS recorded information on the amount of the premium, as well as the date the premium was paid and whether any payments were late or missing. EDS will now maintain that information for enrollment fees.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

S-SCHIP offers 12 months of continuous eligibility. Children's Medicaid has a 12-month redetermination period, but eligibility is not guaranteed during that period.

Both COIN and EDS have data elements that indicate the month of redetermination. EDS sends notification to enrollees roughly 60 days prior to the date eligibility expires. Both systems also contain a field in which caseworkers enter a new date of redetermination when eligibility is renewed.

2. Reasons for Disenrollment or Case Closure

Unless otherwise specified, the information in the table below applies to both S-SCHIP (EDS) and Medicaid (COIN) data systems.

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	Yes for S-SCHIP; n.a. for Medicaid
Private insurance	Yes
Aged out	Yes
Failure to pay premium	Yes for S-SCHIP; n.a. for Medicaid
Incomplete information on redetermination form	Yes
Failure to return redetermination form/did not reapply	Yes
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes, coded as "other" or "non-resident"
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes, "voluntarily withdrew"
Unknown	Yes

n.a. = not applicable

Colorado staff reported that the quality of the disenrollment data in EDS and COIN is good.

3. Identifying Transfers Between Medicaid and SCHIP

COIN contains only a text entry in the case notes if a Medicaid disenrollee is referred to S-SCHIP. In EDS, there is a denial code for S-SCHIP of "Medicaid-Eligible," but, as discussed above, there may not be a record of whether the individual actually enrolled in Medicaid. (Staff noted that, beginning in July 2001, the EDS and COIN systems would be conducting monthly reconciliations to track enrollment across systems.)

Currently, identifying transfers between the programs would require linking the EDS and COIN systems; however, this would require linking by such characteristics as age and date of birth for S-SCHIP enrollees that do not report an SSN. Once the state has adopted the CBMS system, however, individuals will be provided with permanent, unique identification numbers across programs. It will be possible to identify transfers between S-SCHIP and Medicaid in this system.

4. Identifying Disenrollment Prior to Redetermination

Disenrollment prior to redetermination can be identified in both EDS and COIN by comparing the date of disenrollment to the date of redetermination.

5. Automatic Disenrollment

EDS automatically disenrolls S-SCHIP children when they age out of the program. COIN does not automatically disenroll persons from Medicaid for any reason.

E. CONTACT DATA

1. Contact Information Collected in System

Unless otherwise specified, the information in the table below applies to both the S-SCHIP (EDS) and Medicaid (COIN) data systems.

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes
Zip code	Yes, mailing address and street address
Alternate address or phone	Yes, daytime and emergency numbers
SSN	Optional for S-SCHIP[a]; Yes for Medicaid
Case identifiers other than SSN	Yes[a]
SSNs of parents/adults in HH	Yes
Primary language	Yes

[a]The SSN was the ID number for S-SCHIP enrollees in EDS (until March 2001). At that time, they started using another unique ID. This unique ID will allow Medicaid and S-SCHIP records to be linked.

2. Processes for Updating Contact Information

S-SCHIP sends out member newsletters on a quarterly basis. This provides the state with a reasonably good sense of the quality of address information, since the USPS will alert the state if the address has changed. The state also receives information at the time of redetermination from families—they do not have preprinted forms, and the families must report all information. Finally, updated contact information is sometimes provided by the managed care plans. All contact information is updated in EDS by S-SCHIP workers.

For Medicaid, contact information in COIN is updated when it is reported by the enrollee at redetermination or between redeterminations. Also, since COIN maintains eligibility for the FSP and TANF, new contact information may be obtained through 6-month redeterminations for those programs.

3. Quality of Contact Information

Colorado feels that the S-SCHIP contact information is "good" but is unsure about the quality of the Medicaid contact information.

4. Ability to Produce Files with Contact Information and Eligibility History

State staff reported that it would be easy to produce a file containing contact information and eligibility history for S-SCHIP enrollees from EDS. It would be possible, though time-consuming, to produce a similar file for Medicaid enrollees from COIN.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Beginning in January 2001, encounter data are to be reported for S-SCHIP. The data will be reported annually, but the state was unsure at the time of the interview what system would hold the data. Information will be provided to a contracted actuary for analysis.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

Colorado has conducted several satisfaction and disenrollment surveys for S-SCHIP, using contact information from EDS through June 2001.

B. INTERNAL REPORTS

Colorado uses data in EDS to generate monthly reports, looking at such measures as the number of applications, where they were made, reasons for approval/denial, Medicaid referrals, renewals, and enrollment by race/ethnicity. The state noted that EDS is limited by the fact that Colorado's S-SCHIP plan has been in operation only for a short period of time.

IV. DISCUSSION

Eligibility and enrollment data for S-SCHIP and Medicaid in Colorado currently are maintained in two separate systems. Prior to March 2001, these systems did not share a common identifier other than SSN, which is not required in the S-SCHIP system. The S-SCHIP data system (EDS) contains relatively comprehensive data, including individual-level data on denials and disenrollment and historical enrollment data. Families can be linked within S-SCHIP, and the system contains core contact data.

Colorado's Medicaid data system (COIN) contains some of the same data as EDS. It is an antiquated system, however. It contains individual level data on denials and disenrollment, and core contact data but does not contain family-level IDs.

Colorado is in the process of implementing a single eligibility system for S-SCHIP and Medicaid, called the Client Beneficiary Management System (CBMS). The system will assign a common ID across Medicaid and S-SCHIP that will allow tracking of enrollment between the two systems. Implementation was to begin in early 2001, but it will not be fully operational for three years.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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GEORGIA

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Georgia has a separate child health program (S-SCHIP) called PeachCare, which covers children with family incomes up to 235 percent of the federal poverty level (FPL). (The income level for PeachCare rose from 200 to 235 percent in July 2000.) The Georgia Department of Community Health (DCH) oversees PeachCare and Medicaid through its Division of Medical Assistance (DMA). PeachCare uses a third-party administrator (TPA) contractor, Dental Health Administrative and Consulting Services (DHACS), to determine eligibility and administer PeachCare cases. DMA also oversees Medicaid, but Medicaid eligibility is administered in local offices by the Division of Family and Children Services (DFCS), a division of the Department of Human Resources (DHR).

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

PeachCare and Medicaid use a joint application. PeachCare applications are mailed to a post office box in Atlanta and forwarded to DHACS, the PeachCare contractor, in Illinois, for processing. PeachCare eligibility is determined using a data system at DHACS.

Approximately 25 percent of PeachCare applications are filed by applicants who appear to be eligible for Medicaid. In the past, DHACS referred such applicants to a centralized team of state workers who determined Medicaid eligibility. The workers then forwarded enrolled cases to the county DFCS offices for reviews and ongoing maintenance. In August 2000, DHACS began maintaining eligibility and enrollment information for the Medicaid enrollees that originally applied to PeachCare. DHACS refers applications who appear to be eligible for Medicaid to centralized state workers for eligibility determination; after determination, however, all records are sent back to DHACS for maintenance. DHACS also coordinates the six-month renewals for these enrollees by sending redetermination information to the centralized state Medicaid staff for review.

Medicaid applicants who apply in a local DFCS county office have their eligibility determined by caseworkers using SUCCESS (System Uniform Calculation Consolidation Economic Support Services), the state system that also determines eligibility for Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP). DFCS administers SUCCESS.

Both DFCS and DHACS send enrollment information to the state's Medicaid Management Information System (MMIS), which is maintained by DMA. DFCS and DHACS (beginning in April 2001) send information for all eligibles to the MMIS on a nightly basis. Medicaid enrollees who originally applied for PeachCare have their information added directly to MMIS by centralized state workers, who determine the enrollees' eligibility. The eligibility information on the MMIS resides in separate files, based on whether a child applied through

the mail or at a local Medicaid office. One eligibility file contains PeachCare eligibles and Medicaid enrollees who originally applied for PeachCare through the mail; the second file contains those that applied for Medicaid at the county office. The two files are not linked.

EDS, the contractor for SUCCESS, merges selected information from DHACS and SUCCESS for the purpose of case management and claims payments. This merged file sits on the MMIS and contains basic information, such as name, date of birth (DOB) and SSN but it has no detailed eligibility information.

To ensure that there is no dual enrollment in Medicaid and SCHIP, the state does a monthly match between MMIS and DHACS data using first name, last name, SSN, and DOB (although some of the match fields, particularly SSN, are not always filled). If an applicant is dually enrolled, the accounts are merged and cross-referenced, and the PeachCare account is closed.

In addition to the DHACS system, SUCCESS, and MMIS, Georgia uses a Decision Support System (DSS) designed by MEDSTAT. The DSS contains merged information for PeachCare and Medicaid enrollees; however, the information is limited to fields relevant for claims analysis.

C. CHANGES TO SYSTEMS

On April 1, 2001, after receiving approval from the governor, PeachCare began to cover children the month that they applied. In the past, coverage did not begin until the month after a child applied.

DHACS has also implemented an internet-based application through the PeachCare website (www.peachcare.org).

Georgia is also hoping to design a new eligibility system that will enable linking of family members and that will create a unique ID to be used for both PeachCare and Medicaid enrollees. Any system changes that link children will not happen prior to implementation of the new MMIS, which was being procured in late 2000. The goal is for the new system to be operational by October 2002. Ultimately, the new system will manage all state health programs, including Medicaid, PeachCare, the state health benefit plan, and the Board of Regents.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

The DHACS system generates a unique, permanent ID for PeachCare children, while SUCCESS generates a unique, permanent ID for all Medicaid children. There is no common ID between the DHACS system and the SUCCESS, except for the SSN, which is optional for S-SCHIP enrollees.

2. Family-Level IDs

In the DHACS system, a "family account number" links members of a family. This ID number has all children listed in DHACS, regardless of the program for which the children qualify.

There is a case ID on SUCCESS that identifies all siblings on Medicaid within the same case. However, a case may not include all those within a family; for example, a family member on Supplemental Security Income (SSI) might receive a different case number.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

The following table refers to data for S-SCHIP (PeachCare) and Medicaid enrollees who originally applied to PeachCare through DHACS. The state did not provide this information about the SUCCESS system for Medicaid enrollees who apply through the counties.

Selected Data Elements—DHACS	Comments
Date of application	Yes, date signed and date received
Place of application	n.a., all are mail-in
Mode of application	n.a.
Race/ethnicity	Yes
Family composition	Yes, parent, step parent, and other
Family income	Yes, maintains gross income information
Assets	n.a.
Current/prior third party insurance	Yes, maintains information on policy numbers for other insurance held by Medicaid enrollees

n.a. = not applicable

In addition to entering into their data system information from each application, DHACS scans each application and saves it as an electronic image.

2. Reason Codes for Denied Applications

The following table refers to the DHACS system for S-SCHIP and Medicaid enrollees who originally applied to PeachCare.

Selected Reasons for Denial—DHACS	Comments
Income too high	Yes
Income too low	Yes
Age	Yes
Immigration status	Yes[a]
Assets	n.a.
Current insurance	Yes[b]
Prior insurance within waiting period	Yes
Did not complete in-person interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	No[c]
Withdrew application	Yes, "cancelled application' (application status code)

[a]Georgia allows self-declaration of citizenship.

[b]The state reports that "current insurance" is the most frequent denial code for SCHIP.

[c]Children who do not provide complete information on their application are put into a "pending status" for up to two months. If the needed information is not supplied, the children move to "suspended status," where they reside indefinitely; they are not sent to MMIS. It is possible to see why a person is in a pending status in the DHACS system, but there will not be a denial code, since the child is not officially denied eligibility.

n.a. = not applicable

PeachCare staff could not comment on the quality of the DHACS denial data.

State staff did not report the reason codes for denials for Medicaid recipients, which are stored in the SUCCESS system. They did report, however, that the Quality Control unit does a verification to ensure that all Medicaid denials are proper.

3. Ability to Determine Initial Program of Application

It is possible to infer that those Medicaid enrollees with information maintained on the DHACS system initially applied for S-SCHIP; however, none of the other Georgia systems have the ability to determine the initial program of application.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

The Medicaid enrollees maintained on the DHACS system are distinguished from PeachCare children by differences in the participant ID. Medicaid children who apply through the county office also have a different type of participant ID. This number identifies both the child and the program.

DHACS generates the participant ID for all enrollees it manages. In creating the ID, the system uses the available SSN or creates a dummy SSN if necessary. Medicaid enrollees on the DHACS system have a 13-digit ID: 10 numeric digits followed by a "C" and a two-digit number. PeachCare enrollees receive a 10-character participant ID—9 digits with a "Z" suffix. A child moving between Medicaid and SCHIP receives a new participant ID.

Medicaid enrollees who apply through the county office receive a 10-character participant ID from the SUCCESS system. These IDs typically have a "P," "S," or "K" suffix, plus nine randomly generated numbers in place of the SSN. (DFCS collects the SSN for Medicaid enrollees, although this field is not reliably filled.)

2. Historical Enrollment Data

The DHACS system stores eligibility information by monthly segments. It contains data dating to the implementation of PeachCare in September 1998. Eligibility begins during the month in which a completed application (including verifications) is received. If a family submits an incomplete application, the family has 45 days in which to provide all necessary information; once they are determined eligible, they will receive coverage in the original month of application.

MMIS records eligibility in monthly segments so that one year of continuous eligibility equals 12 segments; MMIS maintains eligibility history for up to 3 years. The merged claims file on MMIS also provides a way to examine eligibility history. The person-level data show claims paid over time. For every month of enrollment, a PeachCare or Medicaid enrollee has a case management payment; this payment variable could be used to track enrollment.

The unique ID in the DHACS system makes it possible to distinguish new enrollees from return enrollees. Also, the PeachCare application asks the applicant to identify whether he or she is reapplying for PeachCare; this data element is stored in the system. The unique ID in SUCCESS makes it possible to identify return enrollees within Medicaid.

3. Identifying Retroactive Eligibility

PeachCare does not have retroactive eligibility. Retroactive coverage for Medicaid could be identified by comparing the application date with the enrollment date.

4. Premium Payment Information

The DHACS database maintains data on the premium amount and the dates of payments for PeachCare. Each monthly premium is due by the end of the preceding month. For example, coverage for the month of January must be paid for by the end of December. If a PeachCare enrollee is cancelled for nonpayment of premium and then wishes to reenroll, the family has to pay only for the month of reinstatement, not for the current or previous months. When a payment arrives late, the child is cancelled for the next month, but coverage is never cancelled in the middle of the month. For example, enrollees that pay too late in January are cancelled in February. If the payment is then received at the beginning of February, enrollees will automatically be reinstated for March.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

PeachCare has yearly "passive renewal." Thirty days prior to the redetermination date, DHACS mails a letter to enrollees, informing them that they must contact the program only if there is a change in their personal information. Otherwise, enrollees are reenrolled automatically. If a child is found to be no longer eligible for PeachCare, but potentially eligible for Medicaid, the case is handled like a new application that may be eligible for Medicaid. The applicant's information is sent to the centralized state staff for redetermination. If the child is eligible, his or her information is entered directly into the MMIS, and DHACS is notified to maintain the account.

There is no data element for the date of redetermination in the DHACS system. Instead, the system examines the date of initial enrollment and determines when redetermination should occur.

2. Reasons for Disenrollment or Case Closure

The following table refers only to reasons for disenrollment in the DHACS system.

Selected Reasons for Disenrollment—DHACS	Comments
Income too high	Yes
Income too low	No
Private insurance	No, coded as "voluntary cancellation"
Aged out	Yes
Failure to pay premium	Yes
Incomplete information on redetermination form	n.a., because of passive renewal
Failure to return redetermination form/did not reapply	n.a., because of passive renewal
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	n.a., because of passive renewal
Moved out of state	No, coded as "voluntary cancellation"
Died	No, coded as "voluntary cancellation"
Decided not to reenroll	No, coded as "voluntary cancellation"

n.a. = not applicable

DCH staff report that "voluntary cancellation" is a common reason code.

The MMIS receives cancellation information on a monthly basis from SUCCESS. Typically, the cancellation information sent to MMIS from SUCCESS is the end date and the open/close reason codes for Medicaid enrollees only. For those on Medicaid who appear eligible for PeachCare, DFCS will send a system-generated letter to the family encouraging application to PeachCare. (The state did not provide information on disenrollment reasons in the SUCCESS or MMIS.)

3. Identifying Transfers Between Medicaid and SCHIP

It is possible to track children who transfer between Medicaid and PeachCare if all their records are maintained by DHACS.

In the MMIS, however, children who transfer from PeachCare to Medicaid receive a new participant ID, and a new eligibility segment begins in MMIS. A records match to look for such transfers would require the use of the SSN (if provided) and DOB. DCH staff felt that such a match would be difficult, given the current system and data constraints.

4. Identifying Disenrollment Prior to Redetermination

Disenrollment prior to the planned redetermination date could be identified by comparing the closure date to the anticipated date of renewal, one year from the enrollment date.

5. Automatic Disenrollment

The DHACS system automatically cancels coverage for children who reach the age limit or do not payment the premium.

E. CONTACT DATA

1. Contact Information Collected in System

DCH staff reported that the best source for PeachCare contact information is the DHACS database. The table below refers to the DHACS system.

Selected Contact Data—DHACS	Comments
Name of parent/guardian(s)	Yes, two data fields for parents living in the household, and a field for ”other” parents/guardians
Phone number	Yes
Zip code	Yes
Alternate address or phone	Yes, home and emergency numbers for all parents
SSN	Optional
Case identifiers other than SSN	DHACS ID, participant ID
SSNs of parents/adults in HH	Optional
Primary language	Yes, English and Spanish

The MMIS contains minimal contact information for PeachCare members and Medicaid enrollees.

Medicaid contact information resides in the SUCCESS system; but a number of confidentiality concerns affect the availability of this information. SUCCESS contains information on name, case number, address, SSN, base ID, application date, certification, race, death, date of Medicaid card, phone number (not reliable, depends on the county), and payee. SUCCESS also passes some contact information to the MMIS.

2. Processes for Updating Contact Information

There is no trigger for updating contact information for S-SCHIP and Medicaid enrollees in the DHACS system, other than recertification. Families wishing to report changes are told to call a member service center maintained by DHACS. DHACS does not link with other state databases to update contact information, and there is no followup for those who disenroll. If DHACS receives returned renewal forms in the mail, the enrollee is cancelled. DHACS receives forwarding orders from the USPS, which it uses to locate people.

Contact data for Medicaid cases maintained by DFCS on SUCCESS are updated at renewal. SUCCESS, in turn, updates the MMIS. Since the SUCCESS system is used for other state programs such as food stamps and TANF, contact information for Medicaid enrollees maintained by the counties will be updated on SUCCESS through contacts for those programs as well.

3. Quality of Contact Information

State staff reported that PeachCare has complete contact information; but, given the mobility of the PeachCare population, its accuracy is questionable.

4. Ability to Produce Files with Contact Information and Eligibility History

Staff report that DHACS would be able to produce a contact file for PeachCare enrollees in 24 hours.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Not applicable. Georgia uses a Primary Care Case Management (PCCM) network for Medicaid and PeachCare, and claims are paid on a fee-for-service (FFS) basis. All the PCCM claims data are in the MMIS.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

Georgia has a research arrangement with the Georgia Health Policy Center at Georgia State University. The DHACS database is shared monthly with the group. Their work includes:

1. An ongoing new enrollee survey (random selection from files)
2. A completed disenrollee survey
3. CAHPS (comparing PeachCare and Medicaid against a national benchmark database)
4. Claims analysis on enrollees who have been enrolled for at least 12 months

B. INTERNAL REPORTS

DCH uses DHACS data to provide the PeachCare program with data on rejections, new applications, volume, and monthly county-level enrollment. There have been no challenges in using the data; however, since it is difficult to follow an individual between PeachCare and Medicaid, it is not possible to do longitudinal studies using the MMIS or DHACS system.

IV. DISCUSSION

Georgia uses two separate eligibility data systems for its PeachCare and Medicaid programs. The DHACS system stores data for all PeachCare (S-SCHIP) enrollees and for Medicaid enrollees who originally apply to PeachCare through a mail-in application. The state uses the SUCCESS system to determine Medicaid eligibility for applicants in the county offices; the system also is used for TANF and food stamps. Both of the eligibility systems send enrollment data to the MMIS, but the data from each system sit on separate subsystems within MMIS. No unique ID links data across the two systems.

The DHACS system maintains individual-level data on denials and disenrollment, has core contact data, has historical enrollment data, and allows linking of family members within the system (that is, those on PeachCare and Medicaid children who applied for PeachCare). SUCCESS, the system used for Medicaid, stores denial and disenrollment data and contact data. Historical Medicaid enrollment data is available in the MMIS. In addition, SUCCESS and the MMIS maintain a case ID that can be used to link children in the same family, provided they are on the same Medicaid case.

The MMIS maintains enrollment history for three years but does not contain denied cases or reasons for disenrollment; it also maintains limited contact information. Georgia is currently developing a joint eligibility system for S-SCHIP and Medicaid that will use a unique, individual-level ID and a family-level ID across programs. The state hopes to implement this system by October 2002.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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The DHACS contact is Jay Wells (Jmwells3@aol.com).
The MMIS contact is Joyce Wilson (jwilson@dch.state.ga.us).

ILLINOIS

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Illinois has a combination SCHIP program known as KidCare Assist for M-SCHIP, KidCare Share for S-SCHIP with no premiums, and KidCare Premiums for S-SCHIP with premiums. KidCare Assist covers children in families with income up to 133 percent of the federal poverty level (FPL); KidCare Share covers children from 133 to 150 percent FPL; and KidCare Premiums covers children from 151 to 185 percent FPL. Illinois' Medicaid program is named KidCare Assist Base. The Bureau of KidCare in the Department of Public Aid (DPA) administers the KidCare program.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Two departments are involved in eligibility determination for SCHIP and Medicaid: DPA and the Department of Human Services (DHS). DPA maintains the central KidCare processing unit for mail-in applications and is in charge of policy, rate setting, and payments for SCHIP and Medicaid. DHS runs Temporary Assistance for Needy Families (TANF), the Food Stamp Program (FSP), and other aid programs; it also processes applications for Medicaid and SCHIP through its local offices. A joint application is used for all health programs.

Eligibility for all health coverage is determined through one statewide computer system called the Client Information System (CIS), which is also used for TANF and the FSP and is maintained by DHS. Whether a client makes an application at a local DHS office or through the central processing unit for mail-in applications, workers determine eligibility using the CIS. Eligibility determination is done sequentially—cash assistance is determined first (if an application is made for it); then Medicaid eligibility is determined, followed by SCHIP eligibility. The CIS contains a KidCare subsystem used only to determine eligibility for children and pregnant women who apply for health benefits by mailing in an application to the central KidCare processing unit. The CIS is a mainframe system with flat files.

DPA maintains the state's Medicaid Management Information System (MMIS). DPA also maintains the Public Aid Accounting System (PAAS) system, which stores information on premium-payment history. The CIS passes information on enrollment to the MMIS on a nightly basis—which, in turn, passes information to the PAAS. The PAAS also communicates directly with the CIS in cases where clients are being terminated for failure to pay premiums.

C. CHANGES TO SYSTEMS

Over the past few years, Illinois has updated the CIS to accommodate SCHIP and continuous eligibility for children enrolled in Medicaid.

The state has long-range plans to create a "virtual case management" (VCM) system, a Windows-based interface, which will be a modernized replacement for the CIS. The VCM system will allow the state to better study patterns in Medicaid and SCHIP enrollment. A limited piece of this system may be online in 2002, but the entire system will not be implemented for a few years.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

Medicaid and SCHIP enrollees are assigned a unique, permanent recipient ID number (RIN) that is the same across all programs in the CIS. There is a case ID number as well, but it is not permanent and may change over time if a child has discontinuous coverage. CIS also records the SSN when it is reported.

2. Family-Level IDs

In addition to the RIN, children are assigned a case number. In CIS, records are kept at the case level, with one case record per family. In MMIS, records are at the individual level; each child has his or her own record.

Not all family members have the same case ID. For example, case IDs differ when siblings are in different programs. As a result, siblings in SCHIP and Medicaid cannot be linked. The new VCM system under development will improve the identification of family members.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Data from health care applications are stored in the CIS.

Selected Data Elements	Comments
Date of application	Yes
Place of application	Yes
Mode of application	Yes, mail-in applications distributed through Maternal/Child Health providers
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes, gross and net
Assets	n.a.
Current/prior third-party insurance	Yes, current (and rating for comprehensiveness)

n.a. = not applicable

The CIS is a point-in-time system; new information overwrites older information. Therefore, income and third-party insurance information may not reflect income or insurance status at the time of application. The new VCM system the state is developing will have the ability to keep historical information.

2. Reason Codes for Denied Applications

Data on reasons for denied applications are stored in the CIS.

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes
Prior insurance within waiting period	No
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes, “failed to provide information”
Withdrew application	Yes, “client withdrawal”
Unknown	No

n.a. = not applicable

3. Ability to Determine Initial Program of Application

Not applicable. Joint application is made for all health insurance programs.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

The case ID indicates the eligibility category in KidCare SCHIP or Medicaid. Siblings are generally under the same case ID, except when they are enrolled in different programs.

2. Historical Enrollment Data

The CIS is a point-in-time system; it records only a child's current eligibility information. It is possible to look at a case history in CIS but not an individual's history. The MMIS has historical information on monthly enrollment at the individual level. The RIN makes it possible to distinguish between new enrollees and return enrollees in the MMIS.

3. Identifying Retroactive Eligibility

Up to three months of retroactive eligibility is available to enrollees in Medicaid and M-SCHIP but not in S-SCHIP. Premium Share enrollees can receive two weeks of retroactive coverage, one time only. While the CIS contains the date of application, the MMIS would have to be used to identify the date of retroactive eligibility.

4. Premium Payment Information

The CIS indicates the current premium amount, which is based on family size and income. Complete premium-payment history information is located in the PAAS.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

SCHIP and Medicaid have 12 months of continuous eligibility for children. The CIS contains a data element for the date of redetermination. After a case is redetermined, the CIS automatically sets this date to one year in the future.

2. Reasons for Disenrollment or Case Closure

Reasons for disenrollment are maintained in the CIS.

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	No
Private insurance	Yes
Aged out	Yes
Failure to pay premium	Yes, for KidCare Premium
Incomplete information on redetermination form	Yes
Failure to return redetermination form/did not reapply	Yes
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes
Unknown	No

n.a. = not applicable

There is no code for "missing," "other," or "unknown" in the CIS. A code for "transferred to Medicaid" is used to identify children who transition from SCHIP to Medicaid, but there is no such code to identify children who transfer from Medicaid to SCHIP.

3. Identifying Transfers Between Medicaid and SCHIP

If a child on SCHIP becomes eligible for Medicaid, the SCHIP case will be terminated, and a new case for Medicaid will be opened. Similarly, if a child on Medicaid becomes eligible for SCHIP, the Medicaid case will be closed and a SCHIP case opened. However, CIS will record only a disenrollment code indicating this switch for children who transition from SCHIP to Medicaid, not from Medicaid to SCHIP. Transfers are identified by looking at RINs with multiple case records and examining the case ID, which designates program of eligibility, and tracking eligibility dates on the multiple records.

