Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: Georgia
(Name of State/Territory)

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

Gary Redding, Commissioner
(Signature of Agency Head)

SCHIP Program Name(s): PeachCare for Kids

SCHIP Program Type:

____Medicaid SCHIP Expansion Only
_X_Separate SCHIP Program Only
____Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

Contact Person/Title: Jana Leigh Key, Program Director

Address: 2 Peachtree Street, NW - 39th Floor
Atlanta, Georgia 30303-3159

Phone: (404) 657-9506 Fax: (404) 657-9896

Email: jkey@dch.state.ga.us

Submission Date: January 1, 2002

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.
Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility - NC

B. Enrollment process - In April 2001, PeachCare for Kids implemented an online application process. Families can log onto www.peachcare.org and complete the application on their home computer or at a provider's office, local school or public library. The website prompts the parent when critical information is missing, ensuring that all applications are complete upon submission.

C. Presumptive eligibility - NC

D. Continuous eligibility - NC

E. Outreach/marketing campaigns - In January 2001, PeachCare for Kids joined WSB-TV's Family 2 Family program. This metro area television-based initiative has a long-standing history in the Atlanta area for community-based television coverage and numerous family-oriented events each month. PeachCare for Kids has been present at many events, including Panda and Bunny-Hop Days at the Atlanta Zoo, CPR Saturday trainings by the American Red Cross, the Susan B. Komen Foundation's Race for the Cure, and the Salute 2 America Fourth of July parade. Each event is accompanied by announcements on television which also promote PeachCare for Kids. PeachCare program flyers are also always on display in the other Family 2 Family sponsor locations, including Haverty's Furniture, Verizon Wireless, Promina Health Systems, and Southtrust Bank.

F. Eligibility determination process - On April 1, 2001, PeachCare for Kids began enrolling children the effective the first day of the month in which a complete application is received, including payment of premium, if required. Previously, children were enrolled the first day of the month following the determination of eligibility. With this change, children are initially enrolled in PeachCare for Kids on a fee-for-service arrangement. The children receive a temporary identification card for the first month of coverage. The first day of the following month, they are enrolled with a Georgia Better Health Care primary care provider and receive a permanent identification card.

G. Eligibility redetermination process - NC

H. Benefit structure - NC

I. Cost-sharing policies - With the change in the eligibility determination process (1.1(F)), children enrolled in PeachCare for Kids receive two months of coverage at no cost to the family. The first premium payment, which is required prior to enrollment, is applied to the third month of coverage. For example, a parent can apply for a child on October 20th. If eligible, the child will be enrolled effective October 1st. Coverage for the months of October and November is provided at no cost to the family. The premium payment sent with the application will be applied to the premium payment due November 1st for coverage in December. This ensures that no child begins the program with numerous premiums payments due.

J. Crowd-out policies - NC

K. Delivery system - NC

L. Coordination with other programs (especially private insurance and Medicaid) - See "Screen and enroll process" below (1.1(M)).

M. Screen and enroll process -

PeachCare for Kids enhanced the streamlined referral process implemented August 2000. The Third Party Administrator (TPA) continues to provide case management functions for the children screened and found to be potentially eligible for Medicaid. Once the state eligibility staff provides confirmation of Medicaid eligibility and the initial date of enrollment, PeachCare for Kids sends the children a PeachCare for Kids identification card and information about the additional benefits for which they qualify and notification that they are not required to pay premiums.

While we had worked the previous year to streamline the referral and enrollment process, enrolling all children with PeachCare for Kids identification cards has made a tremendous impact on the how simple the families perceive the program to be. From their perspective, they apply for PeachCare and if they qualify (whether for Title XXI or Title XIX benefits) their children are enrolled in PeachCare. Should there be a change in eligibility from one program to the other, the parents are notified that they will have to start paying a premium to continue on the program or that they are no longer required to pay premiums. The children keep their current identification cards and primary care providers. The children remain on the same enrollment system that the parents initially selected. While we are accounting for the source of program and payment, the families do not feel any affect of being switched back and forth among programs.

N. Application - As stated in 1.1(B), PeachCare for Kids has increased access to the application by having a full application process available to families over the internet. Rather than downloading an application to be mailed-in, a parent can complete and

submit an application at www.peachcare.org. Upon submission, parents are given confirmation that the application is processing and a preliminary estimate of eligibility.

O. Other - NC

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

The State of Georgia relies on the Current Population Survey (CPS) conducted in March of each year for its uninsured estimates. Due to the timing of the CPS our most recent data cover only calendar year 2000, not FFY2001.

In previous years we reported the average of three years of CPS data in order to achieve smaller margins of error. However, for the March 2001 survey covering calendar year 2000, the CPS changed its methodology. The CPS introduced a "check question" that is designed to prompt respondents to verify that they were indeed uninsured for the entire calendar year. As a result of this new question, estimates of the uninsured have been reduced by about 8% nationwide when compared with estimates generated using the earlier methodology. Due to this change in methodology, we can no longer average the March 2001 survey data with that of earlier years. Hence, our estimates have very large margins of error and should be interpreted with caution. Additionally, part of any observed reduction in the number of uninsured children is likely due to this change in methodology.

With these caveats, we report that the number of uninsured low-income children in Georgia dropped from 182,792 in 1999 (based on March 2000 CPS), to 141,489 in 2000 (based on March 2001 CPS).

This reduction in our estimate is due to a decrease in the estimated number of PeachCare eligible uninsured children, which fell from 90,310 in 1999 to 37,043 in 2000. The estimate of Medicaid eligible uninsured children rose slightly over the period.

The March CPS data revealed an interesting result. Our estimates show that just 5.9 percent of PeachCare eligible children in 2000 were uninsured. The percent of children who were ineligible for public programs who were uninsured in 2000 was 4.5%. This difference in uninsured rate across income groups is small and not statistically significant. This suggests that children who are eligible for PeachCare are just as likely to have some form of insurance as higher income children.

	Medicaid Eligible	PeachCare Eligible
1993-1995 (3 year average) Pre-CHIP Uninsured Children Below 200% of FPL	124,621	102,982
1997-1999 (3 year average) Uninsured Children Below 200% of FPL	153,885	93,855
1998 Uninsured Children Below 200% of FPL	291,943	87,522
1999 Uninsured Children Below 200% of FPL	92,482	66,482
1999 Uninsured Children Below 235% of FPL	92,482	90,310
2000 Uninsured Children Below 235% of FPL	104,446	37,043

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

As of November 1, 2001, approximately 92,000 children have been referred to Right from the Start Medicaid for a full Medicaid eligibility determination. On August 1, 2000, a revised referral process was implemented. Since that time, over 54,000 children have been reviewed under the new referral system.

This information was derived from the PeachCare for Kids application and enrollment database.

B. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

PeachCare for Kids enrolled 47,586 children during FFY 1999, 74,084 children during FFY 2000, and 119,012 children in FFY 2001. Note: The 119,012 children enrolled in FFY 2001 includes Title XIX children who applied for PeachCare for Kids and were enrolled through the seamless system implemented July 1, 2001 (see 1.1(M)).

C. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

N/C

_ No, skip to 1.3

_ Yes, what is the new baseline?

What are the data source(s) and methodology used to make this estimate?

What was the justification for adopting a different methodology?

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

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Increase insurance coverage among Georgia's low-income children.	By the end of the third year, enroll 75% of uninsured, non-Medicaid eligible children with family income below 235% of FPL.	Data Sources: Current Population Survey, Enrollment data Methodology: Percent of PeachCare Eligibles Enrolled = Current Enrollees / Total PeachCare Eligibles Total PeachCare Eligibles = Current Enrollees + Uninsured Eligibles Current Enrollees = 144,172 Uninsured Eligibles = 37,043 Progress Summary: By the end of the third calendar year, 76% of eligible children enrolled in PeachCare.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO CHIP ENROLLENT		
Increase insurance coverage among Georgia's low-income children.	Employ marketing and outreach techniques that encourage parents of eligible low-income children to enroll their children in Georgia CHIP. In addition to statewide marketing and last year's mini-grant program, we added an Internet based application to provide another method of application. We also changed the benefits provided by PeachCare to include coverage during the month of application. This change is intended to encourage people seeking care for their children to apply. We also created a Family to Family Community Outreach, a television-based outreach program which incorporates both media coverage and community events for families.	Data Sources: Enrollment and Survey data Progress Summary: In the first 4 months since the Internet application was launched, 3,680 electronic applications were received. These applications sought coverage for 7,736 children. Also, of those who completed a survey at the end of the Internet application, 27% indicated they would not have applied that month if the Internet application were not available. A survey sent to recent applicants yielded the following information about the effect of providing coverage during the month of application. 37% were aware of the policy change. 87% indicated they would have applied that month even if coverage were not provided for the month of application. 45% said that their child needed immediate access to care at the time of application. 30% said their child(ren) received care during the month of application. 27% indicated they would have delayed or foregone care for their child if the child lacked coverage.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Increase the percentage of low-income children with a regular source of care.	Over time, decrease the percent of children matched to a PCP through auto assignment.	Data Source: Enrollment Data Methodology: Percentage of enrollee-months with a self-selected PCP = Number of enrollee-months with self-selected PCP / Total enrollee-months Progress Summary: During 98-99 children had a self-selected PCP for 66.6% of enrollee-months. During 2000 children had a self-selected PCP for 72.1% of enrollee-months. During 2001 children had a self-selected PCP for 72.4% of enrollee-months.
Increase the percentage of low-income children with a regular source of care.	Encourage use of PCP through health plan policies and education.	Data Source: Claims Data Methodology: Percent of children who saw their PCP = Number of children with a medical claim where their PCP was the provider / Total ever-enrolled children *Percent of primary care visits that were made to the child's PCP = Number of primary care visits where the provider was the child's PCP / Total primary care visits* Progress Summary: 53% of children saw their PCP during CY00. 69% of children with 10-12 months of enrollment during CY00 saw their PCP during that time. 66% of primary care visits were made to the child's PCP.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
Increase the percentage of children with a regular source of care.	Maximize the number of enrollees who stay with their PCP for 12 months.	Data Source: Enrollment Data Methodology: Percent of enrollees (with 12 or more months of enrollment) who stay with the same PCP for 12 months = Number who stay with the same PCP for 12 months / Number of enrollees with 12 or more months of enrollment Progress Summary:85% of children enrolled for at least 12 months during 1999-2000 had the same PCP for at least 12 months.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Promote utilization of Health Check (EPSDT) services to achieve targets set by the Health Care Financing Administration and Georgia Better Health Care. (These are 80% for screening.)	Assess how many children receive recommended well-visits and screenings.	Data source: Claims Data Methodology: Percent of children who received EPSDT services = Number who had a medical claim for EPSDT services / number of enrollees Progress Summary: 32.5% of enrolled children received EPSDT services during CY00. 53.2% of children ages 5 and under and who were enrolled for 10 or more months received EPSDT services during CY00.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
Promote utilization of Health Check (EPSDT) services to achieve targets set by the Health Care Financing Administration and Georgia Better Health Care. (These are 80% for screening.)	Assess how many children receive immunizations.	Data Source: Claims Data Methodology: Limited population to children in age groups appropriate to receive immunizations. Also limited population to those children who were enrolled for at least 10 months of CY 2000. Percent of children who received immunizations = number of children who received immunization / total children Progress Summary: 64.4% of children under age 2 and who were enrolled for 10 or more months received immunizations during CY00. 45.1% of children age 4-5 and who were enrolled for 10 or more months received immunizations during CY00.
OTHER OBJECTIVES (SPECIFY)		
Decrease the use of emergency departments for the non-emergency services. A non-emergency service is one that does not meet the prudent layperson definition of an emergency.	Reduce the number of ED visits for non-emergency services.	Data Source: Claims Data Methodology: Percent of ER admissions for diagnoses considered medical emergencies = Number of admissions for emergencies / Total ER admissions Progress Summary: 66% of ER admissions were for diagnoses considered medical emergencies in CY99. 62% of ER admissions were for diagnoses considered medical emergencies in CY00.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
Reduce preventable hospitalizations.	Reduce preventable hospitalizations.	Data source: Claims Data Methodology: Percent of hospitalizations for diagnoses considered preventable = Number of hospitalizations for preventable diagnoses / all hospitalizations Progress Summary: During 1999, 32% of hospitalizations were for diagnoses considered "preventable". During 2000, 37% of hospitalizations were for diagnoses considered "preventable".
Promote the appropriate use of health care services by children with asthma (as defined by the National Heart, Lung, and Blood Institute of the National Institutes of Health).	Assess the number of children whose asthma is managed through appropriate outpatient care.	Data source: Claims Data Methodology: Percent of Asthma diagnosis ER admissions that had a follow-up visit within 2 weeks of discharge = Number of admissions with follow-up visit / all asthma diagnosis ER admissions Progress Summary: 77.2% of asthma related ER admissions had a "follow-up" visit within two weeks.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

Eighty percent of the respondents to the CAHPS survey reported that their child had a primary care provider. However, children have seen their primary care provider for just 50% of their outpatient visits, on average. To address this issue, we have met with our physician advisory group to develop effective methods to encourage enrollees to schedule regular appointments. In addition, we have created a brochure for enrollees which provides an age-specific preventive care schedule and encourages PCP usage.

We are also working with Georgia Better Health Care, the primary care network for PeachCare for Kids and Medicaid to develop network-specific material. The material will be distributed through the PCPs to patients providing information about the roles of a PCP and a medical home.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

N/A

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

We are exploring additional service access and quality issues using CY 2000 claims data. We intend to look at demographic differences in service use rates and investigate the impact of having a PCP on use of other services. In the summer of 2002, we will conduct a similar analysis with claims data for CY 2001.