4. Identifying Disenrollment Prior to Redetermination

Disenrollment prior to redetermination can be distinguished from disenrollment at the time of redetermination by comparing the month of disenrollment to the original redetermination month stored in CIS.

5. Automatic Disenrollment

The CIS will automatically disenroll children in the Premium Share program for failure to pay premiums and for reaching the age limit. However, the system is being changed so that aging out will not generate an automatic case termination. There is also an automatic

system action for failure to return the SCHIP redetermination form, but a Medicaid case can be terminated only by worker action.

E. CONTACT DATA

1. Contact Information Collected in System

Contact data are maintained in the CIS.

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes, if in household
Phone number	Yes
Zip code	Yes
Alternate address or phone	No
SSN	Optional in SCHIP; Yes in Medicaid
Case identifiers other than SSN	Yes, RIN and case ID
SSNs of parents/adults in HH	Optional in SCHIP; Yes in Medicaid
Primary language	No, coded as "does not speak/read English"

2. Processes for Updating Contact Information

Contact information is updated at redetermination and between redeterminations if a family reports a change. If the redetermination packet is returned as undeliverable, the state works with the USPS to try and get forwarding information. Anyone in the local office with access to the CIS can make changes to contact information for cases within their jurisdiction.

Children on Medicaid and food stamps may be kept on the same case in the CIS. For these children, updated contact information from food stamps will change the contact information for the child prior to their Medicaid redetermination. Children on SCHIP and the FSP, however, will have a separate case for each program; therefore, information from collected for food stamps as part of a redetermination for that program will not automatically update the SCHIP case. Nevertheless, caseworkers are able to cross-reference between cases to determine whether address information in the other case for that child has changed.

3. Quality of Contact Information

DPA staff reported few difficulties with the address information in the CIS. Since they have an arrangement with the USPS, they are able to track forwarding addresses. Staff reported that 47 percent of TANF cases have phone numbers on them. The MMIS system does not contain address or phone number information.

4. Ability to Produce Files with Contact Information and Eligibility History

DPA staff reported that producing a file with contact information and enrollment history would be a significant task, since the Department of Public Aid would have to merge the MMIS, which contains the enrollment history, with the CIS file, which contains the contact information.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Health plans report individual-level encounter data to the state on a monthly basis. This information is in the MMIS data system. Staff did not have a sense of the reliability or completeness of encounter data.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

Illinois was not conducting surveys or focus groups at the time of the interview, but it had plans to conduct surveys of enrollee satisfaction, disenrollee surveys, and surveys to study effectiveness of outreach. The Illinois Office of the Inspector General did a survey of children on Medicaid, for which they obtained contact information from the CIS.

B. INTERNAL REPORTS

DPA produces many internal reports using CIS and MMIS data, especially for use by the local offices. They do special reports on SCHIP and Medicaid enrollment, for example, tracking KidCare enrollment by county, zip code, and demographics. Data from CIS can support only reports based on current enrollees.

State representatives felt that the CIS (which is quite old) does the basics very well; however, they would like the ability to produce more automated reports and to look at enrollment histories. At the present, DPA has to make ad hoc inquiries for many reports. They will be able to analyze enrollment histories with their new VCM system. In addition, they are developing a data warehouse on the MMIS side.

IV. DISCUSSION

Illinois maintains eligibility and enrollment data for Medicaid, M-SCHIP, and S-SCHIP in one system, known as the CIS. The system maintains individual-level data on the reasons for denied applications and for disenrollment. It is possible in the CIS to identify siblings who are enrolled in the same program, but not if they are enrolled in separate programs.

The main limitation of the CIS is that it is a point-in-time system, where old information is overwritten with newer information. CIS has no information available on previous enrollment periods, and the income and insurance information may not be the same as at the time of initial enrollment. Current contact information is available in the CIS. While alternate address and phone information is collected on the joint health care application, only one address is entered into the CIS.

The MMIS, which contains eligibility data for all Medicaid and SCHIP programs, is the only system in which one can track enrollment history within and among programs. However, the MMIS does not contain contact data, denial data, or reasons for disenrollment.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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INDIANA

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Indiana has a combination SCHIP program called Hoosier Healthwise package A (M-SCHIP) and package C (S-SCHIP). M-SCHIP covers children ages 1 to 18 in families with income up to 150 percent of the federal poverty level (FPL); S-SCHIP covers children ages 0 to 18 up to 200 percent FPL. The Medicaid program also is part of Hoosier Healthwise package A. Medicaid is overseen by the Office of Medicaid Policy and Planning, within the Family and Social Services Administration. The Division of Family and Children (DFC) within the Family and Social Services Administration administers Hoosier Healthwise.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Indiana maintains eligibility data for S-SCHIP, M-SCHIP, and Medicaid, as well as for Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP), in one system called the Indiana Client Eligibility System (ICES). The Division of Family and Children (DFC) is responsible for eligibility determinations for all these programs. Families may apply for SCHIP and Medicaid in Indiana at one of 120 local Offices of Family and Children (OFC), at one of 500 enrollment centers statewide, or through the mail. (Staff at enrollment centers assist families with completing the application, then forward the application to an OFC office for eligibility determination.) ICES automatically determines eligibility based on the data input by state workers. ICES is a Legacy system, which stores data in IBM mainframe flat files. It is maintained by Deloitte Consulting.

The state also has a data warehousing system, called the Hoosier Healthwise Reporting System, for all Hoosier Healthwise programs (SCHIP and Medicaid). This system uses a PC-based front end called COGNOS. The system allows staff to maintain and manipulate aggregate level data on enrollment. It contains an extract of data from ICES and is updated monthly.

Indiana's Medicaid Management Information System (MMIS) system is called IndianaAIM. The ICES sends data on all Hoosier Healthwise programs to the MMIS. MMIS is maintained by EDS.

C. CHANGES TO SYSTEMS

In 2000, Indiana updated the ICES system for S-SCHIP eligibility coding and implemented the Hoosier Healthwise Reporting System.

The state will continue to improve the data warehouse system. It also will be working on a front-end system to coordinate data in its three separate Legacy systems—ICES, the Indiana

Child Support Enforcement Tracking System (ISETS), and the Indiana Child Welfare Information System (ICWIS)—to facilitate the sharing of data between these systems.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

ICES contains a unique, permanent ID (ICES recipient ID) for all programs on the system. ICES also records the SSN when it is reported.

2. Family-Level IDs

A "case ID" links siblings (and parents) in the same household. The case may include several assistance groups if family members are on more than one program.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Selected Data Elements	Comments
Date of application	No[a]
Place of application	Yes, identifies each enrollment center
Mode of application	Yes, identifies mail-in applications
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes, gross income and information on disregards
Assets	n.a.
Current/prior third-party insurance	Yes

[a]ICES records the date caseworker enters the data and the date eligibility is determined.

n.a. = not applicable

Information on the initial application is stored in ICES at the individual level. The Hoosier Healthwise Reporting System, the data warehouse, stores data at the aggregate level (for example, numbers in different income groups).

2. Reason Codes for Denied Applications

Data on denied applications are stored in ICES.

Selected Reasons for Denials	Comments
Income too high	Yes
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes, including benefits covered under insurance
Prior insurance within waiting period	Yes, coded as "voluntarily dropped" insurance
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes, a number of codes for "failure to cooperate"
Withdrew application	Yes, a number of codes for "voluntary withdrawal"
Unknown	Yes

n.a. = not applicable

DFC staff indicate that "reason unknown" codes are not common.

3. Ability to Determine Initial Program of Application

Not applicable. Families make one application for all health coverage; they do not apply to Medicaid or SCHIP specifically.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

An "aid category" eligibility code is provided in ICES that differentiates Hoosier Healthwise Medicaid eligibility categories and M-SCHIP and S-SCHIP categories.

2. Historical Enrollment Data

ICES contains data on enrollment history for all Hoosier Healthwise aid categories. On an individual level, it is easy to look at a given case number and see the enrollment history. Eligibility information is kept in segments with begin and end dates. Children are immediately enrolled in Hoosier Healthwise Package A, upon being found eligible. For package C (S-SCHIP), children are identified as conditionally eligible until their first

premium payment is received. The permanent ICES recipient ID can be used to identify previous records on the system and to distinguish new enrollees from return enrollees.

3. Identification of Retroactive Eligibility

Periods of retroactive eligibility are identifiable in ICES by comparing the date of determination with the retroactive eligibility date for Medicaid and M-SCHIP. For S-SCHIP, the retroactive date of eligibility is the first day of the month in which a child applies.

4. Premium Payment Information

ICES contains information on premium-payment history, including amount, date of payment, and missed payment. A separate vendor submits these data electronically to ICES.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

In Indiana, both SCHIP and Medicaid offer 12 months of continuous eligibility. ICES contains an element for the redetermination date. ICES automatically generates a message that is sent to the caseworker in advance of the redetermination date. At redetermination, the date is automatically updated in the system.

2. Reasons for Disenrollment or Case Closure

The reasons for disenrollment are maintained in ICES.

Selected Reasons for Disenrollment	Comments
Income too high	Yes, coded as "increase in income"
Income too low	n.a.
Private insurance	Yes
Aged out	Yes
Failure to pay premium	Yes
Incomplete information on redetermination form	Coded as "failure to cooperate"
Failure to return redetermination form/did not reapply	Coded as "failure to cooperate"
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes, "unable to locate" and "mail returned as undeliverable"
Moved out of state	Yes, coded as "not an Indiana resident"
Died	Yes, coded as "death of an assistance group member"
Decided not to reenroll	Yes, coded as "voluntary withdrawal"
Unknown	Yes
Other	No

n.a. = not applicable

DFC staff report that "reason unknown" codes are not common.

3. Identifying Transfers Between Medicaid and SCHIP

One could identify a transfer between programs by looking for a switch in the aid category eligibility code. However, there would be no disenrollment reason code for this, since the child would not actually be disenrolled.

4. Identifying Disenrollment Prior to Redetermination

A closure date is entered into the system when a case is terminated. This date could be compared with the redetermination date, to determine whether a child disenrolled prior to redetermination.

5. Automatic Disenrollment

ICES does not automatically disenroll clients; only caseworkers close cases.

E. CONTACT INFORMATION

1. Contact Information Collected in System

Contact data are stored in ICES and in the MMIS.

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes, list of household members
Phone number	Yes, main and alternate numbers
Zip code	Yes
Alternate address or phone	Yes
SSN	Yes
Case identifiers other than SSN	Yes, ICES recipient ID and case ID
SSNs of parents/adults in HH	Yes, optional
Primary language	Yes, optional field for Spanish language[a]

[a]Staff reported this field was used infrequently.

2. Processes for Updating Contact Information

Contact information is updated at redetermination or if the client informs the state of new information. Also, if contractors receive new information during managed care enrollment, they forward it to the caseworker, and the caseworker enters it into ICES. In some counties, if a caseworker in DFC is unable to locate a family to complete a redetermination, the family's record is sent back to the original enrollment center, so that the enrollment center can attempt to contact the family.

Since ICES is also the eligibility system for the FSP and TANF, any new contact information collected from contacts with those programs would be recorded in the system.

Once a child disenrolls (after a minimum of two attempts to contact the family), there is no further attempt to follow up with disenrollees.

3. Quality of Contact Information

DFC staff report a fair number of redetermination forms are returned as undeliverable, mainly because clients move and do not leave a forwarding address.

4. Ability to Produce Files with Contact Information and Eligibility History

Because there are no standard reports of this nature, an ad hoc request to Deloitte, the ICES contractor, would be required to identify children with certain periods of continuous enrollment in SCHIP and Medicaid in ICES. DFC staff were unsure how long it would take to process ad hoc requests. They reported that it is not easy to identify periods of eligibility other than the predefined ones established in the data warehouse. Programs can be written to get this information from ICES, but that would require contractor resources.

DFC staff sometimes use data from the MMIS system, instead of the ICES, because it is easier to work with. The MMIS system contains eligibility and contact information but does

not include information from the application, information on denied cases, or the reasons for disenrollment.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Medicaid, M-SCHIP, and S-SCHIP plans use the same managed care organizations. All plans report encounter data to the MMIS system (IndianaAIM) every month. Staff reported completion factors of more than 90 percent for different types of services.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

The state conducts annual member surveys. It gets contact information from the MMIS, because it is easier to work with than ICES.

B. INTERNAL REPORTS

The state produces a number of internal monthly reports from ICES. DFC staff report that it has been difficult to use ICES to study enrollment patterns in Hoosier Healthwise; this is why they have developed their Hoosier Healthwise data warehouse. One study based on the Hoosier Healthwise Reporting System looks at disenrollment patterns by reasons for disenrollment, but this analysis is at an aggregate level.

IV. DISCUSSION

Eligibility for Indiana's S-SCHIP, M-SCHIP, and Medicaid programs is determined in one system, known as the ICES, which also is used for TANF and the FSP. Information from the initial application, reasons for denials, and reasons for disenrollment are all available at the individual level in ICES. The reasons for denials and disenrollment are fairly detailed; staff indicated that they are rarely coded as "unknown." Eligibility history is also available at the individual level in ICES and MMIS. Children can be tracked between Medicaid and SCHIP programs; the system maintains unique, individual- and family-level IDs. ICES stores an alternate address and phone number. The ICES sends information on eligibility and basic information, such as contact data, to the MMIS system on a nightly basis.

State staff reported, however, that the ICES mainframe system was somewhat difficult to work with, and that many analyses required requests to their data contractor. The staff have used the MMIS, rather than data from the ICES, to get contact information for sampling frames for surveys; they also have developed an aggregate-level data warehouse system for studying enrollment patterns.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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KANSAS

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Kansas has a separate child health program (S-SCHIP) called HealthWave. The S-SCHIP program covers children ages 0 to 18 under 200 percent of the federal poverty level (FPL). HealthWave and Medicaid are administered by the Department of Social and Rehabilitative Services (SRS).

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

One system is used to determine eligibility for Medicaid and S-SCHIP, known as the Kansas Automated Eligibility and Child Support Enforcement System (KAECSES). KAECSES is maintained by SRS and is used to determine eligibility for Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP). KAECSES is a statewide system in which county-based caseworkers log into the system using desktop computers.

Kansas has two different enrollment data systems for S-SCHIP and Medicaid. HealthWave's fiscal agent, MAXIMUS, maintains S-SCHIP enrollment information. Medicaid enrollment data are maintained by Blue Cross/Blue Shield and are stored in the state's Medicaid Management Information System (MMIS). KAECSES sends information on eligibility in the upcoming month to both MMIS and MAXIMUS, on a monthly basis. In addition, daily files are sent from KAECSES to MMIS to ensure that all Medicaid claims are paid correctly. Records on all three systems—KAECSES, MAXIMUS, and MMIS—are stored as mainframe flat files.

C. CHANGES TO SYSTEMS

Kansas has made many changes to its eligibility data system in recent years. KAECSES was modified and expanded to include new eligibility groups and to account for simplified Medicaid rules. The system was updated in order to have the ability to identify and distinguish family members.

The state hopes to change the administration of Medicaid and HealthWave so that they will appear as one program to beneficiaries and providers. While this will be hard to do, because of eligibility rules, the state had hoped to complete this project by July 1, 2001. It also is contracting with its health plans to serve both populations, and hopes to combine enrollment into one single broker. Finally, the state is considering separating the eligibility data systems for TANF, family medical only, pregnant women and children, and SCHIP.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

KAECSES assigns unique, permanent IDs to all eligibles before the records are transmitted to MMIS and MAXIMUS. Individuals retain these IDs across all three data systems. The systems also record the SSN when it is reported.

2. Family-Level IDs

Siblings can be linked within programs and between programs, using the family case ID, which is created by KAECSES and passed on to MAXIMUS and MMIS.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Unless otherwise specified, the information in the following table applies to the KAECSES eligibility system and to the MAXIMUS (S-SCHIP) and MMIS (Medicaid) enrollment systems.

Selected Data Elements	Comments
Date of application	Yes (MAXIMUS and KAECSES only)
Place of application	No
Mode of application	No
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes (KAECSES only, MAXIMUS and MMIS report percent FPL only)
Assets	Yes (KAECSES only)
Current/prior third party insurance	Yes (MMIS only)

2. Reason Codes for Denied Applications

The following information applies to KAECSES only; KAESCES does not send information on denied applicants to MMIS or to MAXIMUS.

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	n.a., applicants use a joint application for Medicaid and SCHIP
Age	Yes
Immigration status	Yes
Assets	Yes
Current insurance	Yes
Prior insurance within waiting period	Yes
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes, coded as "failure to provide information"
Withdrew application	Yes
Unknown	No

n.a. = not applicable

SRS staff report that eligibility-related data are in good shape; but the process-related reason codes (for example, missing data, withdrew application) are not used consistently.

3. Ability to Determine Initial Program of Application

Not applicable; applicants apply to all health programs jointly.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

Enrollees in SCHIP and Medicaid are distinguished in KAESCES by the "medical subtype" code assigned to each beneficiary.

2. Historical Enrollment Data

KAECSES maintains information that indicates who will be eligible for coverage for the next month. It stores the information in monthly segments and passes it on to MMIS and

MAXIMUS each month. Information also is sent daily to MMIS on current/prior eligibility, for the purpose of paying claims.

KAECSES has enrollment information dating back to 1998. Prior data have been archived. MMIS has data back to November 1993; the rest are archived. MAXIMUS has information since the beginning of S-SCHIP, in September 1998. The unique, permanent KAESCES ID makes possible the identification of previous enrollment in S-SCHIP or Medicaid.

HealthWave is a managed care plan in which children do not become eligible until the month following the date of application. Enrollment authorization cutoffs take place at the end of the month. For example, an application must be submitted by October 21 for the child to become eligible November 1. If the application is submitted after October 21, the child will be enrolled on December 1.

3. Identifying Retroactive Eligibility

Both MAXIMUS and MMIS can identify retroactive eligibility. Medicaid only uses retroactive coverage for newborns.

4. Premium Payment Information

MAXIMUS stores information on premium payments for S-SCHIP, including the amount of the premium, the date it was paid, and whether any payments were late or missed. KAECSES determines the premium level for a family and transmits this information to MAXIMUS for collection and record keeping.

Children are disenrolled from S-SCHIP at the time of redetermination if they fail to pay their premiums. Forty-five days prior to redetermination, enrollees are given a warning that they need to pay their premiums or risk being terminated.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

HealthWave and Medicaid provide 12 months of continuous eligibility. KAECSES is used for eligibility redetermination for both programs.

Redetermination dates are stored in KAECSES and MAXIMUS. No dates of redetermination are stored in MMIS. A new review date is set in KAECSES if the individual is redetermined to be eligible. If MAXIMUS does not receive information from KAECSES indicating that an individual is still enrolled, it generates an end date, at which time MAXIMUS will automatically disenroll the individual.

2. Reasons for Disenrollment or Case Closure

The following information applies to KAECSES only.

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	Yes, for S-SCHIP
Private insurance	Yes
Aged out	Yes
Failure to pay premium	Yes, for S-SCHIP
Incomplete information on redetermination form	Yes, coded as "failure to provide information"
Failure to return redetermination form/did not reapply	Yes, coded as "failed review—never sent back form"
Did not complete face-to-face interview	Yes
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes, classification depends on caseworker
Unknown	No
Other	Yes

The state reports that "other" is coded more often than they would like.

3. Identifying Transfers Between Medicaid and SCHIP

A child's enrollment history, including transfers between S-SCHIP and Medicaid, can be tracked in KAECSES. MAXIMUS and MMIS cannot identify transfers between programs; data must be linked between the two systems for this purpose.

4. Identifying Disenrollment Prior to Redetermination

It is possible in KAECSES to determine whether children disenrolled before their redetermination date only for the most recent period of eligibility, by comparing disenrollment and redetermination dates. It is not possible to compare these dates from previous enrollment segments.

5. Automatic Disenrollment

If MAXIMUS does not receive information from KAECSES indicating that an individual is still enrolled, it generates an end date, and automatically disenrolls the individual.

Only "failure to review" causes automatic disenrollment in KAECSES. All other disenrollment codes require worker intervention. MMIS also has an automatic disenrollment process if they do not receive an eligibility record from KAESCES.

E. CONTACT DATA

1. Contact Information Collected in System

The following information applies to KAECSES, MAXIMUS, and MMIS, unless specified otherwise.

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes (including maiden name)
Phone number	Yes
Zip code	Yes
Alternate address or phone	No
SSN	Yes, optional for S-SCHIP
Case identifiers other than SSN	Yes, individual and family IDs
SSNs of parents/adults in HH	No
Primary language	KAECSES currently records this information only if it is known

2. Processes for Updating Contact Information

Contact information may be updated at any time in the KAECSES system. If the state receives updated information from an outside source (such as a provider), the caseworker will verify that information with the client before changing it in KAECSES. Since KAECSES is used for TANF and FSP eligibility determination, contact data obtained through contact for these programs are available for S-SCHIP/Medicaid enrollees.

3. Quality of Contact Information

SRS staff could not comment on the quality of contact information in the data systems.

4. Ability to Produce Files with Contact Information and Eligibility History

KAECSES cannot produce files with contact information and enrollment history, because it can produce only point-in-time extracts. In other words, it does not track enrollment; it merely tracks current eligibility for programs. It would be possible to extract these data from MAXIMUS and MMIS. However, these two systems are separate; staff reported that producing a file combining Medicaid and S-SCHIP children would take some time.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

HealthWave encounter data are stored in MAXIMUS and are reported monthly. Kansas recently began quality assurance of the encounter data, but no results are yet available.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

SRS began a three-year contract with the Kansas Health Institute (KHI) in 2000. KHI has been examining the level of uninsured children, and how this has changed over time. KHI also is analyzing HealthWave enrollment trends. KHI's investigation includes surveys and focus groups. KHI obtained data for all these studies by merging data from KAECSES and MAXIMUS.

SRS is working with the University of Kansas Department of Health Policy and Management. This project involves longitudinal surveys of new and established enrollees to examine how HealthWave has affected access to health care services.

SRS also conducted a HealthWave disenrollee telephone survey which found that the most common reason for failure to redetermine is the cumbersome redetermination process.

B. INTERNAL REPORTS

Using data from MAXIMUS, SRS creates ad hoc reports relating to the enrollment patterns of children and the success of continuous eligibility and outreach in S-SCHIP.

IV. DISCUSSION

Eligibility determination for S-SCHIP and Medicaid is performed on one statewide eligibility system in Kansas, KAESCES. This system contains application information, individual-level data on denials and the reasons for disenrollment, and core contact data. However, the eligibility system is only contains current eligibility data; historical enrollment data for SCHIP and Medicaid are maintained on two separate enrollment systems—the MAXIMUS system for SCHIP and the MMIS for Medicaid. It is possible to link children between the two enrollment systems using a unique, permanent ID. Siblings also can be identified within and across programs using a family ID.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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KENTUCKY

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Kentucky has a combination SCHIP program called KCHIP. The M-SCHIP component covers children ages 1 to 18, up to 150 percent of the federal poverty level (FPL), while the S-SCHIP component covers children ages 0 to 18, up to 200 percent FPL. The program was phased in over time, beginning in July 1998. KCHIP is administered by the Division of Children's Health Programs. Medicaid is administered by the Department of Medicaid Services, within the Cabinet for Health Services (CHS). The Department of Community Based Services (DCBS), under the Cabinet for Families and Children (CFC) maintains local offices and performs eligibility functions for both programs.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

KCHIP and Medicaid use a statewide automated eligibility system called Kentucky Automated Management and Eligibility System (KAMES). KAMES is a mainframe IMS database and is maintained by the Office of Technology Services, within CFC. KAMES also is used to determine eligibility for Temporary Assistance for Needy Families (TANF), the Food Stamp Program (FSP), and other state programs. KAMES determines eligibility for all programs in a sequential order, searching for all possible eligibility groups.

KCHIP applicants can use a separate application for KCHIP or a combined application with Medicaid. All KCHIP applications are handled and processed at local DCBS offices. Families may either mail their applications or apply in person. Applicants for Medicaid are required to have a face-to-face interview at a local DCBS office. However, applicants who mail in a KCHIP-only application, but who are determined income-eligible for Medicaid do not need to meet Medicaid application requirements that exceed those of KCHIP.

C. CHANGES TO SYSTEMS

The only major change to KAMES in recent years has been the delinking of TANF and Medicaid. The state does not anticipate any major changes in the near future. Kentucky currently is focusing on revising the automated notices sent by KAMES to clients. In addition, DCBS recently stopped allowing mail-in recertifications for KCHIP and Medicaid (and self-declaration of income for KCHIP); beginning in June 2001, enrollees of both programs were required to visit a local office to renew eligibility.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

KAMES requires the SSN for all KCHIP and Medicaid applicants. The system also assigns a unique, permanent number called "SYS ID."

2. Family-Level IDs

KAMES has a case ID called the "family ID." Siblings usually, though not always, will be on the same family ID in KAMES. Each person on a case is identified by a recipient ID. For children on different cases, there are no identifiers to link them (other than searching for parents' SSN).

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Data from the initial application are maintained in KAMES.

Selected Data Elements	Comments
Date of application	Yes, original and most recent application date
Place of application	Yes
Mode of application	Yes, agency contact field, and type of application
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes, person-level gross income and deductions
Assets	n.a.
Current/prior third-party insurance	Yes, current type of insurance

n.a. = not applicable

2. Reason Codes for Denied Applications

Data on denied applications are maintained in KAMES.

Selected Reasons for Denial	Comments
Income too high	Yes, case level
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes, "insurance"
Prior insurance within waiting period	No
Did not complete face-to-face interview	n.a. for KCHIP; "failure to provide information" for Medicaid
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes, "failure to provide information"
Withdrew application	Yes
Unknown	No

n.a. = not applicable

KAMES assigns most denial codes, based on the information a caseworker has entered. Workers can also manually deny applications and enter a denial code. The KAMES staff feel that these codes are of good quality.

3. Ability to Determine Initial Program of Application

KAMES determines eligibility for all SCHIP and Medicaid programs at the same time. As a result, the system contains no code indicating, for example, that a child applied for KCHIP but was found eligible for Medicaid. The system is, however, able to identify children who originally submitted a KCHIP-only application.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

Children in KCHIP and Medicaid are identified by a two-part, state-specific eligibility code. The first part is the program code, and the second part is the recipient status code. Children on KCHIP will have program codes of either "I" or "P." The recipient status codes vary, but yield important information about the group under which the individual qualifies. Recipient codes P1 to P3 are used to identify different poverty-related Medicaid groups by age.

Recipient codes P4 to P6 apply to different income levels of Kentucky's M-SCHIP program, and P7 is the recipient code for the state's S-SCHIP program.

2. Historical Enrollment Data

KAMES currently stores eligibility data back to 1996. Eligibility history is stored in segments. The system contains a variable for the date and time of the last update. KAMES identifies records that are pending; however, staff noted that this pending status is not always overwritten when cases are approved. KAMES sends nightly batch updates with enrollment data to the state's Medicaid Management Information System (MMIS).