We are seeking appropriate benchmark data. To date, we have analyzed CAHPS and claims data for PeachCare recipients and a comparison group of Medicaid beneficiaries. We have also compared the responses of CAHPS respondents to their actual service use, as recorded by the claims. In the next year, we will be able to compare data for Alabama CHIP and Medicaid by virtue of our joint participation in an AHRQ funded project.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

Paper: "Enrolling Children in SCHIP: Georgia PeachCare for Kids Experience"
Summary: CAHPS Responses and Claims Data
Summary: Synopsis of the PeachCare Internet Application Survey

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

NA

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

_____Number of adults
_____Number of children

C. How do you monitor cost-effectiveness of family coverage?

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

NA

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

_____Number of adults
_____Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Crowd out is the voluntary termination of health coverage in order to participate in the S-CHIP program. Voluntary termination of coverage does NOT include the following: divorce or death of a parent; employer cancellation of the entire group plan; loss of eligibility due to parent's layoff; resignation of parent from employment; employment termination; leave of absence without pay; or reduction of work hours; cancellation of COBRA or an individual policy.

The PeachCare for Kids application contains questions about current and previous coverage under group health plans and family members' employment with state agencies. A child is denied eligibility for the following coverage-related reasons:

- the child is eligible for Medicaid;
- it is determined that the child voluntarily terminated coverage under an employer plan during the past three months;
- the child is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act;
- the child is a member of a family eligible for health benefits under a State health benefit plan based on a family member's employment with a public agency in the state.

PeachCare for Kids implemented a three-month waiting period in which enrollees must be uninsured prior to enrollment.

B. How do you monitor and measure whether crowd-out is occurring?

Because of the limitations of CPS and other data sources, we cannot detect disenrollment in private and public insurance programs due to PeachCare for Kids. We do know from focus groups that families consider three months an enormous deterrent.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

In partnership with the Department of Education Division of School Nutrition, PeachCare for Kids distributed 1.6 million program flyers to students during Fall registration. In the two months following the distribution 3,869 children reported hearing about PeachCare for Kids through the school. Of these, 2,535 applied online and 1,334 submitted applications by mail. This outreach effort resulted in an increase in call volume, visits to the website, and applications submitted.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

C. Which methods best reached which populations? How have you measured effectiveness?

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

Families are notified on the application and during the renewal process that they are required to report changes in income and/or household composition within ten (10) days of becoming aware of a change. For children who have applied for PeachCare for Kids, whether receiving S-CHIP or Medicaid benefits, the children have a passive renewal process. Prior to a child's anniversary date, the parent is sent letter with a detail of the eligibility-relevant information on the child's account. Parents are informed that should there be any changes, they may submit updated information either by phone or by mail.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers
___ Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population
___ Information campaigns
_X_ Simplification of re-enrollment process, please describe
Prior to the anniversary of a child's enrollment in PeachCare for Kids, the parent is mailed a renewal letter which contains all of the information PeachCare for Kids has on the families account that relates to program eligibility. If there are any changes to the information presented in the letter, parents are asked to call and update the account. Parents are also reminded that they must call and report changes at any time in the year within 10 days of such change.
___ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe
___ Other, please explain

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

The renewal process described in 2.5(A) occurs annually for Title XXI children and semi-annually for Title XIX children.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

The passive renewal process which allows self-declaration as is allowed with an initial application and requires families to report changes to their account is the most effective way of ensuring that eligible children remain covered.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

Between November 1999 and April 2000, the Georgia Health Policy Center surveyed families who had voluntarily disenrolled from PeachCare for Kids (this excludes children who aged out, became Medicaid eligible, or moved out of the state). Through a combination of telephone and mail surveys, the Health Policy Center contacted a random sample of 1,440 families to ask them about their experiences with the program. 602 families participated in the survey (response rate=42%).

The primary reasons for voluntary disenrollment were: the children received private insurance (23%); parents accidentally got behind on payments (19%); there was a change in family income (7%); and the program cost too much (7%). Overall, 58% of those who disenrolled had insurance by the time of the survey. Of those who said they disenrolled due to a change in income, 62% had other insurance, suggesting their income increased. Of those who got behind on their payments, only 20% now have insurance.

Of those without insurance, 47% said they could not afford it and 5% said there was no insurance available to them. 31% said they did not know where they would go if their children needed health care.

In FFY 2001, disenrollment and retention in the PeachCare for Kids program was included in multi-state evaluations by the Department of Health and Human Services (HHS) and the National Academy of State Health Policy (NASHP). The HHS study included focus groups of parents of eligible children and the NASHP evaluation included a survey of parents of eligible children. The results of both evaluations are scheduled to be completed in the first few months of 2002.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

All children have access to a mail-in application process through PeachCare for Kids. The PeachCare for Kids application requests all of the information required for enrollment in Medicaid. The only exception is enumeration. Children for whom a Social Security number is not provided on the application will be sent notification that the parent must provide a Social Security number, which can be done by phone, or submit proof of application. The Medicaid enrollment process will continue and the children will be enrolled in Medicaid, if otherwise eligible. The parent will have six months to provide this information. At the six month renewal if the information has not been provided, the parent will be notified by mail that they must either provide the Social Security number or proof of application for the child to remain eligible for the program.

Both Medicaid and PeachCare for Kids allow self-declaration for enrollment and renewal of eligibility. Neither PeachCare for Kids or Medicaid require a face-to-face interview for enrollment.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

PeachCare for Kids maintains account and enrollment information for children in PeachCare for Kids and those enrolled in Medicaid. When the parent reports a change in income or there is a change in a child's age that results in a change in Medicaid eligibility, the Third Party Administrator (TPA) for PeachCare for Kids reports the change to Right from the Start Medicaid (RSM). RSM reviews the child's eligibility and reports the eligibility status to the TPA. If the child is denied Medicaid eligibility, the TPA reviews the account for determination of PeachCare for Kids eligibility. If the child is eligible for PeachCare for Kids, the enrollment date is coordinated with the Medicaid cancellation to eliminate gaps in coverage. For children who are enrolled in Medicaid through PeachCare for Kids, the referral process is the same for children who report a change in income or household composition that results in potential eligibility for Medicaid.

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

PeachCare for Kids uses the same delivery system as Medicaid to provide services for enrolled children.

2.7 Cost Sharing:

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

PeachCare for Kids monthly premiums are very low: $0 for children ages five and under, $7.50 for one child over five, and $15 for two or more children. Data from survey and focus groups show that families find this premium very affordable, which contributes to their decision to enroll. In our surveys of new enrollees, 90% of the respondents said that cost was very important in their decision to apply for PeachCare. In a separate question, 43% reported that cost was the most important reason they applied.

Other evidence, however, suggests that for some families, cost is a deterrent. We examined the effect of average premium cost per child on the family decision to enroll in PeachCare for Kids. After controlling for demographic characteristics and the presence of a child with special health care needs, we found that families with a higher cost per child enrolled later than families with a lower cost per child. On average, for a $2.50 increase in the average premium cost per child, there was a 1.15 month delay in enrollment. However, we were not able to control for the number of siblings in the family. The number of siblings is strongly related to average premium cost per child. Thus some the observed influence of premiums might be attributable to other characteristics of large families. The effect of premiums remains an area for further study.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

PeachCare for Kids has a premium for all enrolled children ages 6 and older. There are no co-payments or deductibles that would affect utilization among enrolled children.

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

As described in section 1.6, we have conducted the CAHPS survey as well as claims analysis to assess the quality of care received by PeachCare for Kids children. In addition, we asked disenrollees about their satisfaction with quality of care.

Ninety-five percent of the surveyed disenrollees responded that they would recommend PeachCare for Kids to a friend. Sixty-nine percent of those surveyed responded that they were very satisfied/satisfied with the quality of care they received through the plan. Only 5% responded that they were either very dissatisfied or dissatisfied with the quality of care. Sixty-eight percent stated that they were satisfied with the time it took to get to their doctor or nurse, and 35% were satisfied in being able to see a specialist when they needed to (47% didn't need to see a specialist, and 14% responded "I don't know".)

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

We will be repeating the claims analysis described in sections 1.6. By the end of Fall, 2002, we expect to have analyzed claims data from calendar year 2001.

The Department of Community Health is developing a feedback system so that PCPs can track how children on their panel are receiving primary and preventive care, ER and hospital use, and other measures still under development. Data on PeachCare children will be included in this process, which we expect will lead to improvements in quality and access over time.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

We will be repeating the claims analysis described in sections 1.6 and 2.8b. By the end of Fall 2002, we expect to have analyzed claims data from calendar year 2001.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.
Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility - NA

B. Outreach - In January 2001, PeachCare for Kids joined WSB-TV's Family 2 Family program, a community-based television and public service program. As a partner in Family 2 Family, PeachCare for Kids has participated in numerous family events each month, including CPR trainings by the American Red Cross, the Susan B. Komen Foundation's Race for the Cure, and the Salute 2 America Fourth of July parade. In coordination with the other Family 2 Family sponsors, PeachCare flyers are available at each Haverty's Furniture stores, Verizon Wireless stores and kiosks, Promina Health Systems hospitals and clinics, and Southtrust Banks in the metro Atlanta area. The media coverage, affiliation with the commercial Family 2 Family partners and participation at community events have increased PeachCare for Kids' visibility throughout the metro Atlanta area..

PeachCare for Kids partnered with the Department of Education, Division of School Nutrition Services to distribute 1.6 million flyers to children as part of their back-to-school registration kits. The flyers included PeachCare's toll-free number to request applications and the web address for families to apply online. This outreach effort generated an increase in phone calls to PeachCare for Kids and a significant increase in web-based applications, as detailed in Attachment 3.

C. Enrollment - PeachCare for Kids included a voluntary survey at the end of the Internet application. At present, we have examined the responses to this survey for those who applied on or before August 14, 2001. As of that date, PeachCare had received 3,680 complete applications, seeking coverage for 7,736 children. It is therefore clear that many applicants are choosing to use this mode of application.

Of the 3,680 applicants, 1,772 completed the survey at the end of the application. Survey respondents indicated that most would have applied that month, even if the Internet based application were not available. However 27% of respondents said they would not have applied that month otherwise. So, for a sizeable proportion of applicants, the availability of a computer based application caused them to apply sooner than they would have otherwise (if they would have applied at all).

The Internet application may allow PeachCare to enroll children from a different segment of the population. Internet applicants may differ from other applicants in terms of educational attainment, income, or social networks.

Survey results show that very few of these applicants (7%) hear about PeachCare from a DFCS caseworker or other outreach worker. More than any other source, these applicants learned about PeachCare from a friend or family member (30%). The remainder heard about PeachCare from a variety of sources: advertisement, health care provider, or other source. When our mail surveys of recent PeachCare applicants have been returned, we will be able to compare these responses to those of applicants who applied via mail or telephone.

The Internet survey also shows that Internet applicants have a fairly high level of educational attainment. Fourteen percent have graduated from college. (The percent of Georgians age 25 and above who were college graduates during the 1990 Census was just 9.5%. Year 2000 Census data is not yet available.) Additionally, about 49% of Internet applicants had received some college education, and 32% had completed some amount of high school. Just 4% had not attended high school. When mail surveys of recent PeachCare applicants have been returned, PeachCare will be able to compare the educational attainment of Internet applicants to those of applicants who applied via mail or telephone.

D. Retention/disenrollment - PeachCare for Kids participated in a multi-state study of retention among S-CHIP programs coordinated by the National Academy of State Health Policy. The study included a combination of focus groups and telephone surveys of parents of children who had disenrolled from S-CHIP programs. The results of this study will be available in 2002.

E. Benefit structure - NA

F. Cost-sharing - NA

G. Delivery system - NA

H. Coordination with other programs - PeachCare for Kids enhanced the streamlined referral process implemented August 2000. With the system improvements, applications are screened for Medicaid eligibility and referred for enrollment. The state eligibility specialists notifies PeachCare for Kids of the eligibility determination. Children determined eligible for Medicaid by the state staff and those eligible for S-CHIP are enrolled in PeachCare for Kids and receive a PeachCare identification card. Based on their eligibility, children may receive a letter that they are not required to pay a premium or that a premium is required for their enrollment. This change has made an impact on the how simple the families perceive the program to be. From their perspective, they apply for PeachCare and if they are eligible (whether for Title XXI or Title XIX benefits) their children are enrolled in PeachCare. Should there be a change in eligibility from one

program to the other, the parents are notified that they will have to start paying a premium to continue on the program or that they are no longer required to pay premiums. The children keep their current identification cards and primary care providers. The children remain on the same program and enrollment system that the parents initially selected. While we are accounting for the source of program and payment, the families do not feel any affect of being switched back and forth among programs.

I. Crowd-out - NA

J. Other - NA

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2002-projected budget. Please describe in narrative any details of your planned use of funds.**

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2001	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care			
per member/per month rate X # of eligibles			
Fee for Service	$105,275,950.00	$184,434,931.00	$234,112,819.00
Total Benefit Costs	$105,275,950.00	$184,434,931.00	$234,112,819.00
(Offsetting beneficiary cost sharing payments)	($6,066,466.00)	($6,200,000.00)	($6,500,000.00)
Net Benefit Costs	$99,209,484.00	$178,234,931.00	$227,612,819.00
Administration Costs			
Personnel			
General administration	$8,185,065.00	$8,937,069.00	$9,705,181.00
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs			
Other			
Total Administration Costs	$8,185,065.00	$8,937,069.00	$9,705,181.00
10% Administrative Cost Ceiling	$10,739,454.90	$18,717,200.00	$23,731,800.00
Federal Share (multiplied by enhanced FMAP rate)	$77,077,067.82	$133,453,636.00	$170,205,000.00
State Share	$30,317.491.18	$53,718.364.00	$67,113.000.00
TOTAL PROGRAM COSTS	$107,394,549.00	$187,172,000.00	$237,318,000.00