New enrollees can be distinguished from return enrollees by examining previous eligibility segments for children who are uniquely identified by SYS ID or SSN. KAMES also stores the date of the first application to a program that can be used to identify return applicants.

3. Identifying Retroactive Eligibility

KAMES records an "R" for retroactive eligibility in eligibility segments. (Note: children who live in areas with managed care are given retroactive eligibility back to the application date, while children in areas without any managed care options are given up to three months of retroactive coverage.)

4. Premium Payment Information

Not applicable.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

Kentucky uses a 12-month redetermination period for children in Medicaid and KCHIP. The state recently changed its rules for redeterminations. For a time, it allowed mail-in redeterminations and self-declaration of income. However, as of June 1, 2001, both KCHIP and Medicaid require face-to-face redetermination interviews.

KAMES sends a notice to recipients one month before a redetermination is due. If caseworkers do not use their appointment calendar to schedule an interview, the system will do so automatically, and will send a notice to the recipient. KAMES automatically updates the redetermination date when the case is renewed.

2. Reasons for Disenrollment or Case Closure

Reasons for disenrollment are recorded in KAMES.

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	n.a.
Private insurance	Yes, "not KCHIP eligible"
Aged out	Yes, "over age limit"
Failure to pay premium	n.a.
Incomplete information on redetermination form	n.a. (as of June 2001)
Failure to return redetermination form/did not reapply	Yes, "fail to appear"
Did not complete face-to-face interview	Yes, "fail to appear"
Could not be located at redetermination	Yes, "fail to appear"
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes, could be coded "fail to appear" or "requested case to be discontinued"
Unknown	No

n.a. = not applicable

As with the denial codes, KAMES codes the reason for disenrollment based on the data that are entered into the system, but caseworkers can override the system's decision. The KAMES staff feel that these codes are of good quality.

3. Identifying Transfers Between Medicaid and SCHIP

Transfers between S-SCHIP, M-SCHIP, and Medicaid can be identified by a change in the recipient status code, in consecutive eligibility segments.

4. Identifying Disenrollment Prior to Redetermination

KAMES stores a disenrollment date (end date) at the individual level; this could be compared to the redetermination date in KAMES to identify disenrollment prior to the redetermination date.

5. Automatic Disenrollment

KAMES has the ability to automatically disenroll individuals without worker intervention. (Staff report that reaching the age limit is a common reason for automatic disenrollment.)

E. CONTACT DATA

1. Contact Information Collected in System

Contact data are stored in KAMES.

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes
Zip code	Yes
Alternate address or phone	Yes, alternate address and phone
SSN	Yes
Case identifiers other than SSN	Yes, SYS ID and family ID
SSNs of parents/adults in HH	Not mandatory unless parent is on case
Primary language	Yes

2. Processes for Updating Contact Information

Contact information is updated at the time of redetermination. It also can be provided by the family at any time. Workers may receive new contact information from providers, but this is not standard procedure. If a provider contacts caseworkers with an address change, the information is first verified with the recipient before being updated in KAMES. Only the caseworker or the caseworker's supervisor can update the information.

In addition, contact information in KAMES is updated through client contacts for the Food Stamp and TANF programs. KAMES does not track children once they have disenrolled, although DMS is conducting their own survey of disenrollment.

3. Quality of Contact Information

DCBS staff were not able to provide us with data on the quality of contact information, although they felt that poor contact information in the system would result when enrollees provide incorrect information or fail to provide forwarding addresses.

4. Ability to Produce Files with Contact Information and Eligibility History

DCBS staff felt that it would be easy, but time-consuming, to produce a file from KAMES with eligibility history and contact information. It might be possible to obtain some of these data from an extract (called a SNAP file) that is taken from the data system each night.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Individual-level encounter data are reported by managed care plans to the Department for Medicaid Services on a monthly basis. This information is stored in Kentucky's MMIS.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

Kentucky has conducted a variety of surveys and focus groups among enrollees and disenrollees. The state is currently completing a disenrollee survey.

B. INTERNAL REPORTS

Kentucky regularly compiles several internal reports from KAMES on approvals and denials. KAMES meets their needs for these reports. The reports are used for managerial purposes and are often passed along to the Governor's office, the SCHIP Advisory Committee, and the Legislature.

IV. DISCUSSION

Kentucky uses one statewide automated eligibility system for SCHIP and Medicaid, as well as TANF and food stamps, called KAMES. The system maintains individual-level data on the reasons for denial and disenrollment. The system assigns a unique ID and can track eligibility history for individuals in all programs back to 1996. The contact information includes fields for secondary phone numbers and primary language. The system has a family ID; however, this ID may not identify all siblings, since not all family members are always on the same case number.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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LOUISIANA

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Louisiana has a Medicaid expansion SCHIP (M-SCHIP) program known as LaCHIP, which covers children under age 19 with family incomes up to 200 percent of the federal poverty level (FPL). Medicaid and LaCHIP are administered by the Department of Health and Hospitals (DHH).

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Louisiana uses one mainframe system for Medicaid and M-SCHIP, called the Medicaid Eligibility Data System (MEDS). MEDS is used exclusively for the Medicaid program. (MEDS also interfaces with the Temporary Assistance for Needy Families (TANF) and Food Stamp Program (FSP) eligibility system known as the Louisiana Automated Management Information System [L'AMI].) MEDS has been maintained by a contractor but will be maintained by DHH, beginning in 2001.

When eligibility workers make a determination of eligibility for Medicaid or LaCHIP, they enter information on age and income into MEDS. They fill out a budget worksheet on MEDS, using the income data, and determine the probable assistance group for the family. Eligibility workers also use a separate PC-based LAN system, called the Medicaid Application System (MAS), which helps them track applications and do the resource calculations for eligibility; but this database is not linked to MEDS.

MEDS is a relational database. It sends information on enrollees nightly to the state's Medicaid Management Information System (MMIS). MMIS is a mainframe system maintained by Louisiana's fiscal intermediary, Unisys.

C. CHANGES TO SYSTEMS

DHH implemented MEDS in July 1999 to replace an older system. They continue to fine-tune the initial implementation of MEDS but have no other significant changes planned.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

MEDS assigns a unique person number (based on name, DOB, and SSN) that is never reassigned. MEDS also records SSN.

2. Family-Level IDs

MEDS assigns a "case structure" ID, which identifies the relationship between every member of a family in a case.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Selected Data Elements	Comments
Date of application	Yes, date application data entered
Place of application	Yes, worker location and county of residence[a]
Mode of application	No
Race/ethnicity	Yes
Family composition	Yes, relationship of family members
Family income	Yes, both gross and net income and information on earned income and disregards
Assets	n.a.
Current/prior third-party insurance	No, only indicates data in separate TPL system[b]

[a]More detail on the place of application is tracked at the county level in the PC-based MAS.

[b]Information on current and prior insurance is kept in a separate third-party liability (TPL) system. MEDS contains an element that indicates whether an individual has data in the TPL system. The state is talking about enhancing the systems to allow for a unique identifier or SSN link between MEDS and TPL systems.

n.a. = not applicable

2. Reason Codes for Denied Applications

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	n.a.
Age	Yes, coded as "no proof of age"
Immigration status	Yes
Assets	Yes
Current insurance	Yes, and "voluntarily dropped insurance"
Prior insurance within waiting period	n.a.
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes
Withdrew application	Yes
Unknown	Yes, coded as "other"

n.a. = not applicable

All transactions resulting in denials stay on the MEDS system. MEDS uses a rejection code for "failure to locate." The amount of income also is maintained on a budget worksheet within the MEDS. DHH staff report that the majority of denials have a specific reason.

3. Ability to Determine Initial Program of Application

Not applicable.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

There is a data element on MEDS called "type case," which differentiates Medicaid poverty-based and M-SCHIP eligibility groups. "Type case" also differentiates M-SCHIP enrollees with income less than 133 percent FPL, between 134 and 150 percent FPL, and between 151 and 200 percent FPL.

2. Historical Enrollment Data

MEDS maintains data from July 1999. The state's former eligibility system did not maintain historical enrollment data, but enrollment history prior to July 1999 is available from the MMIS. Enrollment information is entered into MEDS at the time of eligibility

determination. Cases in MEDS have start and end dates. If there is a break in enrollment in M-SCHIP or Medicaid, the record closes and a new record (begin date) is opened. A new case also is started if a child switches "type case." These records are linkable by the unique person number. Return enrollees can be identified by searching for multiple records using the unique ID on MEDS.

3. Identifying Retroactive Eligibility

Retroactive eligibility in Medicaid and M-SCHIP can be identified by comparing the begin date to the application date on the case record.

4. Premium Payment Information

Not applicable.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

Children on Medicaid and M-SCHIP have a 12-month redetermination period. MEDS automatically calculates a redetermination date of one year from the begin date. Workers are notified by MEDS two months before this date that a redetermination is due. If eligibility is renewed, the worker updates the redetermination date in the system.

2. Reasons for Disenrollment or Case Closure

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	No
Private insurance	Yes, coded as "insurance available"
Aged out	Yes
Failure to pay premium	n.a.
Incomplete information on redetermination form	Yes
Failure to return redetermination form/did not reapply	Yes
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes
Unknown	Yes, coded as "other"

n.a. = not applicable

Reasons for disenrollment in MEDS are coded in fields separate from those for denials. As with the denial codes, the state reports that very few closure codes are general or unknown.

3. Identifying Transfers Between Medicaid and SCHIP

When a child switches between eligibility categories in MEDS—for example, from M-SCHIP to Medicaid—the M-SCHIP record will be closed with a reason code for "other certification," and a new record with a new "type case" will begin.

4. Identifying Disenrollment Prior to Redetermination

MEDS contains an end date for each eligibility record; the end date can be compared to the redetermination date, to identify whether the time of disenrollment differs from the redetermination date.

5. Automatic Disenrollment

MEDS does not automatically disenroll children. Before disenrolling any child, a worker will search the other Medicaid eligibility categories to ensure that a child is not eligible for other health coverage.

E. CONTACT DATA

1. Contact Information Collected in System

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes, if reported
Zip code	Yes
Alternate address or phone	No
SSN	Yes
Case identifiers other than SSN	Yes, a unique 13-digit person number and a unique case ID
SSNs of parents/adults in HH	Yes, if reported or applying for benefits
Primary language	Yes

2. Processes for Updating Contact Information

Eligibility workers and paraprofessionals make changes to the contact information in MEDS. Contact information is updated at redetermination and when reported by the family. When a family member reports a new address and/or requires a new medical ID card, the caseworker updates the address for the entire case.

Eligibility staff also are able to look up contact information in other public systems, such as food stamps; but MEDS is not connected to the system for food stamps. Once a child disenrolls (after attempts to contact the family), there is no further tracking of disenrollees from LaCHIP and Medicaid.

3. Quality of Contact Information

DHH staff reported that the quality of the contact data on MEDS is mixed. The populations on Medicaid and LaCHIP tend to move frequently and often do not report address changes. Furthermore, Medicaid used to mail medical cards to enrollees monthly, ensuring more frequent contact throughout the year. Now, the program uses electronic cards and requires only yearly contact for redeterminations, resulting in less contact between families and the state.

4. Ability to Produce Files with Contact Information and Eligibility History

DHH staff felt that it would be easy to generate a list of enrollees' addresses, since they already do this on a regular basis for customer satisfaction reports.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Not applicable.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

DHH conducts a consumer satisfaction mail survey of denied and disenrolled families, using contact data from MEDS. They do not have contracts with outside organizations to conduct research, but anticipate a contract soon for research that will examine the issue of renewal. Currently, the state has only anecdotal evidence about the reliability of contact information.

Local offices use the Medicaid Application System to track the origin of applications, such as where families got the application and where they first heard about the program. However, these data are not uploaded to MEDS.

B. INTERNAL REPORTS

DHH uses MEDS to generate several monthly reports, such as enrollment reports and the reasons for denials and disenrollment. DHH staff report that the data in MEDS generally have met all their internal needs; however, as it is a new system they are still fine-tuning.

IV. DISCUSSION

Louisiana uses one data system, the Medicaid Eligibility Data System (MEDS), to record eligibility and enrollment in its Medicaid and M-SCHIP programs. Eligibility history is available in MEDS from July 1999, when the system was developed. Enrollment data prior to July 1999 are available in the MMIS. The MEDS records individual-level data from the application, core contact data, and includes reasons for denials and case closures. MEDS contains no information on private insurance or on sources of applications or where applicants heard of the program—but these data are kept on two other state systems.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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MARYLAND

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Maryland has a combination SCHIP program. The Medicaid expansion SCHIP program (M-SCHIP) is called Maryland's Children's Health Program (MCHP); a separate child health program (S-SCHIP) is MCHP Premium. Children's Medicaid is known as MCHP. MCHP covers children under age 19 up to 200 percent of the federal poverty level (FPL). MCHP Premium covers children above 200 percent FPL, but at or below 300 percent FPL.[1] Families without access to employer-sponsored insurance (ESI) but within the eligibility limit can receive coverage through the Maryland Managed Care Program for a monthly premium. Some MCHP Premium enrollees are covered by ESI. MCHP Premium acts as a secondary insurance coverage in these cases, making copayments and paying deductibles and co-insurance costs on services covered by the primary (ESI) insurance. The Department of Health and Mental Hygiene (DHMH) administers the Medicaid, MCHP, and MCHP Premium programs. Eligibility for MCHP is conducted by local Departments of Social Services (DSS), within the Department of Human Resources (DHR).

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Maryland uses a joint application for SCHIP and Medicaid but uses separate eligibility systems for S-SCHIP and Medicaid/M-SCHIP. Applications are mailed to the local DSS offices, where caseworkers determine eligibility for Medicaid and M-SCHIP, using the Client Automated Response and Eligibility System (CARES). Maintained by the Department of Human Resources (DHR), CARES is a real-time interactive system that evaluates application information for eligibility for a number of programs, including M-SCHIP, Medicaid, the Food Stamp Program (FSP), and Temporary Assistance for Needy Families (TANF).

S-SCHIP eligibility is determined by DHMH staff. DHR caseworkers refer potential MCHP Premium eligible applications to DHMH for eligibility determination (as long as families have indicated a willingness to pay a premium for coverage). Eligibility information for MCHP Premium is entered directly into the state's Medicaid Management Information System (MMIS) by DHMH case management staff.

CARES sends updates on Medicaid and M-SCHIP eligibility in nightly batches to the MMIS, which is run by DHMH. CARES and MMIS are in DB2 mainframe format.

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[1]Maryland began its separate SCHIP program in July 2001, after the initial interview. Information on the S-SCHIP data systems was provided in written comments from the state following the interview.

The majority of Maryland's MCHP and MCHP Premium enrollees are enrolled in the state's Medicaid managed care plan, HealthChoice. Maryland's MMIS submits eligibility information in nightly batches to HealthChoice's enrollment broker, Benova, via an electronic interface. Once Benova receives an enrollment notification from MMIS, it contacts the enrollee's family; the family then has 21 days to select an MCO. Once the MCO has been chosen, Benova sends updated information back to the MMIS.

C. CHANGES TO SYSTEMS

Recently, Maryland made two significant changes to CARES. First, it delinked Medicaid from TANF; and, second, it made several changes in order to better test for eligibility in various programs.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

CARES assigns a unique, permanent ID that follows individuals throughout programs and over time. Even though Medicaid/MCHP and S-SCHIP have different data systems, they use the same ID system. CARES communicates with MMIS to identify potentially eligible MCHP Premium children. The CARES ID number for each child is used to identify the child in MCHP Premium. CARES records the SSN when it is reported.

2. Family-Level IDs

CARES assigns a permanent nine-digit Assistance Unit (AU) number that can link family members in the same assistance unit; a different AU number, however, is assigned for each program, so that family members in traditional Medicaid have a different AU number than those in M-SCHIP.

MMIS contains a field for the "head of household" number. This number can be used to link family members across Medicaid/M-SCHIP and S-SCHIP.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

The information below applies to CARES and MMIS, unless otherwise specified. S-SCHIP information is available only in the MMIS.

Selected Data Elements	Comments
Date of application	Yes[a]
Place of application	Yes
Mode of application	Yes, CARES only
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes
Assets	n.a.
Current/prior third-party insurance	Yes

[a]The date of application on MMIS remains the original date of application if there is no break in coverage.

n.a. = not applicable

2. Reason Codes for Denied Applications

All information in the following table is stored in both CARES and MMIS, for Medicaid and M-SCHIP, and in MMIS, for S-SCHIP. The reason for denial in CARES is recorded at the individual level but is recorded at the household level in the MMIS.

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes
Prior insurance within waiting period	Yes
Did not complete face-to-face interview	n.a. for children's coverage
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes
Withdrew application	Yes
Unknown	No

n.a. = not applicable

MCHP Premium, which requires families to enroll in ESI if it is available, also has a denial code for "did not enroll in qualifying ESI." DHMH staff reported that the data on denials are reliable.

3. Ability to Determine Initial Program of Application

Maryland uses a joint application for Medicaid, MCHP and MCHP Premium. Applicants do not apply to a specific program.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

CARES and MMIS use an eligibility group code to distinguish between Medicaid and MCHP, using an eligibility code. The code in MMIS also identifies MCHP Premium eligibility groups.

2. Historical Enrollment Data

MMIS and CARES store eligibility data in monthly segments. Eligibility continues in MMIS until CARES tells it otherwise for Medicaid and MCHP, and until DHMH caseworkers advise otherwise for MCHP Premium. Both systems maintain data back to Medicaid's inception; after two years, inactive records are archived. Archived data are maintained in a special database in MMIS, where they are easily accessible. The unique ID in CARES makes it possible to identify return enrollees.

3. Identifying Retroactive Eligibility

CARES and MMIS contain separate fields identifying date of application and the date eligibility began. CARES identifies retroactive coverage by the date of application and date of determined eligibility.

4. Premium Payment Information

Data on premium payments are maintained in MMIS for children enrolled in MCHP Premium.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

Maryland redetermines eligibility every 12 months for MCHP, MCHP Premium, and Medicaid.

CARES contains redetermination end date. The date is calculated by the application begin date and is reset after a redetermination has been completed in CARES. CARES automatically sends out a redetermination packet 90 days before redetermination is due for Medicaid and MCHP enrollees. Once a caseworker receives a redetermination form and

begins to enter it into the system, the case becomes a "pending case." It remains on the system until the worker completes the process.

Redetermination for MCHP Premium begins with mailing a redetermination packet 75 days before redetermination is due. DHMH caseworkers mail the packets, which contain the standard MCHP/MCHP Premium application form. Families applying for continuation of MCHP Premium eligibility complete the application form and send it to the local health department in the county (or Baltimore City) where they reside. CARES records the application as a new application and tests for MCHP eligibility. If the applicant does not qualify for MCHP eligibility because family income exceeds 200 percent FPL, but is at or below 300 percent FPL and the family has indicated a willingness to pay a premium for coverage, CARES refers the applicant to DHMH for MCHP Premium eligibility determination.

2. Reasons for Disenrollment or Case Closure

All information below is stored in both CARES and MMIS, for Medicaid and M-SCHIP, and in MMIS, for S-SCHIP. Reason for disenrollment in CARES is recorded at the individual level but is recorded at the household in the MMIS.

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	n.a.
Private insurance	Yes
Aged out	Yes, coded as "failure to meet technical requirements"
Failure to pay premium	n.a.
Incomplete information on redetermination form	Yes
Failure to return redetermination form/did not reapply	Yes
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	No, coded as "failure to submit verification"
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes, coded as "failure to return form" or "did not reapply"
Unknown	No

n.a. = not applicable

S-SCHIP, which requires families to enroll in ESI if it is available, also has a disenrollment code for "did not enroll in qualifying ESI." DHMH staff reported that the data on disenrollment are of good quality.

3. Identifying Transfers Between Medicaid and SCHIP

It is possible to identify children who transfer from traditional Medicaid to M-SCHIP, and vice versa, by examining the state-specific eligibility codes in consecutive eligibility segments in CARES. Transfers between S-SCHIP, M-SCHIP, and traditional Medicaid can be identified in the MMIS by state-specific eligibility codes in consecutive eligibility segments.

4. Identifying Disenrollment Prior to Redetermination

It is possible to determine the time of disenrollment, if it is different than the time of redetermination, using codes that show scheduled versus unscheduled redeterminations.

5. Automatic Disenrollment

Neither CARES nor MMIS automatically disenroll children. CARES creates an alert report to notify the caseworker when a child ages out of the program. The caseworker takes appropriate action to disenroll the child. The MMIS system creates an alert report for S-SCHIP customers who age out or fail to pay premiums. The report is sent to the DHMH caseworkers for disposition.

E. CONTACT DATA

1. Contact Information Collected in System

All information below is stored in both CARES and MMIS for Medicaid and M-SCHIP, and in MMIS for S-SCHIP.

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes
Zip code	Yes
Alternate address or phone	No
SSN	Yes
Case identifiers other than SSN	Yes
SSNs of parents/adults in HH	Yes, if provided
Primary language	Yes

2. Processes for Updating Contact Information

Caseworkers are prompted by CARES to update contact information at redetermination. If DHMH receives information regarding changes in contact information, they send it to the caseworker. Caseworkers are expected to verify the information, and update the system accordingly. CARES then updates other sources, such as MMIS, if necessary. Updated contact information may also be obtained through contacts for toher programs, such as food stamps and TANF. DHMH caseworkers update MMIS for MCHP Premium customers.

3. Quality of Contact Information

Staff reported that almost all records have phone numbers and addresses. DHMH staff feel the data are of good quality, although DHR does get a significant amount of returned mail. Returned mail cannot be tracked by assistance program; thus, there are no reliable figures on the amount of returned mail for Medicaid versus SCHIP enrollees.

4. Ability to Produce Files with Contact Information and Eligibility History

DHMH staff reported that it would not be difficult to produce a file with eligibility history and contact information. The state tends to use information from the MMIS, but it can also easily use information from CARES, or do both.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Health plans are required to submit individual-level encounter data for all enrollees, including MCHP Premium. The data are stored in MMIS.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

Maryland received funding from the Health Resources and Services Administration (HRSA) to conduct focus groups, in order to study the dynamics of the SCHIP program. Health Systems Research (HSR) is conducting these groups and is recruiting participants, using contact data from MMIS and CARES. The analysis was to be completed in 2001.

The University of Maryland is conducting a disenrollment study.

B. INTERNAL REPORTS

Maryland is participating in the Robert Wood Johnson Foundation Covering Kids Program, and assembled data from CARES on the number of applications processed before, during, and after the program went into effect. Maryland also provided information on hotline activity.

Maryland also provides ad hoc reports on the number of enrolled children by coverage groups, counties, and managed care plans.

IV. DISCUSSION

Maryland's Medicaid and M-SCHIP programs use a statewide eligibility data system, CARES, which is shared by other programs such as TANF and food stamps. The system collects detailed information from the application and about the reasons for denials and disenrollment at the individual level. Enrollees have permanent, unique IDs, which can be

used to track children across programs. Contact information is complete, and staff believe it to be of good quality. All information from CARES is passed on to the state's MMIS, except for individual-level reasons for denials and disenrollment (which are stored in the MMIS at the household level).

Maryland implemented a S-SCHIP program, called MCHP Premium, in July 2001. This program uses the MMIS eligibility data system, which maintains historical enrollment data and contact data for S-SCHIP. Reasons for denial and disenrollment are stored at the household level in the MMIS. A common ID system with CARES (individual and household levels) allows both individuals and families to be tracked between MCHP Premium and MCHP/Medicaid.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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MASSACHUSETTS

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Massachusetts has a combination SCHIP program, called MassHealth, which is administered by the Massachusetts Division of Medical Assistance (DMA) and includes a variety of health programs, including SCHIP and Medicaid. Medicaid and M-SCHIP are known as MassHealth Standard. M-SCHIP covers children ages 0 to 18 years in families with incomes up to 150 percent of the federal poverty level (FPL). The state has three S-SCHIP programs funded by Title XXI: (1) Family Assistance Direct Coverage, for children ages 1 to 18 years with family incomes between 150 and 200 percent FPL; (2) Family Assistance Premium Assistance (FAPA), an employer buy-in program for families with access to employer-sponsored insurance (ESI) and with family incomes between 150 and 200 percent FPL; and (3) CommonHealth, a program for disabled children with family income between 150 and 200 percent FPL.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Massachusetts uses the same application, eligibility determination system, claims processing system, and network of providers for all its MassHealth programs. The eligibility determination system, MA21, automatically assigns eligibility based on the richest benefit package for which a child qualifies, rather than following a sequential eligibility determination process. For reporting purposes, the system flags children meeting SCHIP eligibility rules. For those in MassHealth FAPA, MA21 generates information for the state comptroller and fiscal vendor, who make payments to families or employers. The state maintains MA21 as a mainframe database.

Claims processing occurs in the state's Medicaid Management Information System (MMIS), which receives eligibility information from MA21. Both systems reside in the same location and are easy to link. The MMIS also maintains a "recipient eligibility file" that has information on other programs for which a family is eligible. The recipient eligibility file is sent to the MMIS by the Department of Transitional Assistance (DTA). DTA maintains a separate eligibility file for Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP).

MA21 stores the information needed to determine eligibility; process referrals, notices, and redeterminations; make special payments; and provide premium assistance to members (both calculation and payment). In addition, as part of the Premium Assistance program, MA21 contains information for qualified employers. MMIS contains claims processing information, the results of eligibility determinations, and information about other programs for which a family is eligible.

C. CHANGES TO SYSTEMS

In 1997, the state launched the MA21 system in conjunction with the implementation of welfare reform. DMA regularly makes improvements to MA21 to increase automation in the system.

Currently, DMA uses both MA21 and MMIS to do reporting, but DMA is discussing bringing MA21 data and the MMIS recipient information into one database that will hold all member information.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

DMA assigns a Recipient ID (RID) and a Recipient Historical Number (RHN) to all individuals in the MA21 system. The RID is an SSN—or, for those without an SSN—a state-assigned number. An individual may have multiple RIDs due to multiple eligibility episodes. The RHN is a unique, permanent identifier that can be used to tie together people with multiple RIDs and multiple eligibility segments.

2. Family-Level IDs

MA21 assigns an eight-character case ID number to each household. The last character is an alpha character that distinguishes family groups, if there is more than one family group in a household. In general, family members have the same case ID and can be linked with the case number. However, this ID does not identify the relationship of family members in a case.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Information from the application is stored in MA21.

Selected Data Elements	Comments
Date of application	Yes
Place of application	Yes[a]
Mode of application	No, most are mailed
Race/ethnicity	Yes, optional
Family composition	Yes
Family income	Yes, gross income
Assets	n.a.
Current/prior third-party insurance	Yes

[a]In 2000, DMA began collecting information regarding the location of application initiation. Prior to 2000, the field might contain a provider number or the number of a Community-Based Organization (CBO).

n.a. = not applicable

Information on disability status and disability insurance from the application also is recorded in MA21.