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

N/A

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

_X_ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
___ Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures. No.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name		PeachCare for Kids
Provides presumptive eligibility for children		No
Provides retroactive eligibility		Yes, only to beginning of month of application
Makes eligibility determination		Contractor
Average length of stay on program		The average number of months PeachCare for Kids recipients have been enrolled (between inception and November 2001) is 13.77 months. If PeachCare "Plus" children are included, then the average number of months enrolled is 12.05 months. ***Note: I wasn't sure whether you wanted to include the PCK Plus kids here.***
Has joint application for Medicaid and SCHIP		Yes
Has mail-in application		Yes
Can apply for program over the phone		Yes
Can apply for program over internet		Yes
Requires face-to-face interview during initial application		No
Requires child to be uninsured for a minimum amount of time prior to enrollment		Yes. Children who have voluntarily dropped employer-sponsored group coverage must be uninsured 3 months prior to

		enrollment
Provides period of continuous coverage regardless of income changes		No
Imposes premiums or enrollment fees		Yes. For children ages 6 and older, $7.50 per month for one child/$15.00 per month for two or more children Who can pay? _X_ Employer _X_ Family _X_ Absent parent _X_ Private donations/scholarship _X_ Other
Imposes copayments or coinsurance		No
Provides preprinted redetermination process		Yes, we send out form to family with their information __ ask for a signed confirmation that information is still correct _X_ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The initial application requires an enrollment form be completed and submitted. For the renewal of enrollment, the family does not need to complete a form. Any changes in income or other circumstances can be reported by calling the toll-free PeachCare for Kids number.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

185% of FPL for children under age 1
133% of FPL for children aged 1 through 5
100% of FPL for children aged 6 through 18

Medicaid SCHIP Expansion

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

235% of FPL for children aged up to 19

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes X No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$90 per month for each legally responsible working adult in household	$	$90 per month for each legally responsible working adult in household
Self-employment	$	$	$
Alimony payments Received	$	$	$
Paid	$	$	$
Child support payments Received	$50 per month	$	$50 per month
Paid	$	$	$
Child care expenses	Up to $200 per month for a child under 2 years, up to $175 for a child over the age of 2	$	Up to $200 per month for a child under 2 years, up to $175 for a child over the age of 2
Medical care expenses	$	$	$
Gifts	$	$	$
Other types of disregards/deductions (specify)	$	$	$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups
_X_ No ___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program
_NA_ No ___Yes, specify countable or allowable level of asset test_____

Separate SCHIP program
_X_ No ___Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

_NA_ No ___Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?
___ Yes _X_ No

Enrolling Children in SCHIP:

Georgia PeachCare for Kids Experience

Preliminary: Do not cite or quote without author's written permission.

Jay Patrick Bae, Ph.D.

Department of Economics, GSU

Jennifer N. Edwards, Dr. PH.

& Katherine Gardner, MA

Georgia Health Policy Center, GSU

This study was supported by the Georgia Department of Community Health.

Enrolling Children in SCHIP: Georgia SCHIP Enrollment Study

Jay Patrick Bae, Ph.D.

Jennifer N. Edwards, Dr. PH.

Katherine Gardner, MA

In an effort to help expand health care coverage to uninsured, low-income children, the Congress in 1997 passed Title XXI, State Children's Health Insurance Program (SCHIP), as a Federal-State partnership program. Empowered by this legislation, the State of Georgia in 1998 created PeachCare for Kids (PCK), health insurance for low income uninsured children living in Georgia. The program subsequently went into effect in January 1999.

An important question asked by experts and policy makers regarding SCHIP implementation was if and how SCHIP can be successful in enrolling low-income children? What factors facilitate enrollment? Because Medicaid had not been able to achieve a high participation rate of eligible children (US Genral Accounting Office, 1995; Halfon, et.al., 1997; Arruch et.al. 1998; Newacheck et.al. 1998; Weinnick et.al. 1998), it was perceived a major challenge for SCHIP to achieve a high enrollment rate at that time (Halfon et.al., 1998).

Since its inception, PeachCare has enrolled more than 150 thousand uninsured low-income children in Georgia. This study describes the program's enrollment and analyzes and identifies factors contributing to its enrollment success. This study reveals how underlying social, economic, and racial dynamics affects the outreach efforts. In light of this study's finding, we explore policy options that might help increase the effectiveness of programs. It is hoped that our findings help further guide the policy making process for a more efficient and equitable resource allocation that maximizes outreach effectiveness in other similar public programs.

Background

The Georgia SCHIP program is a separate program from Medicaid, but administered by the state Medicaid agency, Division of Medical Assistance. PeachCare is available for children up through age 18 in families with an income up to 235 percent of the federal poverty line, but not eligible for Medicaid. Premiums are required for children ages 6 and older. The cost is $7.50 per child per month, or $15 per family.

The health benefits include a comprehensive range of services, such as primary, preventive, specialist, dental, vision care, hospitalization, emergency room services, prescription medications, and mental health care. This program is built on a primary care provider system, in which each child selects or is assigned a primary care provider who coordinates the child's care.

Approximately 50% of Georgians live in the urban Atlanta Metro area, however, the rest of state population is scattered in many scarcely populated rural communities. Among the state's general population, minority races account for approximately one-third (33.27%) with African Americans account for over 80% of them. However, depending on areas, racial composition of counties in Georgia varies substantially. Some counties have as low as less than 1% minority residents while some counties have more than 95% minority resident population. Other minorities, such as Hispanics, Native Americans and Asians-Pacific Islanders make up approximately 5% of the state population, and their shares have been growing (US. Census Bureau, 2000).

Sources of data used in this data are as follows. From the PCK eligibility file, we obtained monthly enrollment data. Additional information related to demographic, economic, racial, and family structure of enrollees was obtained from PCK application database. Residence county urban-rural classification was obtained from the Area Resource File (HRSA, 2001).

Enrollment Patterns

Overall Growth Trend

Figure 1 shows the total program enrollment through the most recent period. The enrollment trend shows a continuing increase through out the 29-month period. On average, the enrollment process added 4460 new uninsured children each month. Since the program enrollment began in January 1999, total enrollment has grown to 129,353 children by March 2001, and as of September 2001 enrollment has reached the estimated state's total eligible population of 143,000. The enrollment figure makes Georgia SCHIP the fifth largest program after California, New York, Florida, and Texas. Enrollment growth seems to have slowed down during the last month of the data period. It is unclear if the current enrolment trend can be sustained.

Who Joined Early?

In order to understand enrollment behavior, we looked to the literature that studied health service seeking behavior. Literature on access and use of health care services has recognized complexities in care seeking behavior, and analyzed influences of various socio-economic and demographic factors among the pediatric populations. Typically included variables are: race, family structure, resident community characteristics, economic status, and social network.

For example, studies found that race is a significant factor in explaining many facets of health care utilization, such as physician visits (Kleinman et.al, 1981; Guendelman and Schwalbe, 1986; Kasper, 1987; Lewin-Epstein, 1991; Fleischer et.al. 1994; Flores, et.al. 1999), preventive services and regular source of care (Kasper, 1987; Newacheck and Halfon, 1988; Lewin-Epstein, 1991; Short and Lefkowitz, 1992; Newacheck, 1992; Halfon et.al. 1996), emergency room visits (Yamamoto, 1995; Halfon, et.al. 1996), immunization (Wood, et.al., 1995; Moore et.al., 1996; CDC, 1996 & 1997) and several specialties and services (Wood, et.al, 1990; Fleischer, at.al. 1994; Moore at.al. 1994; Hahn, 1995).