2. Reason Codes for Denied Applications

Information on denials is stored in MA21. The system can record one reason for closure per eligibility episode.

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes, coded as “receipt of health insurance”
Prior insurance within waiting period	No
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes, coded as “failure to provide required verification” (only coded as such after 60 days)
Withdrew application	Yes, coded as “voluntary withdrawal”

n.a. = not applicable

DMA staff reported high-quality denial data. "Failure to provide required verification" is a common denial code, frequently associated with closure of cases for children who were enrolled using presumptive eligibility but then failed to submit the required documentation.

3. Ability to Determine Initial Program of Application

Families make one application to all health coverage.

4. Identification of Presumptive Eligibility

A child with presumptive eligibility is identified through the presumptive eligibility "category of assistance." Once the child's family supplies the necessary verification, that category closes and the child is moved to another category of assistance and begins a new eligibility segment.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

SCHIP and Medicaid enrollees can be distinguished by a combination of "category of assistance" codes, income, age, and third-party liability information.

2. Historical Enrollment Data

Information on eligibility history in the MA21 is stored in eligibility segments with begin and end dates. New enrollees enter the system on the same day as they are approved for coverage. The system keeps information regarding history of the category of assistance (eligibility), but keeps current information only on such fields as income, household composition, and other health insurance. For example, if a family's income increased from 100 to 150 percent FPL, MA21 would have only the latest income level on the system. Return applicants can be identified in MA21 by the recipient historical number (RHN).

Data in the MA21 data back to the system's inception in 1997, while MMIS records date back to 1982. However, the data available are not as rich as the data available in MA21.

3. Identifying Retroactive Eligibility

Retroactive coverage is 10 days from receipt of the application. Retroactive coverage is identified by comparing the begin date with the date of application.

4. Premium Payment Information

For MassHealth Family Assistance Direct Coverage, data on the amount of the premium, dates of payments, and late payments are available through the DMA systems (MA21 and MMIS).

Premium payment information for MassHealth Family Assistance Premium Assistance is kept on the MA21 system. The system records the amount paid to the employer each month and the history of premium amounts.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

Massachusetts has a 12-month redetermination period for SCHIP and Medicaid. The MA21 system contains a data element indicating the month of redetermination. Once a child is successfully redetermined, the system automatically updates the date to one year later.

2. Reasons for Disenrollment or Case Closure

The table below refers to data stored in the MA21.

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	Yes
Private insurance	Yes
Aged out	Yes
Failure to pay premium	Yes, for S-SCHIP; n.a. for M-SCHIP/Medicaid
Incomplete information on redetermination form	Yes, only coded as such after 60 days
Failure to return redetermination form/did not reapply	Yes, only coded as such after 60 days
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes, coded as "whereabouts unknown"
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes, coded as "voluntary withdrawal"

n.a. = not applicable

DMA staff report that the quality of the disenrollment data are good.

3. Identifying Transfers Between Medicaid and SCHIP

If a child transfers between the S-SCHIP, M-SCHIP, and Medicaid programs, he or she is given a new "category of assistance" code and begins a new eligibility segment. For example, if a child is found eligible for Medicaid at redetermination for S-SCHIP, his or her case will be closed, with a disenrollment reason code of "income too low," and a new eligibility segment will begin.

4. Identifying Disenrollment Prior to Redetermination

DMA staff reported that it would not be easy to distinguish between disenrollment at the time of redetermination versus disenrollment at another time; but, with extensive programming, it is possible. One method would be to compare the redetermination date with the last eligibility segment end date.

5. Automatic Disenrollment

The MA21 system does not automatically disenroll children for any reason.

E. CONTACT DATA

1. Contact Information Collected in System

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes
Zip code	Yes
Alternate address or phone	Yes, alternate phone and address
SSN	Yes, optional for S-SCHIP
Case identifiers other than SSN	Yes, RHN, RID, and case ID
SSNs of parents/adults in HH	Not required
Primary language	Yes

2. Processes for Updating Contact Information

Only state eligibility workers can make changes to contact information in the system. They do so when DMA is notified of changes or when renewal occurs. DMA does not link the MA21 with the Department of Transitional Assistance database for TANF and food stamps to obtain or update contact information.

If DMA receives returned mail without any forwarding information, the case is closed. No effort is made to contact the family.

3. Quality of Contact Information

Currently, for all MassHealth programs, there is a 20 to 25 percent nonresponse rate on redetermination letters as a result of poor quality phone and address information.

4. Ability to Produce Files with Contact Information and Eligibility History

DMA staff report that it is very easy to produce a file with contact information.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Working with MEDSTAT, DMA biannually collects individual-level encounter data for MassHealth Programs (excluding MassHealth FAPA and CommonHealth). This project, called the Encounter Data Project, leads to the submission of a yearly Minimum Data Set to CMS. The encounter data are not merged with the MMIS, but are available in SAS format. Currently, DMA is validating the data by replicating HEDIS measures and checking the quality of the plan-level data.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

The Center for MassHealth Evaluation and Research (CMER) conducts research with DMA. Currently it is involved in a number of studies involving surveys and focus groups. Their projects include:

- An evaluation of presumptive eligibility for all children in MassHealth. They are surveying children who were presumptively eligible, but who did not end up enrolling at the end of their presumptive eligibility period.
- An examination of premiums in MassHealth Family Assistance Premium Assistance, to determine whether premiums are a barrier to enrollment and retention.
- A study of redetermination for all MassHealth recipients, involving a survey of disenrollees.
- A study of the quality of benefits, involving a general satisfaction survey using CAPHS, and a Medical Record Review for the MCOs and primary care case management plan.

The surveys for these studies use information from MA21 for their sampling frames.

B. INTERNAL REPORTS

DMA staff reported that the data from the MA21 has met their needs well. However, the data are very complex, due to a variety of aid categories and coverage types and frequent address changes.

IV. DISCUSSION

Massachusetts uses one statewide eligibility data system known as MA21 for its Medicaid, M-SCHIP, and S-SCHIP programs. This system contains individual-level data on denials and disenrollment. It assigns a unique individual identifier that can be used to track enrollment across programs over time, and assigns a unique case ID that can be used to link family members within and across programs. The system maintains complete contact data and enrollment history, but only maintains the most recent data on items such as income level and insurance status.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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MISSOURI

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Missouri's M-SCHIP program, called MC+ for Kids, covers children ages 0 to18 with gross family incomes up to 300 percent of the federal poverty level (FPL). The Missouri Medicaid program for families and children is known as MC+. The Division of Medical Services (DMS) within the Department of Social Services administers the Medicaid/M-SCHIP program.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Missouri uses the same application, eligibility determination process, and enrollment process and the same providers and enrollment brokers for Medicaid and M-SCHIP. There is one data system for eligibility information for Medicaid and M-SCHIP, known as the Income Maintenance System (IMS). The IMS also is used for the Temporary Assistance for Needy Families (TANF) program, but the Food Stamp Program (FSP) uses a separate eligibility system. Eligibility workers are the same for the MC+ and the FSP and TANF.

Applications for Medicaid/M-SCHIP are made at local offices or by mail-in applications (which are sent to a county office or one of seven regional sites). Workers manually determine eligibility and enter the result into the IMS.

Missouri contracts with First Health to enroll families determined eligible for Medicaid into managed care. First Health also tracks premiums for the higher-income M-SCHIP families (225 to 300 percent FPL). First Health maintains their own database on managed care enrollees. The IMS passes eligibility information to the First Health system nightly.

Missouri's Medicaid Management Information System (MMIS) is maintained by GTE Data Services (now Verizon). Eligibility information is passed nightly from the IMS to the MMIS.

The IMS is a mainframe system that stores information in an IDMS database. The system is maintained by the state.

C. CHANGES TO SYSTEMS

The only recent change to the IMS was the addition of new Medicaid eligibility groups.

Missouri plans to change its eligibility system to a Family Automated Management Information System (FAMIS); FAMIS systems allow for a more integrated system that would determine eligibility automatically. It will be a few years, however, before the implementation of the FAMIS system.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. INDIVIDUAL IDENTIFIERS

1. Individual-Level IDs

Individuals in IMS receive a unique state ID number that follows them over time. IMS also stores SSN.

2. Family-Level IDs

The IMS uses a case ID to identify family members. However, family members in M-SCHIP and poverty-related Medicaid categories might be on different cases than family members in 1931 Medicaid.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Selected Data Elements	Comments
Date of application	Yes
Place of application	County of application
Mode of application	No
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes (gross, net, some disregards)
Assets	n.a.
Current third party insurance	Yes
Prior third-party insurance	Yes

n.a. = not applicable

The information on family composition does not distinguish relationships, but it does record the number of people in the household, as well as information on household members that is relevant to determining their eligibility. The system records family income, both gross and net, and some information on source of income and disregards; however, it is not always possible to tell what the disregards are for, since these calculations are done manually by the eligibility worker.

The system also records information on private insurance coverage, such as company name, whether it is a group policy, and the type (for example, medical, dental, or drug). The system does not currently distinguish between employer-sponsored insurance and individually purchased coverage, although it should reflect this in the future after some planned changes to the eligibility process.

2. Reason Codes for Denied Applications

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes
Prior insurance within waiting period	Yes, coded as "dropped insurance". Also have code for access to "affordable insurance"
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Coded as "non-cooperation"
Withdrew application	Yes
Unknown	Coded as "Other"

n.a. = not applicable

The state uses about 16 codes for denied applications. It has a broad "non-cooperation" category that includes failure to provide needed information; but this category does not indicate the information that was not provided (such as income). Missouri also has a code for voluntary withdrawal of the application. "Non-cooperation" is the most common reason recorded for denials. "Other" is also commonly used; DMS staff estimate that about 15 to 20 percent of denials have this code.

3. Ability to Determine Initial Program of Application

Not applicable—there is one application for Medicaid/M-SCHIP coverage.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

IMS has a data element for eligibility group, which distinguishes M-SCHIP enrollees from other Medicaid eligibility groups.

2. Historical Enrollment Data

There are begin and end dates in the IMS for each spell in an eligibility group. The system stores information on active cases all the way back to the first enrollment spell. The system keeps closed cases for a minimum of three years. Eligibility information is entered into the

IMS the day of determination and has a one-day lag in sending it to the MMIS or First Health. Return enrollees can be identified by the unique state ID in IMS, as well as by SSN.

3. Identifying Retroactive Eligibility

Not applicable for M-SCHIP.

4. Premium Payment Information

Missouri's M-SCHIP program charges premiums to higher-income families (225 to 300 percent of FPL). The information on premium amount and payment history is stored in the system maintained by First Health. If a family is terminated due to non-payment of premiums, this information is sent to the IMS and recorded as the reason for closure. The First Health database and the IMS can be linked by case number.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

Redeterminations occur on an annual basis for M-SCHIP and children's Medicaid. The IMS automatically creates a redetermination date one year from the date of enrollment, and notifies the eligibility worker before a case is due for redetermination. If redetermination is successful, the date for the next redetermination will be calculated off of the most recent redetermination ("reinvestigation") date. If a redetermination is due, but not completed, eligibility continues.

2. Reasons for Disenrollment or Case Closure

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	n.a.
Private insurance	Yes, also have code for "affordable insurance"
Aged out	Yes
Failure to pay premium	Yes, for higher income M-SCHIP families
Incomplete information on redetermination form	Coded as "non-cooperation"
Failure to return redetermination form/did not reapply	Coded as "non-cooperation"
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes, but only for case head
Decided not to reenroll	Coded as "non-cooperation"
Unknown	Coded as "Other"

n.a. = not applicable

Disenrollment codes apply only if an entire case is closed, not if an individual member of a family is disenrolled. For example, if one child in the family ages out of a program, this would not be recorded in the disenrollment codes unless the child made up the entire case (but would be reflected in an update to the composition of the household case).

3. Identifying Transfers Between Medicaid and SCHIP

Children moving between Medicaid and M-SCHIP are identifiable by changes in their eligibility code under MC+.

4. Identifying Disenrollment Prior to Redetermination

The date of termination in IMS can be compared to the redetermination date to identify children who disenroll prior to a redetermination.

5. Automatic Disenrollment

IMS automatically disenrolls children for failure to pay premiums. First Health sends information on premium non-payment to IMS, and IMS closes out the case.

E. CONTACT DATA

1. Contact Information Collected in System

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes, for people in family eligibility unit
Phone number	Yes, at first enrollment[a]
Zip code	Yes
Alternate address or phone	No
SSN	Yes
Case identifiers other than SSN	Yes
SSNs of parents/adults in HH	Yes, required only if parents have coverage
Primary language	No

[a]The phone number on IMS is not updated; the system stores only the number recorded at the time of initial enrollment.

2. Processes for Updating Contact Information

Contact information is updated at the yearly redetermination, if the family reports changes, and if the USPS returns a letter with a forwarding address. Contact information may also be updated if an enrollee calls into eligibility hotlines. For fee-for-service enrollees, hotline workers verify the address when they speak with enrollees. For managed care enrollees, updated information reported to the First Health eligibility hotline is passed on to DMS on an ad hoc basis.

However, the phone number recorded in the IMS at the time of enrollment cannot be edited. While the MMIS does not have fields for address or phone number, there is a free-text field

that is used by the hotline staff. In addition, the First Health database has a free-text field that contains contact information.

Contact information on the IMS is also updated through contacts with families on TANF. IMS is not used for the FSP, although caseworkers are able to look up contact information in the FSP system.

The state does not routinely follow up with disenrollees. It sometimes contacts people who have disenrolled because of failure to pay premiums. However, if the state obtained new address information at the time of followup, this information would not be entered in the IMS.

3. Quality of Contact Information

Missouri is not able to update the phone number field in the IMS after the time of the initial application, so phone numbers might be out-of-date. Updated phone numbers are noted in the caseworkers' physical files but are not stored electronically. The IMS contains no information on alternate addresses or phone numbers.

4. Ability to Produce Files with Contact Information and Eligibility History

DMS staff reported that it would be easy to generate a file from the IMS with contact information and addresses. Depending on the resources available at the time, it might take two weeks to one month. However, staff thought it would be difficult to get updated phone number information from the MMIS or the caseworker files, to supplement the phone number on the IMS recorded at the time of initial enrollment.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Not applicable.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

Missouri contracted with Behavioral Health Concepts, Inc. to conduct an annual evaluation of the 1115 waiver program and SCHIP. The evaluation included phone surveys. In one survey of eight MC+ expansion groups, including M-SCHIP, 7,457 out of 16,705 individuals (45 percent) did not have current phone numbers. Among the remaining 9,248 enrollees, 20 percent had "disconnected phone numbers/wrong phone numbers/fax machines."

The state conducted an informal mail survey last year of families who disenrolled due to non-payment of premiums. It also conducts consumer satisfaction surveys, using addresses from the IMS.

B. INTERNAL REPORTS

DMS produces a number of monthly reports summarizing enrollment, reasons for case closures, and denials. Staff reported that the data in IMS generally meet their needs, although the switch to the FAMIS system should improve internal reporting.

IV. DISCUSSION

Missouri maintains eligibility data for its M-SCHIP and Medicaid programs in one system, known as the IMS, which also maintains data for the TANF program. This system uses a unique, individual ID that follows enrollees over time. IMS maintains historical enrollment data for up to three years. A case-level ID is available to link family members; however, if family members in Medicaid have different case IDs, they cannot be linked. The system records many reasons for disenrollment from the program; however, these termination codes are only used if an entire case closes, and do not reflect the reason for disenrollment of an individual if the entire case is not closed. The system also contains reasons for denied applications at the individual level, such as current insurance, prior insurance, or access to insurance. One limitation of the IMS is that the field for phone number cannot be updated; only the phone number recorded at initial enrollment is available. Missouri will be switching to a new eligibility and enrollment system (a FAMIS system), which should address issues noted here; but this switch will not take place for a few years yet.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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NEW JERSEY

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

New Jersey has a combination SCHIP program known as New Jersey FamilyCare (formerly known as New Jersey KidCare). The M-SCHIP program (Plan A) covers children with family incomes up to 133 percent of the federal poverty level (FPL) (Medicaid for families and children is also known as NJ FamilyCare Plan A). The S-SCHIP program (Plans B, C, and D) covers children with incomes up to 350 percent of FPL. Plan B covers children from 133 to 150 percent FPL, plan C covers from 151 to 200 percent FPL, and plan D covers from 201 to 350 percent FPL. The SCHIP and Medicaid programs in New Jersey are administered by the Division of Medical Assistance and Health Services (DMAHS), in the Department of Human Services (DHS).

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

New Jersey uses a joint application for all FamilyCare programs. Families can mail in the application to a central FamilyCare office or to a county social services office; they can also apply in person at a county office. A SCHIP vendor maintains the eligibility system for the state's S-SCHIP population and, prior to 2001, for M-SCHIP eligibles who applied by mailing in their applications to the vendor. The vendor also conducts managed care enrollment for SCHIP. Vendor staff first screen the application for Medicaid or M-SCHIP (Plan A) eligibility. If an applicant appears eligible for Plan A, the application is handed to state eligibility workers who are outstationed at the vendor site. The eligibility workers validate the vendor's preliminary eligibility determination. Whether or not the applicant is determined eligible for S-SCHIP or Medicaid/M-SCHIP, that person remains on the vendor system, as an eligible, denied, transferred, or pending case.

New Jersey's DHS operates a state-supervised, county-administered eligibility system for Medicaid and M-SCHIP enrollees who apply through a county DHS office. Applications made at county offices are entered into a Medicaid eligibility system only after eligibility is determined. Each county may or may not have an internal automated tracking system for applications. Transmittal from the counties to the statewide eligibility system, the Medicaid Eligibility File (MEF), can vary from handwritten data entry forms to manual data entry directly on-line to electronic data transfer (the exception). According to staff, this system is old and technologically unsophisticated and holds a minimal amount of eligibility and demographic information at the individual level.

If a family applying at a county office appears eligible for S-SCHIP, the county forwards the hard-copy application to the SCHIP vendor. For families applying for Temporary Assistance for Needy Families (TANF), there is a separate eligibility system that also accepts input from the counties, and that is slightly more comprehensive than the MEF. The Food Stamp Program (FSP) and other benefit programs have separate systems to which state

staff have inquiry access. Because of the various levels of regulatory privacy issues between agencies, however, there is currently no single tracking system that can quickly display all the assistance requests or transactions for an individual or family.

Both the county and vendor systems send eligibility data nightly to MEF, which is maintained by the Department of Treasury. Thus, the MEF stores records for Medicaid/M-SCHIP and S-SCHIP. Within the MEF, however, identification (ID) numbers are unique to each agency, including the SCHIP vendor. If a client has an open eligibility record originating at multiple agencies, he or she will have multiple records in the MEF. When the MEF sends data to the state's Medicaid Management Information System (MMIS), these records are combined into one record per person, by linking on key identifiers (name, birth date and SSN).

The SCHIP vendor maintains a flat file database. The Department of Treasury MEF is a mainframe system with flat files. Some counties have their own county-specific systems which, as mentioned earlier, can vary from a totally paper-based system to sophisticated relational databases. The state does not have access to these county-based files.

C. CHANGES TO SYSTEMS

New Jersey began contracting with its current SCHIP vendor (Maximus) in January 2001 (replacing a contract with Birch & Davis). In spring 2001, the state was in the process of switching all M-SCHIP and NJ FamilyCare Plan B processing back to the counties from the vendor; this profile, however, is based on operations prior to this change.

The state has also submitted a grant to the Robert Wood Johnson Foundation (RWJF), which is pending approval, for a grant to design a statewide tracking system for the county DHS agencies.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

The SCHIP vendor's system has a "unique account identifier" number that stays with an enrollee each time he or she returns to the vendor's system. Both vendor and county agencies use the same principle of assigning a registration number to each case, but they use different registration numbers. The registration number has a two-digit suffix, or person number, that identifies the individual. The case (registration) number and the person number combined create a permanent ID within each system. Both systems also store the SSN. Although the SSN is optional for S-SCHIP enrollees, state staff report that most families provide them.

The identification numbers in the MEF reflect the location (each county or vendor) where eligibility determination was made (first two digits), the program (third and fourth digits),

the six-digit agency "registration" number, and the person number (last two digits). Thus, the same individual can have two (or more) individual-level IDs if they move between counties or vendors.

2. Family-Level IDs

The SCHIP vendor system, as well as most of the county systems, use the case (registration) number as the family identification number. Within systems, siblings have the same six-digit case ID number, and different individual person numbers as the last two digits of the identification number. Case numbers, however, are not shared across the vendor and county systems, which means that siblings cannot be identified across programs.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

The following table refers to the SCHIP (FamilyCare Plans B, C, D) application information in the SCHIP vendor system.

Selected Data Elements—SCHIP	Comments
Date of application	Yes, and date processed
Place of application	Yes, code of organization/agency that provided application; where applicant heard of FamilyCare
Mode of application	No
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes, and amount of disregards
Assets	n.a.
Current/prior third-party insurance	Yes

n.a. = not applicable

The following table refers to the application data for those determined eligible for Medicaid or M-SCHIP that are sent to the MEF from the local county DHS offices.

Selected Data Elements—MEF	Comments
Date of application	No
Place of application	Yes, county of application
Mode of application	No
Race/ethnicity	Yes
Family composition	Yes
Family income	No
Assets	n.a.
Current/prior third-party insurance	Yes, third-party liability coverage type

n.a. = not applicable

2. Reason Codes for Denied Applications

The vendor's system records the reasons for denial for S-SCHIP and for the M-SCHIP eligibles who submitted mail-in applications (as of spring 2001).

Selected Reasons for Denial—SCHIP	Comments
Income too high	Yes
Income too low	Yes
Age	Yes
Immigration status	Yes
Assets	Yes
Current insurance	Yes
Prior insurance within waiting period	Yes
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	Yes
Missing data/inadequate information on the application	Yes
Withdrew application	Yes

n.a. = not applicable

The staff we spoke with felt the denial data in the vendor system were of good quality.

Denial information is not available at the individual level for those Medicaid applicants and M-SCHIP applicants who applied through the county (a significant number apply through county offices—many are former poverty-level and TANF-eligibles). Any information on denials maintained by the counties is not submitted to the state.

3. Ability to Determine Initial Program of Application

Because families make one application for health coverage, there is no initial program of application. The identification number on the MEF will identify which agency (county or the SCHIP vendor) performed the eligibility determination.

4. Identification of Presumptive Eligibility

FamilyCare plans A, B, and C have presumptive eligibility. Presumptively eligible SCHIP beneficiaries can be identified by a unique number (25) in the first two places of the identification number on the MEF.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

A three-digit program status code in the MEF distinguishes SCHIP and Medicaid eligibility categories.

2. Historical Enrollment Data

Data in the SCHIP vendor's eligibility system date back to February 1998, when the program began. Enrollment history in the vendor file is stored in eligibility segments; if a child switches between S-SCHIP and M-SCHIP, he or she will begin a new eligibility segment. The system is required to keep a history of any status changes at the case and member levels. The unique account number in the vendor's system can be used to identify return applicants to SCHIP.

The vendor system sends enrollment data to the MEF. Counties also report eligibility information to the MEF. If a child becomes ineligible, the record is held for two years in the MEF system. However, since the vendor and each county uses their own ID systems, children who have been enrolled in multiple programs or counties will have multiple records in the MEF. In MEF, the registration number can be used to identify return applicants who have multiple enrollment spells within S-SCHIP and M-SCHIP in the vendor system, or within Medicaid and M-SCHIP in a county. However, it may not be possible to identify return enrollees in Medicaid who applied in different counties, or return enrollees in M-SCHIP who did not enroll each time through the vendor or the same county. Also, records for individuals with no eligibility over two years are purged from the system.

The MEF sends enrollment data to the MMIS, where records are combined into one record per person (using SSN, if available, and other identifying information). The MMIS could be used to track enrollment history in all programs and distinguish new and return enrollees. The MMIS keeps eligible records back to 1980.

3. Identifying Retroactive Eligibility

The vendor system has an indicator for retroactive eligibility for M-SCHIP enrollees, which combined with the system entry and eligibility dates, could be used to identify periods of retroactive eligibility.

For Medicaid cases, if retroactive eligibility is determined at the time of application (or within six months from the month of application), a separate eligibility segment is created on the MEF and identified as retroactive eligibility by assigning a "county of responsibility" code unique to retroactive eligibility.

4. Premium Payment Information

Data on premium payments and premium-payment history information for S-SCHIP are available on the vendor system.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

Redetermination takes place every 12 months for all New Jersey FamilyCare groups. All FamilyCare plans use a universal mail-in form. As of spring 2001, county offices handle redeterminations for SCHIP enrollees who apply through the counties. All other SCHIP redeterminations are handled through the vendor.

The vendor's system includes a data element for the redetermination date. The vendor's system will automatically update this date at the time of redetermination, but there is a manual override. County systems also have their own internal tracking for redeterminations, and can choose to report the redetermination date to the MEF. County workers manually update the redetermination date for Medicaid and SCHIP cases that they process.

2. Reasons for Disenrollment or Case Closure

The following table refers to the reasons for disenrollment stored in the vendor's system for SCHIP enrollees. These data are available only at the individual level in the vendor system; the following table describes the reason codes in the vendor system.

Selected Reasons for Disenrollment—SCHIP	**Comments**
Income too high	Yes
Income too low	Yes
Private insurance	Yes
Aged out	Yes
Failure to pay premium	Yes
Incomplete information on redetermination form	Yes
Failure to return redetermination form/did not reapply	Yes, coded as "failure to respond"
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes, coded as "failure to respond"
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes

n.a. = not applicable

For Medicaid, and M-SCHIP cases processed by the counties, individual-level information on the reason for disenrollment is not available on the MEF. The counties maintain disenrollment information at the individual level; the state has no access to the county systems, nor does it know what specific codes the county systems use. Staff reported that the MEF uses four broad disenrollment codes, which usually are used only if an enrollee has died.

3. Identifying Transfers Between Medicaid and SCHIP

There is a reason code for disenrollment in the SCHIP vendor's system indicating that an enrollee's income was too low. However, the vendor does not transfer the case to a county, nor does the vendor follow up to see if the child enrolls in Medicaid; thus there is no way to definitively identify a transfer to Medicaid from the vendor system. Using the MEF, one could potentially identify transfers by matching records between SCHIP and Medicaid by the SSN, but only for those who voluntarily report SSNs.

The eligibility records in the MMIS can be used to track transfers between Medicaid and SCHIP. The state merges the records for SCHIP and Medicaid into one record per individual in the MMIS, by matching on SSNs and other factors, such as name and date of birth.

4. Identifying Disenrollment Prior to Redetermination

Disenrollment from SCHIP prior to redetermination could be identified in the vendor system by comparing the termination date to the redetermination date in the system. One could also identify disenrollment prior to redetermination in the MEF by comparing the redetermination date and termination/disenrollment date fields in the MEF.

5. Automatic Disenrollment

Both the vendor and the MEF systems will automatically disenroll a child who ages out of the program.

E. CONTACT DATA

1. Contact Information Collected in System

Selected Contact Data—SCHIP	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes, also records "best time to call"
Zip code	Yes
Alternate address or phone	Yes
SSN	Yes, optional for S-SCHIP[a]
Case identifiers other than SSN	Yes
SSNs of parents/adults in HH	Yes, optional
Primary language	Yes

[a]Although families are not required to submit SSNs for S-SCHIP, state staff report that most provide the information for all family members.

Selected Contact Data—MEF	Comments
Name of parent/guardian(s)	Yes
Phone number	No
Zip code	Yes
Alternate address or phone	Yes
SSN	Yes
Case identifiers other than SSN	Yes
SSNs of parents/adults in HH	Yes, if the parent is Medicaid eligible, otherwise optional
Primary language	No

2. Processes for Updating Contact Information

Contact information in the vendor system is updated at redetermination or when provided by the family. Monthly eligibility cards are mailed to families, which serve to encourage families to update address information. Changes to the contact information can occur when disenrollment occurs. County caseworkers and the vendor can make changes to the contact information in their respective data systems. These changes would then be sent to the MEF.

3. Quality of Contact Information

The staff felt that the address information in the vendor's system and MEF is good, mostly as a result of mailing monthly eligibility cards. No phone number is available on the MEF.

4. Ability to Produce Files with Contact Information and Eligibility History

The vendor would be able to produce a file of contact information and enrollment history.

It would not be difficult to produce a file from the MEF with enrollment history and address information. This has been done several times for mass mailings. However, contact information from the MEF would not have phone numbers.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Individual-level encounter data are sent by the HMOs to the fiscal agent. These data are held by the fiscal agent, and eligibility data can then be linked to the fiscal agent data. More information can be gathered from the fiscal agent. The contact for these data is Mike Chiafolo at 609-588-2759.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

A grant from the David and Lucille Packard Foundation will allow the state to conduct surveys and focus groups.

B. INTERNAL REPORTS

The state reported that the data from the SCHIP vendor has met its needs and that several studies are underway. The Rutgers State Health Policy Group is producing a large report about disenrollment with vendor data. The state is conducting studies of enrollment in FamilyCare and Medicaid, looking at the media's influence on enrollment and at the successes and failures of delinking Medicaid and TANF. The state also is conducting quality control studies on disenrollment.

IV. DISCUSSION

New Jersey's SCHIP and Medicaid application and eligibility data are stored in different data systems. A vendor maintains data from all S-SCHIP and M-SCHIP applications that were mailed in to the state. The vendor system maintains individual-level data on SCHIP denials and disenrollment, and contains comprehensive contact data. Siblings can be identified within the S-SCHIP and M-SCHIP programs, but only if their records are maintained by the vendor.

Counties determine eligibility and maintain eligibility data for children who apply through a county office for Medicaid or M-SCHIP. (In spring 2001, New Jersey was planning to change operations, so that counties would process all M-SCHIP cases and, eventually, FamilyCare Plan B S-SCHIP cases.) The counties use separate data systems which have varying degrees of automation. Each county sends data on eligibility to the statewide Medicaid Eligibility File (MEF). The counties, however, do not report data on denials or disenrollment at an individual-level. The MEF stores address data, but not phone numbers. And the ID system for individuals and families is unique only in an individual county agency.

The vendor system also sends information to the MEF; thus address data and historical enrollment data for S-SCHIP, M-SCHIP, and Medicaid is available on this system. However, these programs use different ID systems (vendor or county); children can be linked only across programs, using the SSN. Although the SSN is optional for S-SCHIP, state staff report that most families report SSNs. It is not possible to link siblings across S-SCHIP and Medicaid. The MEF reports enrollment data to the state's MMIS, which uses a reconciliation process to combine multiple records for children who had records from more than one county or the vendor.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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NEW YORK

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

New York has a combination SCHIP program, known as CHPlus, which is administered by two different divisions within the Department of Health (DOH). The M-SCHIP program is administered by the Office of Medicaid Management and covers children ages 15 through 18 with net family incomes up to 100 percent of the federal poverty level (FPL). New York's M-SCHIP and Medicaid programs are known as CHPlus A. The S-SCHIP program, CHPlus B, covers children ages 0 through 18, not eligible for Medicaid, with gross incomes up to 250 percent FPL. The Division of Planning, Policy, and Resource Development (DPPRD) administers S-SCHIP.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS[1]

Eligibility for S-SCHIP is determined by the individual CHPlus health plans, while eligibility for Medicaid/M-SCHIP is determined at the local level by the Department of Social Services (DSS). Families apply for Medicaid/M-SCHIP and S-SCHIP using a joint application and may submit the application in one of four ways. First, applications may be submitted by mail. Second, applications may be submitted using facilitated enrollment. Facilitated enrollers are located at organizations around the community and are trained to assist an applicant in completing the application process for Medicaid, SCHIP, and/or Women, Infants and Children (WIC). During facilitated enrollment, if a child appears eligible for Medicaid/M-SCHIP, the enroller will complete the required face-to-face interview and forward that application to the local social services district. If a child appears eligible for S-SCHIP, the enroller will submit the application to a health plan. Third, an application may be submitted through a health plan; if the child appears to be eligible for S-SCHIP, the health plan will determine eligibility. If the child appears to be Medicaid-eligible, the health plan, if it is a facilitated enroller, will complete the face-to-face interview and forward the application to DSS. If the health plan is not a facilitated enroller, then the Medicaid eligible application will be forwarded to a facilitated enroller or local district. Fourth, applications may be submitted through a local DSS office. A face-to-face interview is required for Medicaid. If a child who applies through a local DSS office appears eligible for S-SCHIP, the DSS office will refer the applicant to a health plan or a facilitated enroller.

[1]We made numerous attempts to schedule an interview with Medicaid representatives from New York but were not able to do so. As a result, we obtained very little detail on the Medicaid data systems.

Each health plan determines eligibility for S-SCHIP using its own system. After determining eligibility for S-SCHIP, the health plan sends enrollment information to DPPRD in a monthly billing file. The billing file contains records for all enrollees for the current month. DPPRD combines the monthly billing files from each plan into a statewide file. The health plan also sends DPPRD monthly aggregate enrollment reports and quarterly denial and disenrollment data. The DPPRD S-SCHIP billing file is a flat file with individual-level data. The aggregate reports sent to DPPRD by the health plan on enrollment and disenrollment are stored in a relational database.

The Welfare Management System (WMS) is used to determine eligibility for Medicaid/M-SCHIP, as well as for Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP). There are two WMS systems, one in New York City and one in upstate New York. Caseworkers in local offices enter application information into the WMS; then a budgeting component of the system, the Medicaid Budget Logic (MBL), automatically assigns an eligibility category. The New York City WMS also uses a system called the Electronic Eligibility Decision Support System (EEDSS) to help determine eligibility. The information from the EEDSS is then passed to MBL.

The two WMS systems send some eligibility information to the state's Medicaid Management Information System (MMIS). The MMIS contains enrollment information for individuals determined eligible for Medicaid and M-SCHIP.

There is no regular linking between the Medicaid/M-SCHIP and S-SCHIP eligibility files; however, DPPRD conducts a search for duplicate enrollment between MMIS and S-SCHIP data using SSN.

C. CHANGES TO SYSTEMS

Currently, the S-SCHIP monthly billing files sent to DPPRD contain a record for every individual enrolled for the specified month. At present, DPPRD is evaluating the current system and realizing that, with volume changes and federal mandates, the form of data processing now being used does not meet its needs. The DPPRD plans to develop a new system that would be more interactive with the Medicaid data, in order to reduce duplicate enrollment; in addition, this would create a unique identifier that follows a child throughout the system, from plan to plan and between SCHIP and Medicaid.

DOH is currently redesigning MMIS to make it easier to get aggregate data for all the data elements it would like to analyze. The newly designed MMIS will be called EMED NY and will have more comprehensive eligibility data from the WMS. It will also be easier to use, will have fewer file synchronization problems, and will better accommodate future connections between programs (for example, the capacity to hold S-SCHIP information).

In addition, the state is working to bring the EEDSS system, now located only in New York City, to a statewide level.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

The SSN is used as a unique ID in S-SCHIP. However, since SSN is optional, if families do not report the child's SSN, the health plan creates an identifier for a child that is similar to an SSN. This plan-based identifier is not permanent; if a child changes plans, the new plan will create another plan-based identifier. (For analytical purposes, when DPPRD matches plan enrollment files, they match by DOB and first and last name for children whose SSN is not reported.)

For Medicaid/M-SCHIP recipients, WMS assigns a unique, permanent Client Identification Number (CIN) that will follow an individual over time and across eligibility groups. The CIN also indicates in which WMS system the record is found.

2. Family-Level IDs

The S-SCHIP billing files have a family ID; however, each plan constructs their own family ID. As a result, siblings can be linked only if they are in the same plan. In addition, the family ID cannot be used to link to siblings enrolled in different programs.

The WMS uses a case number to identify family members within the same case; however, it is not uncommon for different family members to have different case numbers. For example, a mother may have Supplemental Security Income (SSI), while her children have Medicaid through poverty categories; as a result, the mother will be one case and her children will be another. Staff reported that, even though family members can have different case numbers, an indicator in WMS can be used to link children with their mother. No additional information was available on this indicator.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Data from the initial application for S-SCHIP enrollees is maintained in the DPPRD monthly billing file.

Selected Data Elements—S-SCHIP	Comments
Date of application	Yes
Place of application	No
Mode of application	No
Race/ethnicity	No
Family composition	No
Family income	Yes, gross income by FPL
Assets	n.a.
Current/prior third-party insurance	No

n.a. = not applicable

DPPRD maintains a separate database on applications processed by facilitated enrollers. This database is used to track both the destination of applications and their outcome.

2. Reason Codes for Denied Applications

DPPRD receives quarterly denial information from the S-SCHIP health plans, but at the aggregate (not individual) level. The following table refers to the reasons reported in aggregate to the state.

Selected Reasons for Denial—S-SCHIP	Comments
Income too high	Yes
Income too low	n.a.
Age	Yes
Immigration status	No, will use state funds to cover
Assets	n.a.
Current insurance	Yes
Prior insurance within waiting period	n.a.
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes
Withdrew application	Yes
Unknown	Yes

n.a. = not applicable

The health plans also report a denial code indicating duplicate health plan enrollment. DPPRD encourages the plans to not use the "unknown" code. All the codes listed above,

which are used by the state health plans, are specified by the state. Individual-level data on denials would have to be collected from the health plans.

3. Ability to Determine Initial Program of Application

Families make a joint application for health coverage. Limited information is available on children who apply for S-SCHIP through health plans but are found eligible for Medicaid. If a child who applied to a health plan for S-SCHIP is found Medicaid-eligible, the plan may enroll the child for up to two months while the child goes through the Medicaid enrollment process. It is possible to identify these children in the S-SCHIP data; however, not all children receive this temporary S-SCHIP coverage. Medicaid-eligible children who apply for S-SCHIP through venues other than the health plans are not tracked.

4. Identification of Presumptive Eligibility

Presumptive eligibility for S-SCHIP children is identified by a separate code in the billing file. Medicaid does not offer presumptive eligibility.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

Eligibility at the program level can be determined by knowing which data system maintained the child's record. S-SCHIP children are in the DPPRD system, while Medicaid/M-SCHIP children are in the VMS or EEDS.

We were unable to arrange an interview with Medicaid representatives to learn more about the data system and eligibility categories for Medicaid and M-SCHIP in these systems.

2. Historical Enrollment Data

The S-SCHIP health plans send an updated billing file to DPPRD on a monthly basis. Each billing file reflects enrollment only for that month. The state has been maintaining each billing file since the implementation of S-SCHIP. The monthly billing files would need to be merged to construct a history of enrollment in S-SCHIP. Every individual record in each billing file is 232 characters long, although some of the data elements within individual records may change from month to month. All the health plans use the same structure for the billing file.

The SSN can be used to identify returning enrollees but only among children who report SSNs. Within a health plan, the plan ID number could be used to identify return applicants; however, the plan ID is plan-specific. For Medicaid/M-SCHIP recipients, the CIN can be used to identify return applicants.

3. Identifying Retroactive Eligibility

Not applicable. The S-SCHIP program does not have retroactive eligibility.

4. Premium Payment Information

DPPRD is able to identify the level of subsidy the department pays for S-SCHIP; however, the health plans maintain all detailed premium information for the S-SCHIP program.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

Eligibility is redetermined every 12 months in M-SCHIP/Medicaid, but there is no guarantee of eligibility. S-SCHIP offers 12-months of continuous eligibility.

S-SCHIP enrollees may mail in the redetermination form to the health plan, use a facilitated enroller (who forwards the redetermination form to the health plan), or redetermine eligibility in person at the health plan.

The S-SCHIP billing file does not store a redetermination date; rather, the "original enrollment date" indicates that redetermination should occur one year from that date. If a child continues to appear on the billing file, the state assumes that redetermination has occurred.

2. Reasons for Disenrollment or Case Closure

DPPRD receives quarterly disenrollment information from the S-SCHIP health plans, at the aggregate (not individual) level. The following table refers to the reasons reported in aggregate to the state.

Selected Reasons for Disenrollment—S-SCHIP	Comments
Income too high	Yes
Income too low	Yes
Private insurance	Yes
Aged out	Yes
Failure to pay premium	Yes
Incomplete information on redetermination form	Yes
Failure to return redetermination form/did not reapply	Yes
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	No, coded as "other"
Moved out of state	Yes
Died	No
Decided not to reenroll	Yes
Unknown	No, coded as "other"

n.a. = not applicable

Staff reported that "other" is a catchall category that seems to be used primarily for children who could not be located.

3. Identifying Transfers Between Medicaid and SCHIP

The DPPRD data system can identify transfers between Medicaid/M-SCHIP and S-SCHIP, for children who have provided an SSN.

4. Identifying Disenrollment Prior to Redetermination

When a person disenrolls from S-SCHIP, the billing file for that month will show an end date, and that person will not appear in future billing files (unless they reenroll). The end date could be compared to the original enrollment date, to determine whether disenrollment from S-SCHIP occurred at a time other than the yearly redetermination. In some instances, DPPRD does not receive a record with a termination date; they simply stop receiving a bill for the child.

5. Automatic Disenrollment

The health plans conduct all redeterminations and send information to S-SCHIP. If automatic disenrollment occurs, it does so at the plan level.

E. CONTACT DATA

1. Contact Information Collected in System

Contact data are maintained in the DPPRD billing file.

Selected Contact Data—S-SCHIP	Comments
Name of parent/guardian(s)	No
Phone number	Yes
Zip code	Yes
Alternate address or phone	No
SSN	Yes, optional
Case identifiers other than SSN	Yes, family ID and plan-based identifier for those not reporting an SSN
SSNs of parents/adults in HH	No
Primary language	No

2. Processes for Updating Contact Information

S-SCHIP enrollees may update contact information with their health plans any time. The plans will pass this updated contact information to DPPRD via the billing file. Because plans maintain the contact information, any formal process for updating contact information is specific to each plan. The health plans do not link with other state databases to obtain contact information. Followup with a disenrolled child occurs only at a plan's discretion.

3. Quality of Contact Information

DPPRD reported that initial contact data are good. One eligibility requirement includes proof of residency. In addition, there appear to be a high number of S-SCHIP cases with phone numbers. Staff did not have a sense of the quality of contact information after time has elapsed since initial enrollment.

4. Ability to Produce Files with Contact Information and Eligibility History

Staff reported that it would not be difficult for DPPRD to retrieve S-SCHIP contact information from the billing files, although resource availability might affect their ability to deliver this information quickly.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Health plans do not submit S-SCHIP encounter data to the state.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

DPPRD is conducting surveys using data from the billing files.

Researchers at the University of Rochester have conducted research on the grandfathered (pre-Title XXI) CHPlus (S-SCHIP) program in upstate New York covered by one large health plan. (Several studies were published as a special series in the March 2000 issue of *Pediatrics.)* They conducted telephone surveys with parents for children enrolled between 1991 and 1993, and obtained demographic and contact information directly from the insurer and using other methods, such as directory assistance, insurer records and physician records to obtain phone numbers. Contact was successful for 81 percent of the 3,203 families that were in the initial sample. Surveyed parents provided information on enrollment history in CHPlus; DPPRD administrative data were not used for this purpose.

B. INTERNAL REPORTS

The S-SCHIP program mostly does ad hoc reporting, using the billing files. Often the reports are used for federal reporting and to track enrollment. The billing files have met data needs up to this point, but the S-SCHIP analysts would like it to be more linkable with the Medicaid data.

Medicaid has a research unit that does ad hoc reports, including basic evaluations of case closure and duration of enrollment, using internal data.

IV. DISCUSSION

There are separate data systems for the S-SCHIP and M-SCHIP/Medicaid programs in New York. The individual health plans in S-SCHIP determine eligibility and maintain their own files, while submitting a monthly billing file to DPPRD. The state combines the records from each health plan and maintains a complete monthly eligibility billing file for S-SCHIP. It is possible to link records from each monthly eligibility file by SSN to create enrollment histories. However, SSN is voluntary for S-SCHIP enrollees.

The S-SCHIP eligibility billing files contain core contact data on the child but do not collect the names of parents or guardians or an alternate address or phone number. Nor do these files include individual-level data on denials and disenrollment or premium payment data, because plans do not report the individual-level data to the state.

Medicaid/M-SCHIP eligibility is determined in two state systems, one for New York City and another for the rest of the state. These systems send data to the state's MMIS. Medicaid and M-SCHIP use the SSN as an individual-level identifier; since S-SCHIP does not require the SSN, linking S-SCHIP and Medicaid/M-SCHIP depends on the presence of an SSN on S-SCHIP records.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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NORTH CAROLINA

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

North Carolina has a separate child health (S-SCHIP) program, North Carolina Health Choice for Children, which covers all children up to 200 percent of the federal poverty level (FPL). North Carolina's Division of Medical Assistance (DMA), within the North Carolina Department of Health and Human Services, oversees both S-SCHIP and Medicaid.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

S-SCHIP and Medicaid in North Carolina use the same statewide system eligibility data system, called the Eligibility Information System (EIS). The EIS is also used to determine eligibility for Temporary Assistance for Needy Families (TANF). DMA oversees S-SCHIP and Medicaid at the state level, but program eligibility is conducted at the county level by North Carolina's Department of Social Services (DSS), which maintains the local DSS offices and the EIS.

Caseworkers manually determine an individual's eligibility from information on the state's joint application for children's health coverage (applications can be mailed in to or dropped off at local DSS offices). Application information is entered into EIS, which is a mainframe IMS database.

The EIS submits nightly batches of enrollment information to the state's Medicaid Management Information System (MMIS) to be used for Medicaid claims processing and for nightly updates to the Blue Cross/Blue Shield of North Carolina for S-SCHIP card issuance and claims processing.

The state also maintains an IMS Sybase data warehouse, which houses up to 36 months of eligibility and claims information. Data are sent to the warehouse by MMIS on a monthly basis. The state uses the data warehouse as a source for data reporting.

C. CHANGES TO SYSTEMS

North Carolina's eligibility system has not undergone any significant modifications within the past few years. The only noteworthy change was the addition of new eligibility groups (for example, S-SCHIP). Also, minor systems changes were needed to implement an enrollment freeze in S-SCHIP as of January 1, 2001, which was lifted in July 2001.

The state does not have any plans to dramatically change its systems in the foreseeable future. It may possibly add a few fields related to special needs of participants and managed care education data. The state also plans restructure the file location of several other fields so that some information can be maintained on a historical basis—for example, the field

"living arrangement," which is now a case-level field that is overwritten when updated, will soon be stored in individual eligibility segments.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

EIS assigns permanent, unique identification numbers to persons enrolled in Medicaid and S-SCHIP (as well as the other programs maintained in EIS). The ID is a 10-byte alpha/numeric field assigned by the system. The SSN is recorded when it is reported.

2. Family-Level IDs

Although there is no family-level identification number, per se, the head of each case (presumably the parent or guardian) is assigned a unique ID, whether or not this person receives benefits. It is possible to link siblings using this field, regardless of the program in which they are enrolled.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Selected Data Elements	Comments
Date of application	Yes
Place of application	No, the state hopes to add this field in the future
Mode of application	Yes
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes, gross and net
Assets	n.a.
Current/prior third-party insurance	Yes, last date of insurance, insurance provider, policy number, date coverage began

n.a. = not applicable

2. Reason Codes for Denied Applications

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes
Prior insurance within waiting period	Yes
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	Yes
Missing data/inadequate information on the application	Yes
Withdrew application	Yes
Other	No
Unknown	No

n.a. = not applicable

3. Ability to Determine Initial Program of Application

Medicaid and S-SCHIP in North Carolina are marketed together and applicants make a joint application for both programs and do not apply specifically to either program.

4. Identification of Presumptive Eligibility

Not applicable for S-SCHIP or Medicaid child enrollees.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

The EIS has a field for eligibility group, which distinguishes between S-SCHIP or Medicaid. Each eligibility segment on the EIS has an eligibility category. There also is a classification code that identifies income eligibility group.

2. Historical Enrollment Data

Eligibility segments are kept in EIS with begin and end dates for each period of enrollment. After enrollees' eligibility status changes, they receive a new eligibility segment; also clients receive a new eligibility segment when they renew coverage in a program. Return enrollees can be distinguished from new enrollees by searching past eligibility segments using the permanent, unique identification number assigned by EIS.

Eligibility data are updated in nightly batches from the EIS to MMIS, where enrollment data dates back to 1990. The MMIS merges multiple eligibility segments into one, as long as all data elements are unchanged except for the "History Through" date. For example, five segments with continuous coverage from the EIS will be one segment on the MMIS,

reflecting the earliest "History From" and "Authorized From" dates and the latest "History To" date.

3. Identifying Retroactive Eligibility

Not applicable for S-SCHIP. The earliest date of eligibility in S-SCHIP will be the first day of the month of application, regardless of how long it takes the county to establish eligibility.

For Medicaid, retroactive eligibility is identified by an eligibility segment with an "Authorized From" date prior to the "Date of Application."

4. Premium Payment Information

North Carolina does not require premiums for its S-SCHIP program. It does, however, require an enrollment fee for families with income above 150 percent FPL. The enrollment fee is $50 per child ($100 for two or more children).

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

S-SCHIP and Medicaid offer 12 months of continuous coverage. Because eligibility starts on the first day of the month when the application was filed, the date of redetermination for S-SCHIP is always the first of the month. The date of redetermination appears on the individual's S-SCHIP enrollment card and is recorded in the EIS as the "History Through" date, indicating the month in which the redetermination is due.

The redetermination process begins two months prior to the date of redetermination. At that time, the EIS automatically sends reminder notices to enrollees. Caseworkers receive notice of the individual's impending redetermination. Caseworkers receive additional reminders at later dates if the individual has not completed the redetermination process. If a child is successfully renewed, the caseworker enters a new eligibility segment with a new through date.

2. Reasons for Disenrollment or Case Closure

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	No
Private insurance	Yes
Aged out	Yes
Failure to pay premium	Yes, failure to pay yearly enrollment fee
Incomplete information on redetermination form	Yes
Failure to return redetermination form/did not reapply	Yes
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes
Unknown	No

n.a. = not applicable

3. Identifying Transfers Between Medicaid and SCHIP

Using the eligibility category in consecutive eligibility segments, it is possible to identify children who moved from Medicaid to S-SCHIP, or vice versa. For example, children who have moved from S-SCHIP to Medicaid would have an end date in their S-SCHIP eligibility segment, and would begin a Medicaid eligibility segment. The case would be coded as a program transfer in the termination reason field; however, there would not be any disenrollment code (such as income too low), since the case would not be closed.

4. Identifying Disenrollment Prior to Redetermination

It is possible to distinguish between disenrollment at the time of redetermination, and disenrollment at another time, by comparing the termination date with the "History Through" date, which reflects the month in which redetermination is due.

5. Automatic Disenrollment

Children are automatically disenrolled from S-SCHIP if they reach the age limit, if they fail to return the re-enrollment notice, or if the caseworker fails to update the enrollment period in the EIS.

E. CONTACT DATA

1. Contact Information Collected in System

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes
Zip code	Yes
Alternate address or phone	No
SSN	Yes, optional for S-SCHIP
Case identifiers other than SSN	Yes
SSNs of parents/adults in HH	Yes, if provided (only casehead, not other HH members)
Primary language	Yes, if provided

2. Processes for Updating Contact Information

Contact information is updated as part of the redetermination process. It also can be updated before that time, if the family reports any changes. Information is updated as a result of from client contacts for the TANF program. Food Stamp Program (FSP) eligibility is determined in a different data system; however, if the caseheads are the same in both systems, by name or by SSN, then there is a potential for matching across systems. DMA has performed one ad hoc match of children in food stamps to the S-SCHIP/Medicaid universe in EIS.

3. Quality of Contact Information

DMA staff reported that the contact information in the EIS is "very good," with the only inaccurate information stemming from typos. The state has a forwarding address service with the USPS, which allows the state to track enrollees when sending enrollment cards.

4. Ability to Produce Files with Contact Information and Eligibility History

DMA staff reported that it would not be difficult to produce a file with contact information and enrollment history.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Not applicable. S-SCHIP in North Carolina uses a fee-for-service delivery system.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

The Cecil G. Sheps Center for Health Service Research conducted a survey of new enrollees, asking about their access to care, and satisfaction with SCHIP. The survey had a 74 percent response rate. The state is also conducting a CAHPS survey of Medicaid and S-SCHIP enrollees.

B. INTERNAL REPORTS

The Cecil G. Sheps Center for Health Service Research is conducting a study looking at how people with special needs fare on S-SCHIP.

The state is conducting a Robert Wood Johnson Foundation-sponsored study on outreach. Using Wilmington, NC as a comparison, the study examines the effects of outreach efforts in Greenville, NC, comparing enrollment patterns before and after a media push. This study was scheduled to be released in February 2001.

IV. DISCUSSION

North Carolina maintains eligibility data for Medicaid and S-SCHIP in one system, known as EIS. EIS maintains comprehensive individual-level data on reasons for denied applications and for disenrollment. Using the EIS, it is possible to track children over time within and across programs and to identify siblings within and across programs. Staff report that the contact data in the EIS are good, but the quality depends on how well the counties maintain the data.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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OHIO

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Ohio has a Medicaid expansion SCHIP program known as Healthy Start, which covers children ages 0 to 18 with family incomes up to 200 percent of the federal poverty level (FPL). (The eligibility limit was increased from 150 percent in July 2000.) Medicaid and M-SCHIP are administered by the Office of Ohio Health Plans (OHP) within the Ohio Department of Job and Family Services (ODJFS).

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Ohio's eligibility and enrollment data for Medicaid and M-SCHIP are maintained in one statewide system, the Client Registry Information System—Enhanced (CRIS-E), along with eligibility and enrollment information for Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP). Eligibility data are entered into CRIS-E by caseworkers in local offices in Ohio's 88 counties.

The CRIS-E is maintained by the ODJFS. The system is operated in an online/interactive format, which allows workers to determine eligibility and track benefits for a number of programs. Caseworkers enter all data and all explanations for approvals and denials. While the eligibility determination is automated, caseworkers must approval final eligibility.