The literature documents that family structure and social networks influence health service use among the pediatric population. (Horwitz, 1978; Cafferata, 1985, Horwitz et.al, 1985; Newacheck, 1986; Newacheck and Halfon, 1986; Newacheck, 1988, Flores, 1999). To the extent that children need initiation and assistance of adults to seek health care, the number of parents in the household should be of particular interest. Studies that examined children with special health care needs, selective congenital or acquired chronic conditions, such as asthma, spinabifida, and schizophrenia, found that their

service utilization behavior reflect their high need for medical care. (Shenkman XX) Also relevant is the degree of urbanization, as residents and health care systems in rural communities have long been facing various challenges (Frary, 1979; Pryor, 1992; Arnold, 1993; Ricketts, 2000). This question has relevance in that the success of PCK will depend in part on its ability to reach out to rural families, traditionally underserved by both the public and private sector programs. It would be useful for policy makers to identify and understand factors that help or hamper qualifying children to get on and stay on the program.

The Georgia PCK is structured as a program that has no copay, but requires a monthly premium for children over 6 year. Although the monthly premium is capped at $15 per household, the premium requirement may not be negligible for families who are closer to the poverty line.[1] Previous literature on health care access and utilization of children found income to be a significant and almost always positively correlated factor. (Horwitz, 1978; Newacheck and Halfon, 1986.a; Newacheck and Halfon, 1986.b; Newacheck and Halfon, 1988; Wood, D.L., et.al., 1990; Short and Lefkowitz, 1992). This positive association between income and health care utilization among children is largely consistent with study findings among the adults (Citations Here).An enrollment study of a previous children's health insurance program confirmed that many factors of service use also affect enrollment (NY state study). We include household income to estimate its effect on enrollment timing.

Who Joined Early: Bivariate Analyses

Initially, we compare average length of enrollment by various characteristics. For example, over the 21-month study period, a child who enrolled in the very first month of the program has 21 months of program experience to contribute toward the group mean, whereas a child who enrolled on the last month has only one month to contribute to the group mean. The bivariate analysis results are presented in Figure 2.

Given the steady growth in enrollment over our study period of 21 months, the average for the entire program participants was very close to the halfway point at 10.3 month long. The strongest factor in early enrollment seems to be the presence of a chronic condition that defines the child as having a special health care need[2]. The bivariate comparison shows that children with special health care needs had 12.4 months of program exposure, compared with 9.9 months of children without such conditions.

Next, we present average length of program exposure by household net income of deduction. Average program experience length was highest for the bottom income quartile at 10.5 months, and the shortest for the highest income quartile at 9.9 months. This suggests that children from relatively lower income households joined the program earlier than those from relatively higher income families. In terms of urban-rural differences in their residence counties, we found the largest urban area, i.e. twenty Atlanta Metro counties, lagging behind the rest of the counties, including the most rural regions of the state.

As discussed, the PCK program exempts children under 6 years of age from paying premium, while older children are subject to a monthly premium of $7.50 per child subject to a household-level maximum of $15 per month. Average length of enrollment duration is compared by age. Children under 6 years of age had a 9.1 month average while older children had a 10.8 month average. This somewhat surprising result will be revisited later.

Data revealed that length of enrollment was increasing with the number of siblings per household variable. It was 9.8 months for a household with one eligible child, but increases to 10.4 months for 2 children, and 10.6 for household with three or more children. Thus, it appears that families with many children joined earlier. An important aspect of household structure was number of parents. The PCK application process requires all applicants to answer his or her relationship to enrolled child, and collects information about parent-child relation. From this variable, we know how many parents the child lives with (none, one, or two), and their relationship to the child (biological, step, and other). Here, we present average program experience length of enrollees by number of parents. We found that children who live without either parent joined earliest with the enrollment period of 10.7 months, followed by children that lived with two-parents with 10.4 months and lastly children who lived with a single-parent with 10.1 months.

In terms of racial differences, we note that the Caucasians had the longest average enrollment length with 10.7 months, followed by the African American group with 10 months, Asians/Pacific Islanders with 9.3 months, and the Hispanic group with 8.7 months.

Although the bivariate comparisons suggests that there are systematic differences along the comparison groups, to the extent that many of these factors are confounding the relationship, analyzing the problem in a multivariate setting is warranted.

Who Joined Early?: Multivariate Duration Analysis

In order to better understand multiple factors that affect enrollment pattern at the household level we employ a multivariate duration model. The estimation model was specified with following explanatory variables and estimated as follows[3]:

$$\text{Log (EnrolExpos)} = \alpha_1 \text{ SHCN} + \alpha_2 \text{ Income} + \alpha_3 \text{ Urban/Rural} + \alpha_4 \text{ Premium} + \boldsymbol{\alpha i} \textbf{ Age Factor} + \boldsymbol{\alpha j} \textbf{ Household} + \boldsymbol{\alpha k} \textbf{ Parental Structure} + \boldsymbol{\alpha l} \textbf{ Race} + \varepsilon$$

Where
EnrolExpos: Total months since first time enrollment.
SHCN: Presence of special health care need conditions.
Income: Household income net of deduction.
Urban/Rural: USDA Urban-rural scale (1: most urban to 9: most rural)
Premium: Average cost of premium per child.
Age Factor: Age of child or Schooling age status
Household: Family structure, e.g. siblings, parent structures (two, single, or no parent)
Race: Race of child as dummy variables: Caucasian, African American, Hispanic, Asian, and Others.

The dependent variable, EnrolExpo, is total number of months from first enrollment month through the last month of study period (Exposure ≤ 21). Thus, those who enrolled earlier have longer EnrolExpos. Literature suggests inclusion of various demographic, racial and family structure. One variable particularly worth explaining is the premium cost variable.

Bivariate tabulation showed that families with more children joined the program earlier. In order to properly investigate economic reasons for such result, premium cost per child is calculated. Premium structure of the program is such that a child costs $7.50 per month except children under 6 years of age, but no family is required to pay more than $15 per month. Such premium structure gives rise to a range of average cost of program participation per child at the family level. We use this average cost per child as the direct price of joining PeachCare.

Results

Regression results are shown in Table 1. Most variables were significant by Chi-square statistics. The special health care need status variable consistently reported large positive coefficients raging from 0.158 to 0.157, indicating earlier joining of these children. The family income variable reported small negative coefficients around –0.000034 to –0.000053. Urban

influence variable, which classified areas from the most urban to the most rural (from 1 to 9), had a small negative but insignificant coefficient ranging from –0.00049 to –0.00066. Child age being over 6 was positively associated with the enrollment exposure with coefficient around 0.1269 and 0.150. Number of siblings in the family variable had small positive coefficients around 0.0216.

Number of siblings had a positive effect on enrollment in the bivariate analysis. In our multivariate regression, we included the sibling number variable. Estimated parameters for this variable was positive and significant around 0.0216. Alternatively, premium cost per child was used. This variable is the direct cost of joining the program per child. Estimates were negative with parameter value of –0.0037.

Parental structure was estimated in a couple of ways. First, they were grouped by number of parents: zero, one, and two. Secondly we divided single parent households by gender of the parent, i.e., single mom and single dad. Estimation of single parent variable produced negative coefficients in the range of –0.04957 to 0.04993, and no parents variable produced coefficients between –0.09532 to –0.10388. When single parent households were examined separately, household with mother only exhibited parameter of –0.042, while dad only variable had parameter ranging between –0.036 to –0.037.

Each race of children was classified into five groups and tested respectively as a dummy variable. The Caucasian race reported the largest positive coefficients (0.089 – 0.091), followed by the African American group (0.043 – 0.045). On the other hand, Hispanic race reported negative coefficients raging from –0.060 to –0.062. Asian race dummy had small negative results, but not significant.

In order to show magnitudes of various factors on enrollment duration, we present simulated effects in Figure 3. Reference group is selected as Caucasian children under 6 year old who do not have special health care need, and lives with both parents in a household of average characteristics. The reference group had an average enrollment of 10 months and 27 days.

The multivariate results were largely consistent with the bivariate results with a few exceptions. The strongest predictor of early joiner was the presence of special health care need. Other things being equal, children with special health care need joined 1.87 months sooner than children without, or 17.16% longer enrollment duration. This is anticipated because children who are at a high risk of using health care services will likely to benefit more from the program than children who are healthy, and will likely to respond sooner.

The income variable is constructed as family income after deduction. Comparison was made between mean household income of $1944 and the third quartile threshold of $2333. Simulation shows that an additional income of $389 was associated with a 0.23-month delay in joining the program. Lower income people joining earlier seem plausible under the following scenario. Lower income households are more likely to come into contact with various public sector assistance programs, and information about SCHIP may have been disseminated more quickly among this group. Also, their past experience and knowledge with the public assistance programs may have helped navigate the enrollment system better. This group may have acted more quickly strictly for economic reasons. Other things being equal, they have less ability to pay for medical cost if medical care is needed.

Very small and insignificant negative effects of urban rural degree variable from the regression showed that, controlling for other factors, there was no meaningful difference between urban areas and rural areas in terms of timing of enrollment. Although numerous studies documented multidimensional disparities between urban and rural health care systems (Frary, 1979; Pryor, 1992; Arnold, 1993; Ricketts, 2000) our finding showed that the state's enrollment outreach performance in rural communities was at par with the urban communities.

The multivariate result shows that six years or older children were likely to join the program earlier by a month and a half (13.58% longer), similarly to our earlier bivariate result. As discussed before, the PeachCare for Kids program has exempted preminum for children under 6 years of age. The zero premium policy would have made children under 6 years of age to join sooner than older children. However, our study found a strong opposite effect, in which premium paying age children enrolled sooner. We conjecture that this result is due possibly to dominance of other effects this variable also captures. For example, in an effort to increase awareness of the program, the program outreach staff were located in major retail stores throughout the state to inform the parents about the program during the week before back-to-school. Also, partnering with the state Department of Education, the program distributed 1.4 million information flyers to all children enrolled in public school.

Earlier bivariate results showed that families with more children joined the program earlier. In order to properly investigate the reason for such a result, we first tested its significance in the multivariate setting, and then tested price effect on enrollment by using average premium cost per child. The sibling effect turned out to be a positive factor in regression. Effects of having an additional child in the family meant that the family joined approximately one week earlier (or 2.19% longer

exposure) than otherwise. However, we suspected that this relationship is predominantly due to premium effect, and apart from the premium effect, number of siblings, per se, should not influence the enrollment timing. When sibling variable was replaced with average premium cost, we found higher average premium cost is a strong delaying factor in enrollment decision. Simulated effect of $2.50 increase in effective premium cost per child caused 1.15month delay (10.6% shorter) in enrollment duration relative to the reference group.[4]

Parental structure was an important predictor of enrollment time. Children living with neither parent were associated with more than a full month delay (or 9.85% shorter in length of program exposure). Children living with a single parent joined the program about two week's later (4.84% shorter) compared with children living with both parents. Children living with someone other than parents were slowest to enroll with 1.07 month delay (9.82% shorter) than children living with two parents. From this, it is apparent that parents are important decision makers in getting their children insured, and their absence hampers or delays participating and benefiting from public programs.

Multivariate results confirmed that race was a significant predictor of enrollment timing. Caucasian race was associated with earlier enrollment with relatively larger positive coefficients than other groups. African Americans were next group in terms of enrollment duration, followed by "others or unknown" race group. Hispanics and Asian-Pacific Islanders were considerably slower to join than the comparison group. Simulated duration of enrollment shows that, compared to Caucasian race, African American group's enrollment was 0.48 month slower (-4.40%), and "other or unknown" racial group was 0.94 month slower (-8.62%). Hispanic group, on average, was the slowest racial group to enroll in the program 1.54 month later (-14.13%) than the Caucasian group.

Discussion

Exceeding its initial enrollment target, Georgia's SCHIP, PeachCare for Kids, has successfully enrolled more than 150 thousand uninsured low-income children in Georgia. Being a single state experience, exploiting comparative evaluation design was not possible. Also, not being able to include eligible non-joiners in the study was an important limitation. Despite the limiations, this study evaluated the program's enrollment process, and identified a number of factors that contributed to the successful enrollment.

In summary, this study found that the parents or the households made enrollment decisions primarily by perceived cost and benefit of joining the program. Those who were more likely to use service, such as children with special health care need, were the early joiners. Financial factors played an important role in enrollment decision. Those who had a lower ability to absorb financial shock of medical expenditure joined earlier, and so did those families who faced lower effective premium. We found suggestive evidence that more experience of parenting, by children's age or by number of children, may have been a positive factor toward enrollment decision. Children living with two parents enrolled earlier than children living with a single parent. Children living with someone other than parent joined the last as a group.

Being a state with a significant rural population, it is particularly encouraging that enrollment process was comparable in the rural communities as it was in the urban areas. We also found significant racial disparities in the enrollment pattern, in which especially non-English speaking minorities were slowest to join. Although application form had been available in Spanish early in the enrollment process, it was about a year later that information flyers in Spanish became available. Distribution of applications in Asian languages, e.g., Chinese, Vietnamese, and Korean, began in the summer of 2001 through various Asian community centers accompanied by flyers in translations. This suggests that language barriers may have initially hampered enrollment of eligible children from non-English speaking households. Availability of information in translation will certainly help increase enrollment rate.

The analysis suggests a number of ways to improve the enrollment process. In terms of program structure, the PeachCare requires monthly premium, but does not require any copay. The effect of average premium cost suggests that the required premium, however small, may have delayed the decision to join for some. It is conceivable that structuring the benefit as zero premium with nominal copay may have help increased the enrollment.[5] With respect to information dissemination, it is recommended to continue outreach effort targeting particularly under school-age children, households with single parent or no parent, and non-English speaking minority population.

Narrowly seen, this has been a case study of one state SCHIP enrollment for low-income children. More broadly, however, this experience represents a statewide public outreach program that targeted low-income people. It is hoped that lessons generated from this study help improve enrollment of eligible children in other states SCHIP and in Medicaid programs, as well as other public outreach program targeting low income people.