The CRIS-E is a mainframe system with flat files, designed by Touche-Ross, a precursor to Deloitte & Touche. (Florida, Delaware, and Wisconsin use similar systems.) Ohio's Medicaid Management Information System (MMIS) operates separately but receives its enrollment data from CRIS-E.

C. CHANGES TO SYSTEMS

Ohio updated its eligibility system in July 2000. Medicaid eligibility standards were loosened, allowing self-declaration of citizenship status, date of birth, and address. The state also has made a commitment to the ongoing task of improving the denial and renewal processes. In addition, Ohio hopes to implement a Graphic User Interface (GUI) for CRIS-E soon, in order to make the system more compatible with Windows.

Over the next few years, the state is hoping to improve the delinking of 1931 Medicaid and poverty-related eligibility categories in CRIS-E. It hopes this will facilitate the use of mail-in applications in the future.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

All individuals have a unique, permanent MMIS ID number in CRIS-E. The system also records SSNs.

2. Family-Level IDs

The ID is in three parts: a 10-digit CRIS-E case number (which identifies persons in a household on the same case); a three-letter category code that indicates the program of eligibility (for example, Medicaid versus food stamps); and a sequence number for each household member. Because the sequence number does not identify the type of relationship, family members can be linked if they are enrolled in the same case number, but relationships cannot be determined.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Selected Data Elements	Comments
Date of application	Yes
Place of application	No
Mode of application	No
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes, collected at case-member level. Gross income
Assets	n.a. (unless application is completed in conjunction for cash assistance or food stamps)
Current/prior third-party insurance	Yes, current insurance

n.a. = not applicable

There are also elements in the CRIS-E for child's school, names of employers, and other free-text fields. The field for insurance coverage distinguishes between employer-sponsored insurance and individually purchased coverage.

2. Reason Codes for Denied Applications

Selected Reasons for Denial	Comments
Income too high	Yes, many different reasons
Income too low	n.a.[a]
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes
Prior insurance within waiting period	n.a.
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes, also code for "failure to cooperate"
Withdrew application	Yes
Unknown	No

[a]If income is too low for M-SCHIP, applicants are enrolled into another Medicaid category; however, this is not recorded as a denial.

n.a. = not applicable

The staff we spoke with felt that the data on reasons for denials are not entirely reliable because of the large number of codes and the subjective nature of their assignment. For example, some caseworkers tend to use the "missing data/inadequate information" code, while others use the "failure to cooperate" code for the same reason.

3. Ability to Determine Initial Program of Application

Not applicable. Families make one application for health coverage.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Eligibility Categories

CRIS-E contains a variable that identifies the eligibility group (for example, M-SCHIP versus traditional Medicaid) to which enrollees belong.

2. Historical Enrollment Data

Enrollment history in CRIS-E is available back to 1991. CRIS-E stores eligibility history with begin and end dates. CRIS-E maintains a "benefits issuance history," which uses SSN

or MMIS ID to look back at eligibility over time. Staff reported that it is easy to look back at eligibility history in all programs on CRIS-E for a given MMIS ID.

3. Identifying Retroactive Eligibility

The date of application and the date of eligibility are recorded separately in CRIS-E and could be used to identify retroactive eligibility.

4. Premium Payment Information

Not applicable.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

Healthy Start requires eligibility redeterminations every 12 months. Currently, Ohio offers 12 months continuous eligibility for families with income from 151 to 200 percent FPL.

CRIS-E alerts caseworkers to an upcoming redetermination date, and automatically calculates the next redetermination date when eligibility is renewed. However, CRIS-E was developed to recognize only one schedule for redeterminations, even if a child is on multiple programs, such as Medicaid/SCHIP and food stamps. Ohio was implementing a process that would allow for separate redetermination schedules for children who are in more than one program, to protect them on Medicaid from being disenrolled due to disenrollment from food stamps.

2. Reasons for Disenrollment/Case Closure

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	n.a. [a]
Private insurance	Yes, only for those at 151 to 200 percent FPL
Aged out	Yes
Failure to pay premium	n.a.
Incomplete information on redetermination form	Coded as "failure to cooperate"
Failure to return redetermination form/did not reapply	Yes
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes
Unknown	No

[a]If income is too low for M-SCHIP, applicants are transferred into another Medicaid category; however, this is not recorded as a disenrollment.
n.a. = not applicable

CRIS-E has hundreds of reason codes for cause of disenrollment. In April 1999, roughly one-third of enrollees up for redetermination were found ineligible because of process-related reasons (for example, failure to return form), while most others had incomes that were too high.

The staff with whom we spoke felt that these reason codes are less useful for research than they are for such administrative purposes as state hearings. Many of the same codes are used repeatedly, while many other codes are never used, because there are simply too many codes for caseworkers to remember. Caseworkers can record up to three reason codes. One of the reason codes refers to the cause of disenrollment/failure to redetermine, while the other two are used to provide text in the letters. It may be difficult, however, to determine the hierarchy of the codes.

3. Identifying Transfers Between Medicaid and SCHIP

A transfer between Title XIX and Title XXI within the Healthy Start Program would be identified by a change in the eligibility group variable.

4. Identifying Disenrollment Prior to Redetermination

Disenrollment from Medicaid or M-SCHIP at a time other than the scheduled redetermination date can be identified in CRIS-E by comparing disenrollment date and the expected date redetermination, based on the date of enrollment.

5. Automatic Disenrollment

CRIS-E does not automatically disenroll children; only a caseworker can disenroll children.

E. CONTACT DATA

1. Contact Information Collected in System

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes
Zip code	Yes
Alternate address or phone	Yes
SSN	Yes
Case identifiers other than SSN	Yes, MMIS ID
SSNs of parents/adults in HH	Yes, only if parent is applying for benefits
Primary language	Yes, but not often used

2. Processes for Updating Contact Information

Contact information is updated at redetermination. Information would also be updated if a family voluntarily reported it to the caseworker. (Caseworkers try to convey the importance of updating contact information to their clients.) Since CRIS-E contains data for food

stamps and TANF, contact information also is updated at redetermination for these programs.

The state does not track disenrollees from Medicaid/M-SCHIP, unless the child continues to be enrolled in TANF or food stamps. Some counties do significant followup on disenrollees, but this varies by county.

3. Quality of Contact Information

The staff we spoke with felt that the addresses in CRIS-E are fairly accurate because information is updated monthly in cases where benefits are administered on a monthly basis. They also felt that the phone numbers are fairly accurate.

4. Ability to Produce Files with Contact Information and Eligibility History

Staff reported that in order to determine the length of time needed to generate this sort of information, parameters would need to be given to programmers.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Not applicable.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

As of December 2000, OHP was not conducting any surveys or focus groups.

The Medicaid Technical Assistance and Policy Program (MEDTAPP) has an agreement with the Ohio Board of Regents to release a research agenda every 18 months to research firms and universities. (The MEDTAPP is a health services research initiative for the development of population-based clinical performance measures for managed care and fee-for-service delivery systems through the analysis of claims and encounter data.) Contractors may conduct research on outreach strategies and outcomes, as well as caseload activity. No surveys were planned at the time of the interview in December 2000.

B. INTERNAL REPORTS

OHP does a monthly summary of its caseload and flows between programs, but this is done at an aggregate level. The staff we spoke with felt that the reports from the CRIS-E are not helpful from a management perspective, because they are at the aggregate level. As a result, the summary reports cannot distinguish between new enrollees and reenrollees.

Therefore, much of the research work done by the department is on an ad hoc basis, and not from standard reports in CRIS-E. The Department did a report in April 1999 on the reason

codes for denials and disenrollment. However, staff reported that some of the reason codes are outdated and many are unreliable for analysis because of their subjective nature. Also, the Department would like some sense about how well outreach is working; information on the source of the application or program knowledge is not available in the CRIS-E.

IV. DISCUSSION

Ohio's Medicaid and M-SCHIP eligibility and enrollment data are maintained in a single statewide system known as CRIS-E, which is also used by the TANF and Food Stamp programs. Enrollment history in the CRIS-E is available back to 1991. The system contains individual-level data on reasons for denials and disenrollment; however, the staff we spoke with reported that many of the codes are outdated and are used inconsistently. It is possible in CRIS-E to track individuals and siblings over time within and across programs. The system also contains core contact data.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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OREGON

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Oregon has a separate child health program (S- SCHIP) that covers children in families with incomes up to 170 percent of the federal poverty level (FPL). The Office of Medical Assistance Programs (OMAP), in the Oregon Department of Human Services, administers SCHIP and the Medicaid component of the Oregon Health Plan (OHP), an 1115 demonstration program.

Oregon's SCHIP program was designed to be seamless with OHP. SCHIP and Medicaid use the same application and eligibility determination processes and the same quality improvement program. Services are received under the same delivery system for SCHIP and Medicaid, and the benefit packages are nearly identical.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Adult and Family Services (AFS), within the Department of Human Services (DHS), determines eligibility for most children in Medicaid and SCHIP. Oregon has four state-run data systems involved in eligibility and enrollment for SCHIP and Medicaid:

1. The Client Information (CI) System contains personal information. It is the system in which a unique, permanent identifier is assigned to an individual (prime ID), which follows a person across programs and over time. Many programs other than Medicaid and SCHIP also use CI, such as the Food Stamp Program (FSP). CI is a mainframe system and is maintained by AFS.

2. The Client Maintenance (CM) System is used to determine eligibility for Medicaid and SCHIP, along with eligibility for other programs, such as Temporary Assistance for Needy Families (TANF). CM contains current information on clients, including the begin and end dates for the most current enrollment period; the system does not store historical information. CM is a mainframe system and is maintained by AFS. CI and CM communicate daily through batch processing.

3. The Recipient History File (RHF), a subsystem of the state's Medicaid Management Information System (MMIS), receives its data from the CM system. The RHF contains a history of medical eligibility in segments; each segment also identifies eligibility for other state programs. The RHF also contains a program code, assigned by the CM system, to describe the type of program. It has a subsystem that contains information on managed care enrollment. The RHF is a mainframe system maintained by OMAP. It receives nightly batches from the CM system.

4. A SYBASE database system contains information taken from the RHF (and in some cases from CM) on children in Medicaid and SCHIP. OMAP uses the SYBASE system for program analysis.

C. CHANGES TO SYSTEMS

There have been no significant changes to the CM system or the RHF over the past few years; and there are no plans to change the systems in the near future. The last significant change to the RHF occurred in 1994, when it was altered to allow for enrollment in fully capitated health plans (for OHP).

The Office of Information Services (OIS) within DHS and OMAP has been working to develop a better interface for the CI system. The Office would like to improve the CI system's interface with other systems, such as those for Senior and Disabled Services, Foster Care, Child Support, and the FSP. Specifically, it would like the interaction between the systems to be more real-time and less batch-driven.

OMAP also is contracting to replace its current relational database management system (SYBASE) with another, in order to develop a decision support system.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

All data systems for SCHIP and Medicaid in Oregon use a unique identifier (prime ID), which is assigned by the CI system. The prime ID is the same for all medical programs within AFS. The prime ID is a unique, permanent number that can be used to track a child's enrollment across programs. The SSN is also recorded in the data systems when it is reported.

2. Family-Level IDs

The CI, CM, and RHF systems can be used to identify and link siblings in SCHIP and Medicaid. The CI and RHF systems contain historical information on the family unit, including information on family members not eligible for benefits. The CM system contains only information on the current status of family members.

Each child has two IDs—a case ID and an individual ID (the prime ID). Siblings can be identified using a case number; however, under certain circumstances, family members will have different case numbers (for example, children in foster care may not have the same case number as the other family members). Siblings enrolled in SCHIP would have the same case number as long as they reside in the same household.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Selected Data Elements	Comments
Date of application	Yes, on CM system[a]
Place of application	No
Mode of application	No
Race/ethnicity	Yes, on CI and RHF systems[b]
Family composition	Yes, on CI and CM systems[c]
Family income	Yes, on CM system[d]
Assets	Yes, on CM system[e]
Current/prior third party insurance	Yes, on CM system

[a]The CM system records the current date of an application to any program, which may not be the application date for SCHIP if client is on multiple programs.

[b]Historically, the race field defaulted to "white" if no race was entered into the system; staff reported that the system may still have this default.

[c]On the CI and CM systems, there is a "family identifier" that reports family composition.

[d]The CM system contains only current income information. The RHF does not record family income, but based on the eligibility category, you can determine what income standards were met. The SYBASE system has some income information derived from the CM system.

[e]The CM system stores only current asset information. OMAP staff report that this information is not reliable.

2. Reason Codes for Denied Applications

Denials to S-SCHIP and Medicaid are maintained only on the CM system.

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	Yes
Current insurance	No
Prior insurance within waiting period	No
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes, coded as "failed to provide required information"
Withdrew application	Yes
Unknown	Yes, coded as "other"

n.a. = not applicable

The denials in CM are only kept on the system for 90 days; after this time, they are archived. Archived denial records are stored on tape and maintained by DHS Computer Center staff. A special request is needed to access these records.

OMAP staff report that the reason codes for denials are not always specific or accurate. For instance, if someone applies for OHP and day care together and is approved for day care, but not for OHP, then the denial of OHP will not show up on CM. There is a case management system, TRACS, which might show some denial information; however, it is difficult to access this information. TRACS is maintained by the DHS OIS TRACS Team.

3. Ability to Determine Initial Program of Application

Not applicable. Because the same application is used for SCHIP and Medicaid, application is made to both programs simultaneously.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

An eligibility group data element in the systems identify children who are on S-SCHIP versus Medicaid.

2. Historical Enrollment Data

The CM system contains only the current eligibility segment for each individual. Historical enrollment information is available in the RHF system. The RHF stores enrollment histories in segments with begin and end dates for each enrollment period. A new eligibility segment is added when a person's case status or program code changes, or after a period of ineligibility. The RHF has data back to the early 1980s, but some eligibility dates precede this period, since files were downloaded from a previous system. Inactive records are kept on RHF.

The SYBASE system used by OMAP has data back to 1994; in addition, it stores eligibility history in segments with begin and end dates for each enrollment period. The SYBASE system is used to generate two eligibility tables. One is generated on the second Saturday of each month and includes everyone in OHP/SCHIP. The second is updated monthly and produces an enrollment table of managed care enrollees (as of the 25th of the previous month). OMAP uses these tables to report enrollment to CMS.

The prime ID can be used to identify children in the RHF or SYBASE systems with previous enrollment in Medicaid or SCHIP.

OMAP staff report that, on average, a person in OHP/SCHIP will have 3.3 eligibility segments per year on RHF, but fewer segments (1.4) when in managed care.

3. Identifying Retroactive Eligibility

Retroactive coverage is identified on the CM system for the current eligibility segment. The system stores a retroactive date that is separate from the application date. The RHF contains a "case descriptor" that shows the code "RM" for retroactive coverage; the length of retroactive coverage, however, cannot be determined using information from this file.

4. Premium Payment Information

Not applicable.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

OHP and SCHIP both offer six-months of continuous eligibility. The CM system is used for eligibility redeterminations. This system records a review date based on program type and the date enrollment began. Redetermination notices are generated by the CM system based on this review date.

If a family does not return their redetermination package in time, the child will be dropped from the CM system automatically. If a child is successfully renewed, a new redetermination date is entered by the caseworker. The CM system has an edit that will ensure that the redetermination date reflects the proper length of enrollment (six months).

The results of the eligibility redetermination are then sent from the CM to the RHF in the nightly batch update.

2. Reasons for Disenrollment or Case Closure

The reasons for disenrollment are maintained on the CM system.

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	No
Private insurance	No
Aged out	Yes
Failure to pay premium	n.a.
Incomplete information on redetermination form	Yes, coded as "did not provide required documentation"
Failure to return redetermination form/did not reapply	Yes, coded as "did not provide required documentation"
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes
Decided not to reenroll	No
Unknown	Yes, coded as "other"

n.a. = not applicable

The disenrollment data in CM are kept on the system only for 90 days; after this time, the records are archived. Archived records are stored in master files. They can be accessed only by special request.

OMAP also receives information from health plans about those who have disenrolled from the plan; however, many of the reasons are grouped in an "LE" category (for loss of eligibility) and are not more specific.

3. Identifying Transfers Between Medicaid and SCHIP

The eligibility group code in consecutive eligibility segments on the RHF would indicate transfers between Medicaid and SCHIP.

4. Identifying Disenrollment Prior to Redetermination

Children who disenrolled before redetermination could be identified on the RHF by comparing the end and redetermination dates. These children could also be identified on the CM as long as the disenrollment is no more than 90 days old.

5. Automatic Disenrollment

The CM system automatically disenrolls children whose families do not return their redetermination forms in a timely manner. Also, the system automatically disenrolls children when they reach the age limit. The RHF will not disenroll children without receiving information from the CM system.

E. CONTACT DATA

1. Contact Information Collected in System

Contact information is stored in a number of systems.

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes, on CM and RHF systems
Phone number	Yes, on CM system
Zip code	Yes, on all systems[a]
Alternate address or phone	Yes, authorized client representative or mailing address if different from home address
SSN	Yes, optional for SCHIP
Case identifiers other than SSN	Yes, prime ID (all systems) and case ID
SSNs of parents/adults in HH	Yes, optional; stored in CI, CM, and RHF if given
Primary language	Yes, on CM and CI systems[b]

[a]The child's home address is kept on all systems. The OMAP SYBASE has the address at the time of application and the current address, while the CI and CM systems maintain only current address information.

[b]Primary language is only recorded at the case level. The state is planning to change the CI so that it stores primary language at the person level.

2. Processes for Updating Contact Information

Contact information is updated at the six-month redetermination. If an HMO contacts OMAP with new information, it will first be verified and then entered into the CI system (at which time it is used to update the CM system). Caseworkers makes changes on the CI system.

Since the CI system is also used for other programs, such as food stamps, information gathered during contacts for those programs will be reflected in the SCHIP and Medicaid systems, which maintain contact information.

After a child disenrolls, the contact information in the systems will not be updated.

3. Quality of Contact Information

OMAP staff report that 80 to 90 percent of contact information is accurate. Reliability tends to vary by population. AFS reports that clients on TANF will have more accurate information than individuals in other programs because these cases are managed more closely.

The state mails out monthly medical cards with orders not to forward. As a result, they routinely receive notices from the USPS regarding undeliverable mail. However, staff reported that friends and neighbors sometimes forward the cards, in which case, OMAP may not learn of an address change.

4. Ability to Produce Files with Contact Information and Eligibility History

OMAP staff reported that it would not be hard to produce a file with eligibility history and contact information on it. This information would come from a number of sources, including records from the SYBASE system.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

There are separate subsystems on the mainframe system for fee-for-service (FFS) and individual-level encounter data. OMAP staff believe the data are transmitted daily from the health plans. The health plans do not provide prescription drug data in the encounter data. OMAP has drug information on FFS enrollees and on carve-out medications (such as, anti-depressants and anti-psychotics).

The claims come in standard formats: HCFA 1500, NSF (National Standard Format) data, and UB92. The state produces weekly mainframe reports on FFS data and encounter data. It also analyzes the FFS and encounter data from the SYBASE database.

A few years ago, OMAP did a validation of encounter data based on chart review, which showed that about 15 percent of services were omitted. OMAP staff reported that they believed that the data have improved since then—in part, because the state is planning to use encounter data to set rates.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

The state has conducted several CAHPS surveys of children and adults in OMAP programs. Otherwise, they have not conducted any surveys of specific enrollees since SCHIP started. They have no future plans for surveys or focus groups, aside from CAHPS.

OMAP is piloting a project to match claims data to survey data. One component of this project includes using the prime ID to match enrollment and claims records.

B. INTERNAL REPORTS

OMAP produces monthly demographic reports, as well as reports based on two years of enrollment data. It also produces a seven-year review of eligibility data based on the SYBASE database.

OMAP did a project for CDC (Medicaid Behavioral Risk Factor Survey), for which it was able to correlate eligibility and enrollment data over time. The methodology used in this study was useful in projecting caseloads and rates.

IV. DISCUSSION

Oregon uses one eligibility determination system for S-SCHIP and Medicaid (CM system), as well as TANF and food stamps. The state uses another system to store current demographic information on enrollees (CI system). SCHIP and Medicaid historical enrollment data are maintained on the state's MMIS system (RHF), as well as in a SYBASE database used for program analysis.

All systems use a unique ID (the prime ID), and there is a case ID that can be used to identify family members in a household. Information on all family members and their relationships is available from the CI system. The RHF system (the state's MMIS) can be used to track an individual's enrollment over time and transfers between the SCHIP and Medicaid programs.

The eligibility system has individual-level data on reasons for denial and disenrollment, but this information is kept for only 90 days, after which it is archived. All enrollment data systems and enrollment data systems contain address information; however, only the CM system stores phone numbers.

V. CONTACT PERSON FOR PARTICIPATION/DATA INQUIRIES

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PENNSYLVANIA

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Pennsylvania has a separate child health program (S-SCHIP) known as PA CHIP, which covers children under age 19 with family incomes up to 200 percent of the federal poverty level (FPL). PA CHIP is administered by the Pennsylvania Insurance Department. The Department of Public Welfare administers Medicaid, or Medical Assistance.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

In Pennsylvania, Medicaid and PA CHIP have separate eligibility data systems. As of late 2000, there was also no statewide database for eligibility and enrollment in PA CHIP. Since the beginning of the program, the seven individual, managed care contractors for PA CHIP have performed their own eligibility determinations, using PC-based systems.

Families may apply for SCHIP or Medicaid by mailing a common health coverage application to their County Office of Assistance (COA). Families may also apply for SCHIP at the SCHIP health plans. If applicants to one program are determined to be eligible for the other program, their application is forwarded to the correct location. Applications of children who appear eligible for PA CHIP are forwarded to the appropriate managed care contractor for the applicant's county.

Eligibility and enrollment data for S-SCHIP are maintained by each managed care organization and are not reported in a unified state system at the individual level; nor are health plan databases linked with other health plan databases. Eligibility and enrollment data for Medicaid are stored in the statewide Client Information System (CIS), maintained by the state's Department of Public Welfare. This system also contains eligibility information for the Food Stamp Program (FSP), Temporary Assistance for Needy Families (TANF), and other public aid programs. The CIS is a UNISYS mainframe system.

At the time of the interview in late 2000, eligibility and enrollment data for S-SCHIP and Medicaid could not be linked. The Pennsylvania Insurance Department and the Department of Public Welfare would compare enrollment information in batch mode, to retrospectively check enrollment lists from other systems.

However, Pennsylvania is implementing a statewide, unified eligibility data system for S-SCHIP, which will be maintained by the Pennsylvania Insurance Department. The new eligibility and enrollment data system will be called CHAPS, and the new centralized Web-based enrollment interface used by the managed care contractors will be called the Central Application Processing System (CAPS).

Once the new S-SCHIP system is implemented, it will be possible to link enrollment data for Medicaid and S-SCHIP. The systems will be linked by SSN or by other identifiers if SSN is not reported (the SSN is not required for S-SCHIP enrollees). If an SSN is not available, workers use name and date of birth to identify records; however, initial reports with contractor data suggest that virtually all children have SSNs. The new S-SCHIP system will be interfaced with the CIS, so that a worker determining eligibility in S-SCHIP will be able to tell whether a child is enrolled in Medicaid, and vice versa. When a child is determined eligible for a program, this information will be electronically transferred to the other program. The new system will be a centralized system using servers with a Web interface—a hybrid system that uses an Oracle relational database.

C. CHANGES TO SYSTEMS

As discussed above, Pennsylvania is implementing major changes to its eligibility data systems for the S-SCHIP program. The Pennsylvania Insurance Department started developing the new unified system in 1999. The system was expected to be fully implemented at all seven contractors in July or August 2001

The state also is making enhancements to the CIS system, which probably will be done in 2002. Currently, the system includes data on basic demographics, but the new system will include the same core elements as on the S-SCHIP system. The eligibility determination for Medicaid is also being automated; at present it is done manually by caseworkers.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

Currently, all historical information on the program enrollment of S-SCHIP applicants is available in the individual systems of the managed care contractors; no unique ID is shared across systems.

The new CAPS system will use the SSN or another identifier if the SSN is not reported (it is not required for S-SCHIP enrollees). If an SSN is not available, workers use name and date of birth to identify records; however, initial reports with contractor data suggest virtually all children have SSNs. In Medicaid, the CIS records SSN for each enrollee.

2. Family-Level IDs

At present, siblings cannot be linked across the S-SCHIP and Medicaid programs, due to the lack of a unique family ID. Within S-SCHIP, siblings cannot be linked if they are enrolled in different managed care organizations. We did not assess individual managed care data systems to determine whether each plan uses a family-level ID that would permit linking siblings who are enrolled in the same plan.

In the new CHAPS system, there will be a family-level ID that will make it possible to link children from the same family within S-SCHIP. In addition, it will then be possible to match across programs by linking with the CIS system.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Currently, each S-SCHIP contractor maintains information from the initial application, but reports it only to the state at the aggregate level. The new unified S-SCHIP system, CHAPS, will store data from the initial application to S-SCHIP at the individual level (see the table below).

Selected Data Elements—CHAPS	Comments
Date of application	Yes
Place of application	No, but records where applicant heard of program/got application
Mode of application	n.a., mail-in application
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes, gross income and disregards
Assets	n.a.
Current/prior third-party insurance	Yes, new system will distinguish between employer-sponsored and individual

n.a. = not applicable

2. Reason Codes for Denied Applications

Currently, there is no information on denied applications in a statewide system at the individual level. The health plans send the Pennsylvania Insurance Department a monthly report with the number of applications received and their disposition—number enrolled, number denied, and reason for denial. The Department also reports the number of applications forwarded to Medicaid (the most common reason for denials to S-SCHIP). About five percent of SCHIP applications are denied because income is too high. Since denials are reported by intake workers at the time of application, very few of them are coded, “reason unknown.”

In the CHAPS system, reasons for denied applications will be available at the individual level. The table below reflects information in the new system.

Selected Reasons for Denial—CHAPS	**Comments**
Income too high	Yes
Income too low	Yes
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes
Prior insurance within waiting period	n.a.
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes
Withdrew application	No
Unknown	Yes

n.a. = not applicable

Reasons for denial from Medicaid are stored in the CIS, but this information was not collected during interviews with the state.

3. Ability to Determine Initial Program of Application

Currently, applications to S-SCHIP that appear to be Medicaid-eligible are forwarded to Medicaid, but only the individual contractors' systems maintain a record of this transfer (although counts are reported in aggregate to the Pennsylvania Insurance Department). In the new system, a data element will record the transfer of a SCHIP application to Medicaid in each child's record. The denial code in these cases will be "income too low."

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

There is no need to distinguish S-SCHIP from Medicaid children by an eligibility code, since enrollment data for the two programs are kept in separate databases.

2. Historical Enrollment Data

The Pennsylvania Insurance Department receives monthly reports from the managed care contractors about the number of S-SCHIP enrollees in each plan. It is unclear how each contractor stores their enrollment data. The staff we spoke with in the Insurance Department thought that the data systems of individual contractors probably only contain data on current enrollees, for the purposes of paying claims and verifying eligibility.

The new CHAPS system will keep a record of enrollment in S-SCHIP for as long as the case is active. Since the state has 12 months continuous eligibility, records will be kept active at least for 12 months and will contain begin and end dates for the 12 month eligibility period. Older eligibility data will be archived. In the new system, as children are enrolled in the S-SCHIP program, they will be entered instantaneously into the data system.

Through the CAPS system, information on previous enrollment will be available when determining eligibility through the Web-based system. In Medicaid and in the new SCHIP system, the SSN can be used to identify return enrollees.

3. Identification of Retroactive Eligibility

Not applicable.

4. Premium Payment Information

Not applicable.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

SCHIP provides 12 months of continuous eligibility. Medicaid uses 12-month redetermination periods but does not have continuous eligibility.

Currently, each managed care contractor performs eligibility renewals for S-SCHIP enrollees, using their own data systems. With the new system, the plans will use the CHAPS system to perform renewals. The CHAPS system will trigger the renewal process 100 days before the yearly renewal is required. There will be a date for reapproval in the system, and a child will be reenrolled the day after approval. Pennsylvania uses a month-end system, in which the last day of the month is the reapproval date.

2. Reasons for Disenrollment or Case Closure

In the current system, the reasons for disenrollment are reported by the managed care plans to the state only at the aggregate level. "Other" is the category used for unknown reasons. Currently, about 20 percent of disenrollees are coded "other" as the reason for disenrollment.

In the CHAPS system, the reasons for disenrollment will be available at the individual level. The table below reflects data for the new system.

Selected Reasons for Disenrollment—CHAPS	**Comments**
Income too high	Yes
Income too low	Yes
Private insurance	Yes
Aged out	Yes
Failure to pay premium	n.a.
Incomplete information on redetermination form	Yes
Failure to return redetermination form/did not reapply	Yes
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes
Unknown	Yes, coded as "Other"

n.a. = not applicable

It was unclear at the time of the interview what level of detail would be reported in CHAPS on disenrollment for "procedural" reasons, such as failing to return the redetermination form, incomplete information, or unable to locate.

The reasons for denial from Medicaid are stored in the CIS, but this information was not collected during interviews with the state.

3. Identifying Transfers Between Medicaid and SCHIP

In the current system, referrals from S-SCHIP to Medicaid are reported in aggregate by the health plans to the state. In the CHAPS system, a transfer to Medicaid will be indicated in the reason for disenrollment. Transfers will be observable at the individual level by linking with the Medicaid CIS system.

4. Identifying Disenrollment Prior to Redetermination

Time of disenrollment will be identified in the new system by a disenrollment date. Since the program has 12 months of continuous eligibility, the disenrollment date could be compared to the redetermination date to identify disenrollment before the renewal date.

5. Automatic Disenrollment

The CHAPS system will not automatically disenroll children.

E. CONTACT DATA

1. Contact Information Collected in System

Currently, each managed care contractor maintains all contact information, and each assigns its own ID number. The information in the table below reflects data in the new system.

Selected Contact Data—CHAPS	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes
Zip code	Yes
Alternate address or phone	Yes, work phone
SSN	Yes, optional in SCHIP
Case identifiers other than SSN	Yes, family ID
SSNs of parents/adults in HH	Yes, optional
Primary language	Yes

2. Processes for Updating Contact Information

Contact information in the CHAPS system will be updated at renewal only. However, if a family contacts the health plans with new information during the year, information will be updated in the system by health plan workers through the CAPS interface.

Updated contact information obtained through redetermination for other public programs, such as food stamps, will be available for S-SCHIP enrollees because it will be possible to link CHAPS with CIS.

3. Quality of Contact Information

In the current system, the Pennsylvania Insurance Department has anecdotal evidence that about 25 percent of letters are returned at renewal. They were not sure about the accuracy of phone numbers, but would guess that it would be the same as with the addresses.

The Department of Public Welfare staff report that the Medicaid contact information in the CIS system is “pretty good.”

4. Ability to Produce Files with Contact Information and Eligibility History

An ad hoc request to the new S-SCHIP system will be required to obtain a file with contact information and enrollment history. The Pennsylvania Insurance Department estimates that such a request would not take long to process, provided all the preparatory work and permissions were done in advance. The Department of Public Welfare believes that it would be easy to generate a list of contact information from the CIS system for Medicaid enrollees.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Currently, the health plans do not report individual-level encounter data to the state. They report aggregate HEDIS data on a quarterly basis. At the time of the interview, the Pennsylvania Insurance Department was unsure whether they would require health plans to submit individual-level encounter data in the future.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

In 2000, the Pennsylvania Insurance Department contracted with a media firm (PPO&S) to conduct focus groups with parents who did not renew S-SCHIP coverage at the time of renewal. ("Forgot" was the main reason given by participants for not reenrolling; but families generally reported that health insurance was important, and that they had had a good experience in S-SCHIP.) Contractors provided contact information of recent SCHIP dropouts (three months or less) to the media firm, which did the sampling. State officials reported that the response rates varied among counties, although the focus group report we received does not include information on the response rates of parents.

Highmark Blue Cross/Blue Shield, one of the managed care contractors for PA CHIP, conducted a study using administrative (encounter) data and medical records comparing HEDIS measures for privately insured and S-SCHIP children in their plan. The study revealed that S-SCHIP enrollees did better than the privately insured on many HEDIS measures. Other contractors will be required to submit this same report in the future.

A few studies are currently under way. Health Management Associates is conducting focus groups on redetermination in a few states, including Pennsylvania. Also, the Insurance Department has contracted with Barrents Group to look at the efficacy of outreach efforts; this study is expected next year. Another study indicated increased awareness from initial outreach efforts.

B. INTERNAL REPORTS

Currently, the Insurance Department uses only aggregate data for internal reporting purposes. The Department receives aggregate monthly reports from contractors on the numbers enrolled and patterns of enrollment. They compare these data with Medicaid enrollment data. In addition, the Department has received lists of enrollees from the managed care contractors and has compared these lists to the CIS database, in order to retrospectively identify children with Medicaid coverage. They found that about four percent of S-SCHIP enrollees were active on the CIS system, but that closure dates were pending for many of these.

The Department is also working with the Department of Public Welfare and the Pennsylvania Partnership for Children (the Covering Kids grantee) to study the trend in the

ratio of enrolled children (in S-SCHIP and Medicaid) to the number of uninsured (from the CPS).

Currently, the state data systems for S-SCHIP are unable to track individual enrollment patterns. Under the new CAPS system, the Insurance Department will be able to track enrollment within S-SCHIP and Medicaid, at the individual level.

IV. DISCUSSION

Pennsylvania's new S-SCHIP data system, which was scheduled to be fully implemented in August 2001, will provide individual-level denial and disenrollment data and contact data for SCHIP. The new system will be separate from the Medicaid data system, but a common ID will make it possible to track individuals and siblings over time between programs. The system will store historical enrollment data from its inception, but will not contain enrollment data prior to this time.

For analyses examining enrollment prior to August 2001, Pennsylvania's data systems for S-SCHIP are unable to support a statewide individual-level study unless the data are obtained directly from the seven participating managed care organizations, each of which collects and maintains its own eligibility and enrollment data. These separate data systems were not assessed in our interviews, and it is not known if they could be linked.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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SOUTH CAROLINA

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

South Carolina has a Medicaid expansion (M-SCHIP) SCHIP program, called Partners for Healthy Children. It covers children ages 1 to 19 with incomes up to 150 percent of the federal poverty level (FPL). M-SCHIP and Medicaid are administered by the Department of Health and Human Services (DHHS). Eligibility for the program is administered by the Department of Social Services (DSS).

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

South Carolina has one eligibility and enrollment system for Medicaid and M-SCHIP, the Client Information System (CIS). The state's DHHS contracts with DSS to maintain CIS and determine eligibility. Application can be made through the mail or in person, and eligibility is determined manually by a caseworker. Once eligibility is determined, information is entered into CIS by the caseworker. The CIS is separate from the state system used to process eligibility for Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP); however, the CIS does share TANF eligibility information with the CIS on a nightly basis.

CIS submits information on a nightly basis in batch form to the state's Medicaid Management Information System (MMIS), and the data are processed by MMIS on the following night. The MMIS system was designed to mirror the CIS; thus, data from the two systems are highly compatible. MMIS sends Recipient Special Program (RSP) and Third-Party Liability (TPL) data back to CIS.

CIS and MMIS are Legacy systems. All records are stored in a flat file framework.

C. CHANGES TO SYSTEMS

No changes have been made to the systems within the past few years. According to DHHS staff, however, a project is underway to replace the CIS in 2002 with a new system called the Medicaid Eligibility Determination System (MEDS). The new system will have two advantages over the current system. First, the CIS system currently conducts edits as part of overnight batch submissions; MEDS is designed to have online, real-time edits. Second, the new system will do an improved job of maintaining enrollment history (the present system overlays, rather than maintains, eligibility history).

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. INDIVIDUAL IDENTIFIERS

1. Individual-Level IDs

Individuals receive a unique, permanent Medicaid ID in CIS. This ID is a 10-digit one that follows individuals throughout their lifetime. The SSN is also recorded.

2. Family-Level IDs

Siblings can be linked within the system by a family identification number. However, if siblings are in different payment categories (such as 1931 Medicaid versus poverty-related Medicaid and M-SCHIP), they will not have the same family ID number.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

Selected Data Elements	Comments
Date of application	Yes
Place of application	No
Mode of application	No
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes, records "total income," as well as earned and unearned income
Assets	n.a.
Current/prior third party insurance	Yes

n.a. = not applicable

The MMIS also stores information from the original application, for children who are found eligible.

2. Reason Codes for Denied Applications

All information on denied applications is stored in CIS. Selected information on denied cases is sent to MMIS as well.

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	n.a.
Age	No, coded as "no eligible child"
Immigration status	Yes
Assets	n.a.
Current insurance	n.a.
Prior insurance within waiting period	n.a.
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes
Withdrew application	Yes
Unknown	No

n.a. = not applicable

The state reported that the data on denied records are reliable.

3. Ability to Determine Initial Program of Application

Applicants apply for one health program. Applicants who have too little income for M-SCHIP are enrolled in traditional Medicaid.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

M-SCHIP eligibles can be distinguished from traditional Medicaid eligibles in the data by a combination of payment category, age, and an indicator for major medical coverage, within the appropriate poverty-level range. (M-SCHIP and poverty-related Medicaid are coded as the same payment category on the system.)

2. Historical Enrollment Data

Eligibility and enrollment data are stored in the CIS in segments containing begin and end dates. (Only closed cases have end dates.) The system allows users to look back at as many

as 36 eligibility segments. Individuals are purged from the system after being ineligible for three years.

The Medicaid ID can be used to identify return enrollees across eligibility segments in the CIS. However, since the system purges inactive records after three years, no historical data would be available in the system for children who reenroll after three years.

3. Identifying Retroactive Eligibility

Staff reported that it was not possible to identify retroactive eligibility. The CIS has fields for date of application and date of eligibility; however, the date of application can be overlaid.

4. Premium Payment Information

Not applicable.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

South Carolina provides 12 months of continuous eligibility in M-SCHIP and Medicaid. When an application is approved, a date of redetermination is entered manually into CIS. As the time of redetermination approaches, the caseworker receives a printout indicating that it is time to contact the enrollee. If the individual is redetermined as eligible for M-SCHIP, the caseworker enters a new date; that is, redetermination dates are not maintained on a historical basis.

2. Reasons for Disenrollment or Case Closure

All information on disenrollment is stored in CIS.

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	n.a.
Private insurance	n.a.
Aged out	No, coded as "no longer eligible child"
Failure to pay premium	n.a.
Incomplete information on redetermination form	Coded as "unable to complete determination/redetermination"
Failure to return redetermination form/did not reapply	Coded as "unable to complete determination/redetermination"
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Coded as "moved or could not locate"
Moved out of state	Coded as "moved or could not locate"
Died	Yes
Decided not to reenroll	Coded as "unable to complete determination/redetermination"
Unknown	No

n.a. = not applicable

The state feels these data are of high quality. There is also a code for "failure to cooperate."

3. Identifying Transfers Between Medicaid and SCHIP

It would be possible to determine if a child transferred from M-SCHIP to traditional Medicaid, and vice versa, by analyzing the appropriate payment category, age, insurance and income variables for an enrollee's eligibility segments. These variables are necessary to distinguish M-SCHIP from traditional Medicaid categories.

4. Identifying Disenrollment Prior to Redetermination

Staff reported that the CIS cannot distinguish between the disenrollment date and the redetermination date because date fields are overlaid. But it is possible to identify disenrollment prior to redetermination by comparing the end date on the record with a date 12 months from the begin date.

5. Automatic Disenrollment

Children are not automatically disenrolled by the CIS. Caseworkers are notified by the system that a case is due for review or of changes in eligibility circumstances; they follow up on this information, and make all decisions to terminate eligibility.

E. CONTACT DATA

1. Contact Information Collected in System

The following information is maintained on both the CIS and MMIS systems.

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes[a]
Zip code	Yes
Alternate address or phone	Yes (address only)
SSN	Yes
Case identifiers other than SSN	Yes, Medicaid IDs and CIS numbers
SSNs of parents/adults in HH	Yes, optional, but applicants tend to provide
Primary language	No (this is being added)

[a]Phone number does not include area code.

2. Processes for Updating Contact Information

Contact information is updated at the time of renewal. In addition, information is updated when there is reason to do so; for example, if monthly eligibility cards are returned, or if the caseworker is notified by the eligible. (Prior to December 2001, CIS sent monthly paper eligibility cards to enrollees; beginning in December 2001, enrollees will receive a permanent plastic card.) Caseworkers and clerical workers can update this information.

Because DSS workers also handle the Food Stamp and TANF programs, information can be shared between the programs. However, caseworkers would have to enter the new information into the CIS system, as well as the system used for TANF and food stamps.

3. Quality of Contact Information

Staff reported that the address information on the CIS (and MMIS) is comprehensive and complete. The state uses a return service on addresses for their monthly enrollment cards, so they are able to monitor address changes. The phone numbers on the system, however, do not have area codes, and staff reported that the number is often missing.

4. Ability to Produce Files with Contact Information and Eligibility History

Staff reported that it would be easy to produce a file from the CIS that contained contact information and enrollment history.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Not applicable.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

South Carolina conducted a short survey of disenrollees. The survey asked about current insurance coverage and satisfaction. Among 241 families in the sample, five surveys were returned as undeliverable.

B. INTERNAL REPORTS

South Carolina produces ad hoc internal reports on disenrollees, total enrollees, new enrollees, reenrollees, and continuous eligibility.

IV. DISCUSSION

All eligibility data for M-SCHIP and Medicaid in South Carolina are maintained in one system. The CIS contains comprehensive information on applicants, disenrollees, and reenrollees. Family members can be linked within M-SCHIP and Medicaid. While the address information is complete, the phone number on the system does not include area code. One flaw with the CIS system relates to difficulties in maintaining enrollment history; records for individuals that have been ineligible are purged after three years, and the system overrides many dates, making it impossible to identify retroactive coverage periods and disenrollment prior to the scheduled redetermination date. A project is underway to replace the CIS, which will be completed in 2002.

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TEXAS

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Texas has a combination SCHIP program. The M-SCHIP program covers children ages 6 through 18 with family incomes up to 100 percent of the federal poverty level (FPL), and the S-SCHIP program covers children ages 0 through 18 with family incomes up to 200 percent FPL. The Texas Health and Human Services Commission (HHSC) oversees both programs. S-SCHIP uses an administrative contractor, Birch & Davis, to process applications, determine eligibility, and manage ongoing cases. Medicaid eligibility is processed by the Department of Human Services (DHS).

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

There is a joint application for SCHIP, Medicaid, and Texas Healthy Kids (a state-funded program for children who do not qualify for SCHIP or Medicaid). The application can be mailed or phoned in to the S-SCHIP administrative contractor, Birch & Davis. Families can also apply in local DHS offices. DHS determines final eligibility for Medicaid and M-SCHIP, and Birch & Davis determines final eligibility for S-SCHIP.

Birch & Davis, under contract with HHSC, manages the S-SCHIP data and enters all information from mail and phone applications in an in-house database, known as the INFORM system. The system also stores all enrollment information.

DHS has two primary systems: (1) Welnet Generic Worksheet System (GWS), a client-server application used in local offices for case documentation and eligibility determination; and (2) System for Application, Verification, Referral, & Reporting (SAVERR), the mainframe database, benefit issuance, and reporting system. Medicaid eligibility is integrated on DHS systems with other programs administered by the agency, including Temporary Assistance for Needy Families (TANF) and the Food Stamp Program (FSP).

The Texas Department of Health (TDH) manages the state's Medicaid Management Information System (MMIS) and contracts with DHS to maintain it. DHS systems provide TDH contractors' systems with eligibility data for enrollment in managed care and for claims payment.

If a mail- or phone-in applicant appears eligible for Medicaid or M-SCHIP, Birch & Davis sends the electronic application data and the original hard copy to the appropriate local DHS office. The family is then notified by a caseworker and by letter, stating that they are required to have an in-person interview at a DHS local office. When a child is referred to DHS by Birch & Davis, the application information is retained in INFORM for 90 days.

When application is made in a local office, information is input into the DHS eligibility system, GWS. If an applicant appears eligible for S-SCHIP, information is sent electronically to the INFORM system through an interface that is available on a statewide basis to all local DHS offices.

There is a daily interface between GWS and the INFORM for referrals and responses, in addition to a monthly match between S-SCHIP enrollees who have an SSN on file and SAVERR client records. S-SCHIP children who are identified through this match as having ongoing Medicaid eligibility are reported to Birch & Davis.

INFORM is an Oracle database. The SAVERR system, originally developed in the 1970s, resides on a UNISYS mainframe. GWS was developed in the 1980s as part of a product called "Advanced Revelation." It has PC, LAN, and mainframe access.

C. CHANGES TO SYSTEMS

Within the past few years, SAVERR has been updated to address new federally required eligibility groups. There have been several significant projects that enhance SAVERR and GWS so that they can accommodate welfare reform changes (such as delinking Medicaid and TANF) and implement SCHIP. Over the same time period, Birch & Davis built an entirely new system for S-SCHIP.

Birch & Davis also is setting up the INFORM system to handle the renewal process for S-SCHIP enrollees. DHS is in the midst of a major project to replace GWS, and ultimately SAVERR, with a new Web-based system known as Texas Integrated Eligibility Redesign System (TIERS). The current schedule has GWS replacement by the end of calendar year 2003. For more information on TIERS, see the DHS Web site (www.dhs.state.tx.us) link under Projects & Initiatives.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

INFORM records SSNs for S-SCHIP enrollees who report them (staff reported that 60 to 70 percent of S-SCHIP enrollees report SSNs). The system also assigns an account number to each child. This account number is a permanent ID, to the extent that children who return to the system can be identified by SSN and other data.

SAVERR assigns unique client ID and case ID numbers to enrollees in Medicaid and M-SCHIP.

There is no other common unique identifier between INFORM and the DHS systems, aside from SSN, which is optional for S-SCHIP enrollees.

2. Family-Level IDs

Siblings can be identified within the S-SCHIP data system, based on a nine-digit family ID in INFORM. The first seven digits are a family number, and the last two are person-specific.

Within SAVERR, a case number identifies eligibility groups but not necessarily family relationships. There is no unique identifier to link the cases (eligibility groups) within a household, although it would be possible to identify other cases in which a client is included as a required member of the eligibility group. This means that siblings on the same type of Medicaid program (eligibility group) and within the same household would be linked by case number; but the case number does not identify their relationship.

It is not possible to link siblings between S-SCHIP and M-SCHIP/Medicaid, due to the lack of common IDs.

B. INITIAL APPLICATION DATA

1. Data Elements from Application

The following information is kept on eligible and denied applications. (Additional data are gathered and retained through the eligibility-determination process.)

The INFORM system, maintained by Birch & Davis stores application data for S-SCHIP.

Selected Data Elements—S-SCHIP	**Comments**
Date of application	Yes
Place of application	No
Mode of application	Yes, mail-in or by phone
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes
Assets	n.a.
Current/prior third-party insurance	Yes

n.a. = not applicable

The Medicaid systems (SAVERR and GWS) maintained by DHS store data from the initial application for M-SCHIP and Medicaid.

Selected Data Elements—Medicaid/M-SCHIP	Comments
Date of application	Yes
Place of application	No
Mode of application	No
Race/ethnicity	Yes
Family composition	No
Family income	Yes[a]
Assets	Yes, only in GWS
Current/prior third-party insurance	Yes, in GWS (indicator for any insurance and name of insurance)

[a]SAVERR keeps gross and net income. Detail, including source and disregard, is retained in the GWS records.

2. Reason Codes for Denied Applications

The table below describes reasons for denials to S-SCHIP in the INFORM system.

Selected Reasons for Denial—S-SCHIP	Comments
Income too high	Yes
Income too low	Yes
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes
Prior insurance within waiting period	Yes
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	No[a]
Missing data/inadequate information on the application	No, coded as "incomplete application"
Withdrew application	n.a., there is no process for withdrawing applications
Unknown	No

[a]An enrollment fee is not collected during the application process; it is collected only during the enrollment process that occurs after a child is determined eligible for SCHIP.

n.a. = not applicable

The state feels that the denial data for S-SCHIP are of good quality.

The following information is kept on denied applications to Medicaid/M-SCHIP on the SAVERR and GWS systems).:

Selected Reasons for Denial—Medicaid/M-SCHIP	**Comments**
Income too high	Yes, based on denial code
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	Yes
Current insurance	Yes, GWS and flag in SAVERR
Prior insurance within waiting period	No
Did not complete face-to-face interview	Yes
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	Yes
Withdrew application	Yes
Unknown	No

n.a. = not applicable

SAVERR retains data on denied applications for a year. The state feels that the denial data for Medicaid/M-SCHIP are of good quality. Denials require a reason code. The list of codes is extensive, but some actions are coded as "Other /Miscellaneous."

3. Ability to Determine Initial Program of Application

Families use a joint application for health coverage; they do not apply for a specific program. However, it is possible in INFORM to determine whether an application was made by mail or phone to Birch & Davis, and in which local DHS office the application was made. It also is possible to tell whether an application was made in person at a local office and transferred to Birch & Davis.

According to DHS, the GWS has a SCHIP subsystem (Change Verification System) with a flagged field that identifies children who were referred from DHS to S-SCHIP because of potential eligibility for the program (but it does not track actual enrollment in S-SCHIP).

4. Identification of Presumptive Eligibility

Not applicable. Medicaid and M-SCHIP have presumptive eligibility only for pregnant women. S-SCHIP does not have presumptive eligibility.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

In SAVERR, children enrolled in M-SCHIP are differentiated from Medicaid enrollees by a state-specific eligibility group (there is a flag in the case for the specified program). Children in S-SCHIP reside in the INFORM database.

2. Historical Enrollment Data

INFORM makes a distinction between enrollment and coverage in S-SCHIP. While a child may have an enrollment date of June 15, the child's coverage will not begin until July 1. Similarly, if a child disenrolls on August 15, he or she will still be covered until August 31.

S-SCHIP enrollment history is recorded in monthly segments in INFORM. The system keeps enrollment information on active records back to the program's inception in May 2000. The system archives records that have been inactive for 90 days. Birch & Davis keeps archived information on CDs for up to four years, which are accessible, if necessary. Return enrollees can be identified by linking multiple eligibility segments by the account number on INFORM.

Eligibility approvals made by GWS each day are sent to SAVERR that night. After cases are determined eligible in GWS, the worksheet records are sent to the mainframe for storage on disk and cartridge tape. GWS records are retained and are retrievable for at least three years; but GWS data are not stored in a manner that allows summary reporting.

Medicaid/M-SCHIP eligibility is recorded in monthly segments in SAVERR (which has client records and case records for Medicaid enrollees). Medicaid eligibility history can be tracked in the individual client records by the unique client ID. Client records contain eligibility segments by program type and case number; that is, the programs, case numbers, and eligibility segments for an individual can be identified from the client record. Case records identify members of the eligibility group, case budget (including some income at the individual level and some at the case level), last-case activity, and benefit periods. SAVERR retains data on denied applications for one year and on denied cases/clients for at least three years.

3. Identifying Retroactive Eligibility

Not applicable for S-SCHIP. Medicaid has a three-month retroactive period that is identifiable in the data on SAVERR.

4. Premium Payment Information

All premium payment information for S-SCHIP is stored on the INFORM system, including the amount and date of the payment. Using the date of payment field, it is possible to determine whether a payment is late or missing.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

S-SCHIP provides 12-month continuous eligibility. The INFORM system is programmed to send a redetermination letter to an enrollee during the tenth month of the 12-month continuous eligibility period. As children are successfully renewed, their records will automatically receive a new renewal date.

Medicaid and M-SCHIP have six-month redetermination periods. The GWS system sets a redetermination date upon entry of the eligibility decision. Cases with action due are included on reports to local offices and available in a system for central mail-out of reapplication forms. Results of redeterminations are recorded into GWS and then submitted to SAVERR.

2. Reasons for Disenrollment or Case Closure

The tables below describe reasons for denials to S-SCHIP (on the INFORM system) and Medicaid/M-SCHIP on the SAVERR system.

Selected Reasons for Disenrollment — S-SCHIP	**Comments**
Income too high	Yes
Income too low	Yes
Private insurance	Yes
Aged out	Yes
Failure to pay premium	Yes
Incomplete information on redetermination form	Yes, coded as “incomplete application”
Failure to return redetermination form/did not reapply	Yes, coded as “incomplete application”
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	No, coded as “failure to renew”
Moved out of state	Yes
Died	Yes
Decided not to reenroll	No, coded as “failure to renew”
Unknown	No

n.a. = not applicable

The state did not yet know the quality of disenrollment data for S-SCHIP at the time of the interview, because the first group of children renewed on May 1, 2001.

Selected Reasons for Disenrollment—Medicaid/M-SCHIP	Comments
Income too high	Yes
Income too low	n.a.
Private insurance	n.a.
Aged out	No
Failure to pay premium	n.a.
Incomplete information on redetermination form	Yes
Failure to return redetermination form/did not reapply	Yes
Did not complete face-to-face interview	Yes
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes
Decided not to reenroll	Yes, coded as "withdrawal"
Unknown	No

n.a. = not applicable

SAVERR maintains the end of coverage date on the client record, but specific reasons for disenrollment are on the case-level record only. The disenrollment data are of good quality. It is possible to distinguish between a failure to redetermine (for example, incomplete information on form) from disenrollment due to ineligibility.

3. Identifying Transfers Between Medicaid and SCHIP

INFORM can identify whether children on S-SCHIP were disenrolled because they became eligible for Medicaid/M-SCHIP (through the "income too low" reason code), but it does not contain any information on whether or not they actually enrolled in Medicaid/M-SCHIP.

It is possible to identify transfers from one Medicaid program to another from the SAVERR client record, but DHS cannot identify transfers from S-SCHIP into M-SCHIP or Medicaid.

4. Identifying Disenrollment Prior to Redetermination

It is possible to determine whether a child disenrolled at renewal, versus another time, through date fields (date of disenrollment and redetermination date) in INFORM and the DHS systems.

5. Automatic Disenrollment

INFORM automatically disenrolls children when their eligibility status changes (for example, due to age or failure to pay premiums).

The DHS systems suspend cases that have reached the age limit for worker review. The case is not automatically denied.

E. CONTACT DATA

1. Contact Information Collected in System

The tables below describe reasons for denials to S-SCHIP (on the INFORM system) and Medicaid/M-SCHIP (on the SAVERR and GWS systems).

Selected Contact Data—S-SCHIP	Comments
Name of parent/guardian(s)	Yes
Phone number	Yes
Zip code	Yes
Alternate address or phone	No
SSN	Yes, optional[a]
Case identifiers other than SSN	Yes, INFORM ID, family ID
SSNs of parents/adults in HH	No
Primary language	Yes

[a] State staff reported that SSN is present for 60 to 70 percent of enrollees.

Selected Contact Data—Medicaid/M-SCHIP	Comments
Name of parent/guardian(s)	Yes, in GWS; SAVERR has caretaker/payee
Phone number	Yes
Zip code	Yes, in GWS; at the case level in SAVERR
Alternate address or phone	No
SSN	Yes
Case identifiers other than SSN	Yes
SSNs of parents/adults in HH	Yes
Primary language	No

2. Processes for Updating Contact Information

Birch & Davis update contact information at the time of renewal. Enrollees are sent renewal forms, which they are required to return. Changes of address need to be noted on these forms. Birch & Davis also updates contact information if families report address changes through the S-SCHIP hotline. Finally, health plans report changes to Birch & Davis. Because only Birch & Davis employees have access to the INFORM system, S-SCHIP health plans are required to submit address changes to the company, along with any other pertinent member information. These changes are sent via a virtual private network using a standardized form developed for this purpose.

DHS updates contact information for Medicaid/M-SCHIP enrollees when changes are reported (at or between reviews). Changes reported for TANF and the FSP also will be updated in SAVERR. Authorized staff may make address changes through the Change Verification System (a subsystem of GWS). All other changes outside GWS require SAVERR data entry security permissions. The contact information for those who disenroll would not be updated unless the family became eligible again.

3. Quality of Contact Information

Staff could not comment on the quality of the S-SCHIP contact data, because, at the time of the interview, the state had yet to do an annual redetermination for S-SCHIP and had done no surveys itself. However, in a study conducted by the Institute for Child Health Policy (cited below), ICHP was unable to locate 28 percent of enrollees for a survey using Birch & Davis contact data.

Staff did not comment on the quality of the Medicaid or M-SCHIP contact data.

4. Ability to Produce Files with Contact Information and Eligibility History

Staff felt that it would be easy to generate contact information and enrollment history for S-SCHIP enrollees from INFORM. It would be more challenging to obtain information from the archived S-SCHIP data on CDs relative to data on current enrollees, but it could be done.

To produce a file with enrollment history and contact data for Medicaid/M-SCHIP would require a special run. The ability to do this depends on the availability of resources and funding.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

The Institute for Child Health Policy (ICHP) at the University of Florida maintains the S-SCHIP encounter data for the Texas S-SCHIP program (Birch & Davis does nothing with encounter data). Data are reported at the claim level, on a quarterly basis. The ICHP is also responsible for analyses of these data. (Utilization analyses include studies on HEDIS measures, behavioral health, and dental care.)

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

Birch & Davis sends eligibility data to the ICHP, who develops and maintains enrollment history records. The company also performs data quality checks and has identified a number of anomalies.[1]

ICHP recently completed a survey of new enrollees in S-SCHIP. Using enrollment data supplied by Birch & Davis, from June to August 2000, ICHP selected a random sample of

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[1] For example, ICHP staff reported that many children show one month of S-SCHIP enrollment before transferring to Medicaid. Also, children may apply multiple times to S-SCHIP and receive multiple IDs from Birch & Davis.

enrollees. ICHP was unable to locate 28 percent of enrollees; they had a 13 percent refusal rate. One-third of the survey calls were conducted in Spanish. (See http://www.ICHP.edu).

ICHP also is conducting a survey of individuals who have applied for, but not yet enrolled in, M-SCHIP or S-SCHIP. In February 2001, they initiated an S-SCHIP satisfaction survey using CAHPS. This survey supports comparison across plans and service areas. Finally, ICHP is planning to administer a disenrollee survey.

A survey was conducted in 2000 as part of a TANF leaver/diversion study of the effects of removing the asset test for Medicaid. Data on reasons for case denials were downloaded monthly from the SAVERR mainframe database. Cases denied for assets were selected, and these data were matched to prior-month files that contained client addresses and phone numbers. This file was then provided to researchers who conducted the survey. Staff reported that these data were provided to the researchers in a timely manner.

B. INTERNAL REPORTS

Birch & Davis currently produces a wide variety of reports from INFORM for administrative and state management purposes, such as monthly enrollment reports.

DHS produces M-SCHIP/Medicaid reports monthly showing the number of applications, reviews, and caseloads by Medicaid eligibility group, county, and other dimensions; ethnicity profiles by eligibility group; reports showing number of new applicants during the fiscal year; and reports of denials by reason and eligibility group. DHS also provides reports to field staff. (DHS can provide a copy of the SCHIP/Medicaid report sent to CMS, if requested. It also can provide samples of summary management reports produced.)

Medicaid data are also used to answer questions about Medicaid enrollment, for analysis of proposed legislation, to develop federal and state reports, and for analysis of policies. For example, legislation is being proposed to implement continuous eligibility for different lengths of time. Medicaid spell data provides information for estimating the cost and impact of doing policy. The Medicaid data also are being used as part of a TANF leaver/diversion study to determine whether these people get or continue to get Medicaid after leaving TANF or being diverted from TANF.

IV. DISCUSSION

Texas SCHIP and Medicaid eligibility and enrollment data reside on three separate systems. S-SCHIP data are maintained by a contractor, Birch & Davis, on the INFORM system. INFORM contains data on applications, ongoing enrollment, renewal, and contact information. The system assigns an account number to each child, although enrollees may have more than one account number if they disenroll and reenroll. About 60 to 70 percent of S-SCHIP records have SSNs. Siblings can be identified within S-SCHIP using a family ID.

Medicaid and M-SCHIP eligibility and enrollment data are maintained by the Department of Human Services on two systems, GWS and SAVERR. These systems maintain data on

denials, eligibility and ongoing enrollment, disenrollment, and core contact data. The GWS is used primarily by local offices for case documentation and eligibility determination, as well as the way in which records are submitted to the SAVERR system nightly. SAVERR maintains information on Medicaid eligibility history at the client level and on a monthly basis. However, the reason for disenrollment and the address are maintained only at the case level. Siblings in the same Medicaid eligibility group, and within the same household, can be linked by case number; but the case number does not identify their relationship. Nor can siblings be linked across Medicaid eligibility groups.

Record linkages between the INFORM system and SAVERR are possible for those S-SCHIP enrollees who voluntarily report an SSN. Otherwise, it would be difficult to match the S-SCHIP and Medicaid/M-SCHIP eligibility and enrollment data for the S-SCHIP records without an SSN. In addition, there is no way to link siblings across S-SCHIP and Medicaid/M-SCHIP.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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UTAH

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Utah has a separate child health program (S-SCHIP), called Utah CHIP, which covers children ages 0 through 18 up to 200 percent of the federal poverty level (FPL). Utah's S-SCHIP program is administered by the Department of Health. The state's Medicaid program is administered jointly by the Department of Health and the Department of Workforce Services.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Utah determines eligibility for its Medicaid and S-SCHIP children through its Public Assistance Case Management Information System (PACMIS). This system also handles the Food Stamp Program (FSP) and Temporary Assistance for Needy Families (TANF). Eligibility is determined sequentially, whereby the system first determines Medicaid eligibility, and then determines S-SCHIP eligibility. PACMIS is a state-administered system maintained by Utah's Department of Workforce Services. County caseworkers log on to PACMIS and enter eligibility information. PACMIS is a relational database.

The eligibility system is separate from the enrollment system for S-SCHIP and Medicaid, called the Family and Medical Assistance System (FAMIS). This system is part of the state's Medicaid Management Information System (MMIS).

C. CHANGES TO SYSTEMS

Utah previously applied to HCFA for permission to develop a stand-alone eligibility system for SCHIP and Medicaid. The plan was rejected by HCFA, due to a lack of funding; but the state still would like to implement such a system in the next few years.

Because researchers and administrators within the state often have difficulty creating ad hoc reports from PACMIS and FAMIS for their use, the state is in the process of creating a data warehouse. Utah hopes this data warehouse, which will be set up at a very detailed transaction level, will allow them to perform analytic studies with less difficulty. Implementation of the data warehouse is planned for 2002.

In addition, Utah is developing a new enrollment system, called the Medicaid Managed Care System. The current system, FAMIS, was developed to handle only one type of managed care plan; but it has not adapted well to the increase in managed care penetration and the use of managed care carve-outs for dental and mental health care. The new enrollment system will allow for enrollment in many different managed care plans and support payments to these plans. It also will be able to provide accurate, timely encounter data. The new was expected to be operational by fall 2001.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

PACMIS assigns each individual a permanent, unique identifier. The SSN is also recorded when it is reported.

2. Family-Level IDs

PACMIS assigns a unique ID to families. This field allows users to identify persons in the same household. The field also allows a user to identify an individual's relationship to the head of household.

B. Initial Application Data

1. Data Elements from Application

Information from the initial application is stored in PACMIS.

Selected Data Elements	Comments
Date of application	Yes
Place of application	Yes
Mode of application	No
Race/ethnicity	Yes
Family composition	Yes
Family income	Yes, gross income
Assets	n.a.
Current/prior third-party insurance	No[a]

[a]The state calls the employer to verify the information, as part of the eligibility determination process. This information is not entered into the system, however.

n.a. = not applicable

2. Reason Codes for Denied Applications

Data on denials are stored in PACMIS.

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	n.a.
Age	Yes
Immigration status	Yes
Assets	n.a.
Current insurance	Yes
Prior insurance within waiting period	Yes
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	No
Withdrew application	Yes
Other	Yes

n.a. = not applicable

The state reported that the denial data are "good." Although there is an "other" field, this field is accompanied by a text field that allows the caseworker to explain the reason for denial. The text field is kept in the file and sent through the PACMIS system.

3. Ability to Determine Initial Program of Application

Applicants make one application for health care coverage, and do not apply to a specific program.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

S-SCHIP and Medicaid enrollees are distinguished through codes in an aid-category variable in PACMIS.

2. Historical Enrollment Data

The PACMIS system stores eligibility data for up to three years, after which it is archived. The permanent, unique identifier assigned by PACMIS allows users to search eligibility records for enrollment in the previous three years. In order to identify when S-SCHIP

enrollment began, a user could also look in FAMIS at the date the first payment to a managed care plan was made. In Medicaid, the start of enrollment can be identified as the first day of the month after eligibility was determined.

3. Identifying Retroactive Eligibility

Not applicable. The S-SCHIP program does not use retroactive eligibility.

4. Premium Payment Information

Not applicable.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

Utah provides 12-month continuous eligibility for S-SCHIP. Dates of redetermination are automatically calculated by PACMIS. The system establishes an automatic review period one year from the date of eligibility. As this date approaches, a review notification is mailed out. Once eligibility has been redetermined, the system recalculates the date of eligibility for another year.

Medicaid eligibility is redetermined monthly.

2. Reasons for Disenrollment or Case Closure

Data on reason for disenrollment are stored in PACMIS.

Selected Reasons for Disenrollment	Comments
Income too high	Yes
Income too low	Yes, these children would be automatically enrolled in Medicaid
Private insurance	Yes
Aged out	Yes
Failure to pay premium	n.a.
Incomplete information on redetermination form	No
Failure to return redetermination form/did not reapply	Yes, state would automatically close the case
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes, state would automatically close the case
Moved out of state	Yes
Died	Yes
Decided not to reenroll	No
Unknown	No

n.a. = not applicable

The state reported that data on disenrollment are accurate.

3. Identifying Transfers Between Medicaid and SCHIP

Children who disenroll from S-SCHIP and enroll in Medicaid, or vice versa, could be identified by examining their enrollment history in PACMIS.

4. Identifying Disenrollment Prior to Redetermination

Children who disenroll prior to their redetermination date can be identified by comparing the disenrollment date in relation to the redetermination date.

5. Automatic Disenrollment

PACMIS also automatically disenrolls children who age out of the program.

E. CONTACT DATA

1. Contact Information Collected in System

Selected Contact Data	Comments
Name of parent/guardian(s)	No
Phone number	Yes
Zip code	Yes
Alternate address or phone	Yes, at the option of the applicant
SSN	Yes, optional for SCHIP
Case identifiers other than SSN	Yes, PACMIS individual ID and family ID
SSNs of parents/adults in HH	Optional
Primary language	No, but the system contains placeholders for future recording of this information

2. Processes for Updating Contact Information

Contact information is updated at the time of redetermination. Families also are supposed to notify the state about any address changes during the year. Health plans may notify the state of changes in contact information. Since PACMIS contains eligibility information for TANF and food stamps, contact information may be updated through new information obtained for these programs. The state does not track disenrollees.

3. Quality of Contact Information

The state reported that contact data are good for current eligibles. Only a small percentage of mail is returned as "undeliverable." They do not have a good sense of the quality of contact information for disenrollees.

4. Ability to Produce Files with Contact Information and Eligibility History

The state reported that it would be relatively easy to produce a file with contact information and eligibility history from PACMIS.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Health plans report individual-level encounter data to the state on a quarterly basis; the data are submitted nine months after the end of each quarter. The state then subjects the data to a series of audits.

Evaluation of these data is ongoing. Plans are having difficulty accurately reporting services. Currently, these data are too poor in quality to be used by the state for their own studies. The state hopes that implementation of its new Medicaid Managed Care System will improve encounter data.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

Utah has conducted an ad hoc disenrollee survey by phone. Of the initial sample of 113 persons, 21 percent could not be located, and 4 percent had moved out of state. The state learned that 38 percent had obtained private insurance, 8 percent had enrolled in Medicaid, 3 percent had reenrolled in SCHIP, and 26 percent said they were going to re-apply for SCHIP.

Utah also is participating in a study sponsored by the David and Lucile Packard Foundation, which is being administered by the National Academy for State Health Policy (NASHP). The study, which uses PACMIS data to identify individuals for focus groups and surveys, is examining reasons for failure to complete the application process.

The state also is conducting a Medicaid satisfaction survey biannually, using a modified CAHPS survey instrument.

B. INTERNAL REPORTS

No reports are generated from PACMIS on a regular basis. Utah conducted an internal study on redetermination patterns for the past two years. Staff reported that there is little access to ad hoc reporting with PACMIS, due to lack of programmer time. The implementation of the data warehouse should make it easier to perform internal studies.

IV. DISCUSSION

Utah uses one statewide eligibility system (PACMIS) to determine eligibility for SCHIP and Medicaid, as well as TANF and the FSP. The system contains individual-level data on denials and disenrollment. PACMIS contains individual and family-level IDs that allow children to be tracked across programs and over time; siblings can be linked within and across programs. The system also contains core contact data.

The state has difficulty accessing the PACMIS data for ad hoc reports but is creating a data warehouse for this purpose. This new data warehouse also is expected to improve the individual-level encounter data available for SCHIP.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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VIRGINIA

I. OVERVIEW

A. SCHIP AND MEDICAID PROGRAMS

Virginia has a separate child health program (S-SCHIP). Originally, the program was called Virginia Children's Medical Security Insurance Plan (CMSIP) recently, however, the name was changed to Family Access to Medical Insurance Security Plan (FAMIS). FAMIS covers children ages 0 to 19, with family incomes up to 200 percent of the federal poverty level (FPL). (Previously, CMSIP covered children up to 185 percent FPL.) Virginia's Department of Medical Assistance Services (DMAS) administers SCHIP and Medicaid.

B. ORGANIZATION OF SCHIP AND MEDICAID ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

Virginia's Department of Social Services (DSS) is responsible for eligibility determination for S-SCHIP and Medicaid and for such programs as the Food Stamp Program (FSP) and Temporary Assistance for Needy Families (TANF). DSS maintains a statewide system (called the Medicaid Pending System, or MEDPEND) for storing eligibility information and information on the action (approval or denial) taken by the local agency.

Virginia's Medicaid and S-SCHIP programs use a joint application, which can be mailed to or dropped off at the DSS office in the applicant's county of residence. When an application is received, the caseworker enters the information into MEDPEND. Caseworkers determine eligibility manually, then enter the result into MEDPEND. The caseworker also enters information about approved cases into the state's Medicaid Management Information System (MMIS). Virginia's MMIS is maintained by DMAS. Data are stored as flat files in MMIS.

C. CHANGES TO SYSTEMS

Virginia has made no significant changes to its eligibility data systems within the past few years but is in the process of developing a new MMIS. Work began on the MMIS in 1998, which, the state hoped to complete by December 2001. The new system will include new screens and more fields. Data will also be stored as part of a relational database rather than as flat files.

The implementation of Virginia's new MMIS is expected to coincide with the statewide adoption of a new eligibility determination system for family and children cases, called ADAPT. ADAPT will replace MEDPEND and will automate eligibility determinations. The new eligibility system will allow administrators to create individual ID numbers that follow people within a program and from program to program. The state also is developing a central processing unit (CPU) data system for application and brochure distribution, eligibility determination, and health plan enrollment for FAMIS.

II. SPECIFIC DATA ELEMENTS IN ELIGIBILITY AND ENROLLMENT DATA SYSTEMS

A. IDENTIFICATION NUMBERS

1. Individual-Level IDs

Individuals in the current MEDPEND and MMIS systems do not have permanent, unique IDs; the SSN is recorded when reported, however. If an individual is eligible for Medicaid through TANF in one month, and becomes eligible through SSI in the next month, that person will receive a new ID in MEDPEND.

The new ADAPT system will assign a permanent, unique ID. Virginia's new MMIS also will be capable of assigning permanent, unique IDs. Although the MMIS ID will not necessarily be the same as the ADAPT ID, it will be possible to cross-reference the two.

2. Family-Level IDs

It is possible to link family members within the same case in MMIS. As long as children are members of the same case, they can be identified across programs. Each family has a 12-digit Case ID. The first nine digits of the ID are the same for all members of the family. The 10th and 11th positions of the case number indicate information about the individual ("00" indicates that the information is for the case, "01" and "02" are for the parents, and "03" – "29" are for the children). The 12th position is a "check digit."

B. INITIAL APPLICATION DATA

1. Data Elements from Application

MEDPEND contains information from the application, but it cannot store historical information. New information overwrites any existing information.

Selected Data Elements	Comments
Date of application	Yes
Place of application	Yes, it has county/city of application
Mode of application	No
Race/ethnicity	Yes
Family composition	No
Family income	No
Assets	n.a.
Current/prior third-party insurance	No

n.a. = not applicable

2. Reason Codes for Denied Applications

Information on denied applications is stored at the case level in MEDPEND. It is not passed to MMIS.

Selected Reasons for Denial	Comments
Income too high	Yes
Income too low	No
Age	No, included in "other non-financial"
Immigration status	Yes
Assets	n.a.
Current insurance	No, coded as "health insurance/state employee"
Prior insurance within waiting period	No, coded as "health insurance/state employee"
Did not complete face-to-face interview	n.a.
Did not pay enrollment fee	n.a.
Missing data/inadequate information on the application	No, coded as "other non-financial"
Withdrew application	Yes
Unknown	No

n.a. = not applicable

The quality of the denial data varies and depends on the worker inputting the data. DMAS staff reported that some workers code the fields carefully, while others do not.

3. Ability to Determine Initial Program of Application

Not applicable. Applicants complete one joint application for health coverage.

4. Identification of Presumptive Eligibility

Not applicable.

C. ELIGIBILITY AND ENROLLMENT DATA

1. Program Eligibility

S-SCHIP children are identified in MEDPEND and MMIS by four specific program designation codes. Medicaid eligible children have other program designation codes.

2. Historical Enrollment Data

MEDPEND does not store historical information on application and eligibility. Current information overwrites historical information. MMIS stores data on enrollment history. Enrollment records in Virginia's MMIS are divided into two parts. The first holds "base data" common to eligibles in any program. Fields in this section include information on the

person's address, review date, county of residence, and caseworker identification. The second part of the enrollment records in Virginia's MMIS contains information pertinent to individual enrollment in SCHIP or Medicaid.

Enrollment history in MMIS is recorded back to 1969, for cases with active enrollment within the prior three years. MMIS can hold up to 10 enrollment segments. Each segment contains fields that hold information on an individual's program designation, type of coverage, eligibility dates, and reason for disenrollment. Individual recipient data also includes birth date, and former enrollee ID number ("former Medicaid ID number"). Once a year, MMIS purges all records for cases in which all members have been disenrolled for at least three years.

MEDPEND is unable to distinguish new versus return enrollees. New application information overwrites any historical application information held in the system. However, the current MMIS has a field for historical ID information, which would permit users to identify an individual's prior enrollment.

The new ADAPT system will assign a permanent, unique ID that will allow the state to identify return applicants. The new MMIS also will have a permanent, unique ID that could be used to identify return applicants.

3. Identifying Retroactive Eligibility

Not applicable.

4. Premium Payment Information

Not applicable.

D. REDETERMINATION AND DISENROLLMENT DATA

1. Redetermination Dates and Outcomes

Virginia uses a 12-month redetermination period for SCHIP and Medicaid. DSS caseworkers enter the date of redetermination into the individual's MMIS record. MMIS automatically sends reminders to caseworkers two months before the end of eligibility. If the individual's eligibility is redetermined, the system will repeat the notification process in another 12 months. MEDPEND is not used at redetermination.

2. Reasons for Disenrollment or Case Closure

Disenrollment data are stored in MMIS, not in MEDPEND.

Selected Reasons for Disenrollment	Comments
Income too high	Yes, coded as "no longer meets financial eligibility requirements"
Income too low	Yes, coded as "no longer meets financial eligibility requirements"
Private insurance	Yes
Aged out	Yes
Failure to pay premium	n.a.
Incomplete information on redetermination form	No
Failure to return redetermination form/did not reapply	No
Did not complete face-to-face interview	n.a.
Could not be located at redetermination	Yes
Moved out of state	Yes
Died	Yes
Decided not to reenroll	No
Unknown	No

n.a. = not applicable

Information also is recorded about the individual's access to insurance. The state feels that the disenrollment data are complete.

3. Identifying Transfers Between Medicaid and SCHIP

If children retain the same case number when switching programs, it is easy to identify transfers. The "transfer" would be reflected in the program designation codes in two consecutive eligibility segments. If an individual's case number has changed (for example, if a child was eligible for Medicaid via TANF, then became eligible via SSI), it is more difficult, but not impossible, to track them across programs. This could be done using the "former enrollee ID" field or the SSN field. In the new MMIS, an enrollee will retain one permanent, unique identifier number.

4. Identifying Disenrollment Prior to Disenrollment

It is possible to distinguish between disenrollment prior to the time of redetermination by comparing the review date and the disenrollment date.

5. Automatic Disenrollment

Children are automatically disenrolled by MMIS if they age out, or they obtain private health insurance.

E. CONTACT DATA

1. Contact Information Collected in System

Unless otherwise specified, the information below pertains to MEDPEND and MMIS. (Following eligibility determination, caseworkers reenter the contact data they entered into MEDPEND into MMIS.)

Selected Contact Data	Comments
Name of parent/guardian(s)	Yes
Phone number	No
Zip code	Yes
Alternate address or phone	Yes, in MEDPEND only
SSN	Yes, optional for S-SCHIP
Case identifiers other than SSN	Yes
SSNs of parents/adults in HH	Yes, only if the adult is enrolled
Primary language	No, although this information will be recorded in ADAPT and the new MMIS

2. Processes for Updating Contact Information

Contact information is updated when reported by a family or at redetermination. There are no triggers to remind caseworkers, but it is part of every review process. Contact information changes can be made either by DSS workers or DMAS staff, although it is extremely unusual for DMAS staff to do so. Both parties have direct access to MMIS data—DSS through the multisystem update (MSU) or directly, and DMAS through a direct interface. Staff also can update contact information through MEDPEND, which does not interface with MMIS.

3. Quality of Contact Information

DMAS staff reported that contact information in the systems is of high quality; however, the system does not record phone numbers. DMAS staff have no data to show that contact information for S-SCHIP enrollees is more or less likely to be reliable than for enrollees in other programs. Only 1.6 percent of ID cards sent to all enrollees are returned because of incorrect addresses.

4. Ability to Produce Files with Contact Information and Eligibility History

The state would be able to produce files with contact information and eligibility history from MMIS without difficulty.

F. ENCOUNTER DATA FOR SEPARATE SCHIP PROGRAMS

Managed care encounter data are reported at the individual level to MMIS. The data are submitted monthly (fee-for-service data are submitted daily). Our contacts did not feel comfortable commenting on the quality of the encounter data.

III. STATE RESEARCH ACTIVITIES BASED ON ELIGIBILITY AND ENROLLMENT DATA

A. SURVEYS AND FOCUS GROUPS

No surveys or focus groups are currently taking place.

B. INTERNAL REPORTS

Virginia produces several reports using MEDPEND and MMIS. The features in MEDPEND allow local offices to produce many custom reports for their use. The localities can produce reports that show data on processing time, pending applications, and application approvals/denials during a specified time. DSS produces four monthly reports and two quarterly reports from MEDPEND.

Weekly FAMIS reports are generated from MMIS, listing basic aggregate enrollment data, such as number of enrollees, and percent change from prior week. The state is starting to look at turnover, patterns of enrollment, and discontinuous enrollment. The MMIS generates monthly caseload-management data, reports of reviews due, and alphabetic enrollee lists for use by local DSS offices.

IV. DISCUSSION

Virginia uses the same eligibility and enrollment data systems for its S-SCHIP and Medicaid programs. The state maintains two databases, MEDPEND and MMIS. MEDPEND is an application-tracking system that captures most pertinent information on applications, including those that are denied. MEDPEND application-tracking system does not maintain historic information on application characteristics.

Caseworkers manually enter some of the enrollment data from MEDPEND into the MMIS. MMIS stores comprehensive data on Medicaid and S-SCHIP enrollment history, redetermination, and disenrollment, as well as encounter data. (Data on denied applications reside on MEDPEND and are not transferred to the MMIS.) The MMIS maintains address information but contains no phone numbers. It is possible to link siblings and families through case numbers. The current system is limited, however, because it does not assign a permanent, unique ID to each child. The state is developing a new eligibility determination system (called ADAPT) and a new MMIS, both of which will have a permanent, unique ID for each enrollee.

V. CONTACT PERSON FOR EVALUATION/DATA INQUIRIES

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