Figure 1. PeachCare Enrollment Trend

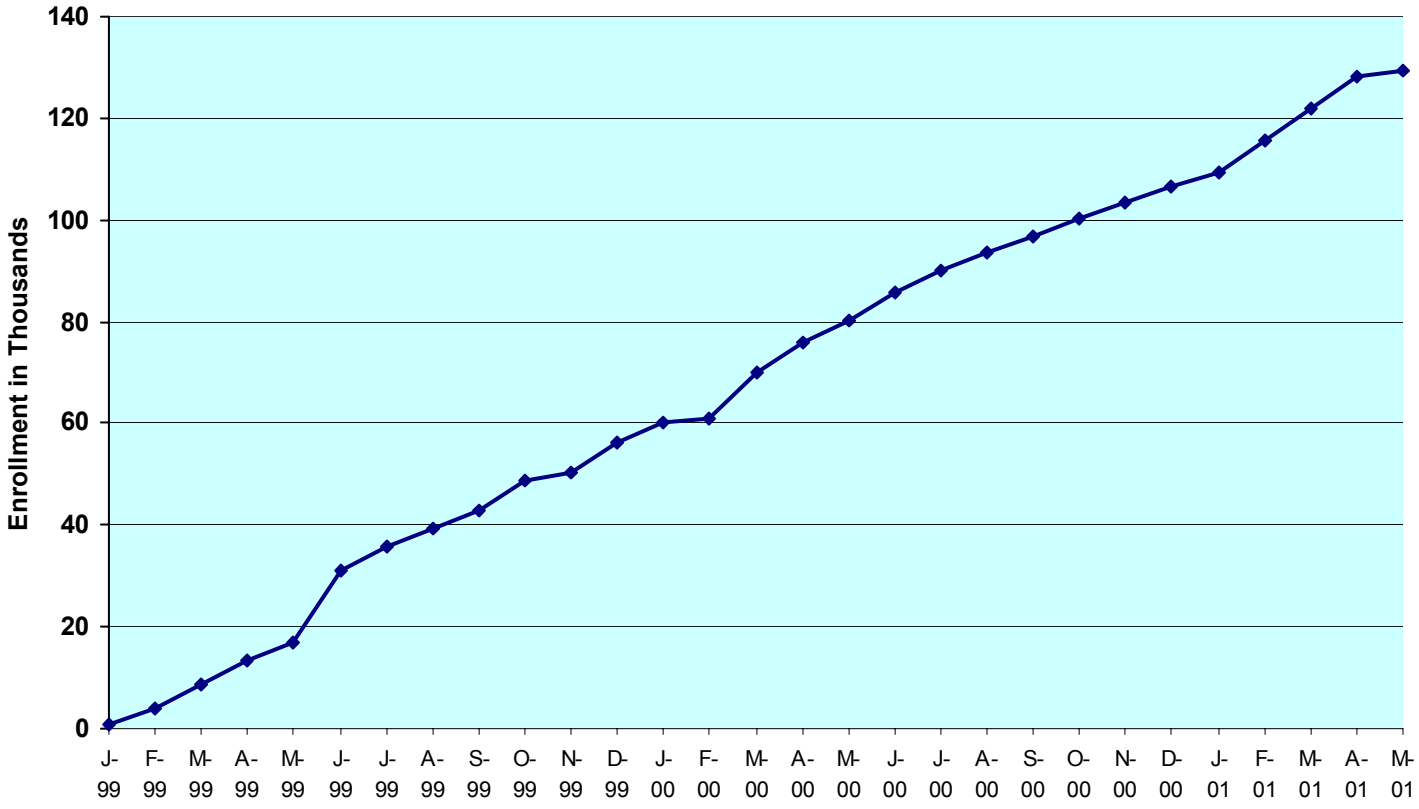


Figure 2. Who Joined Early?: Average Months Enrolled

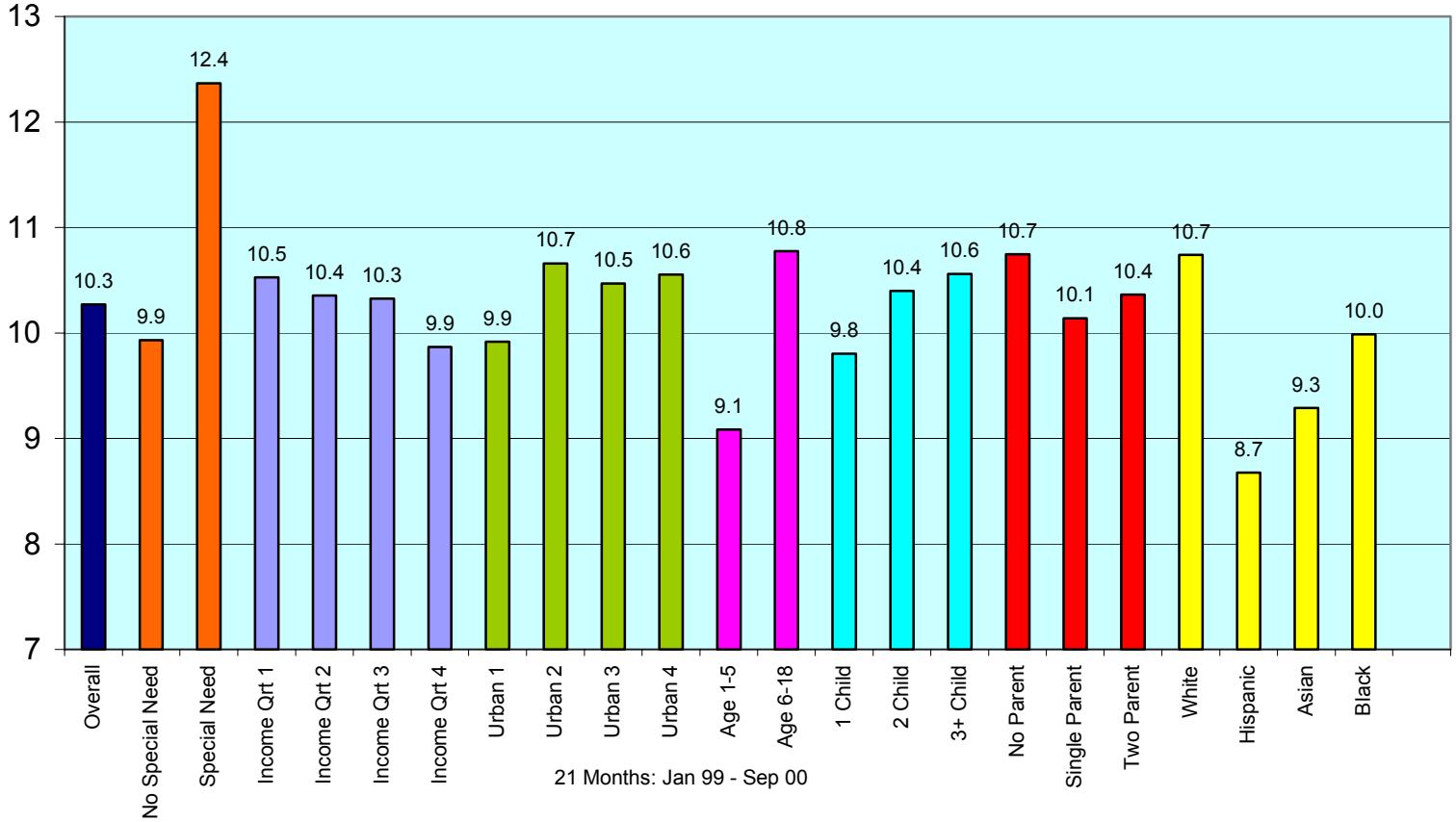
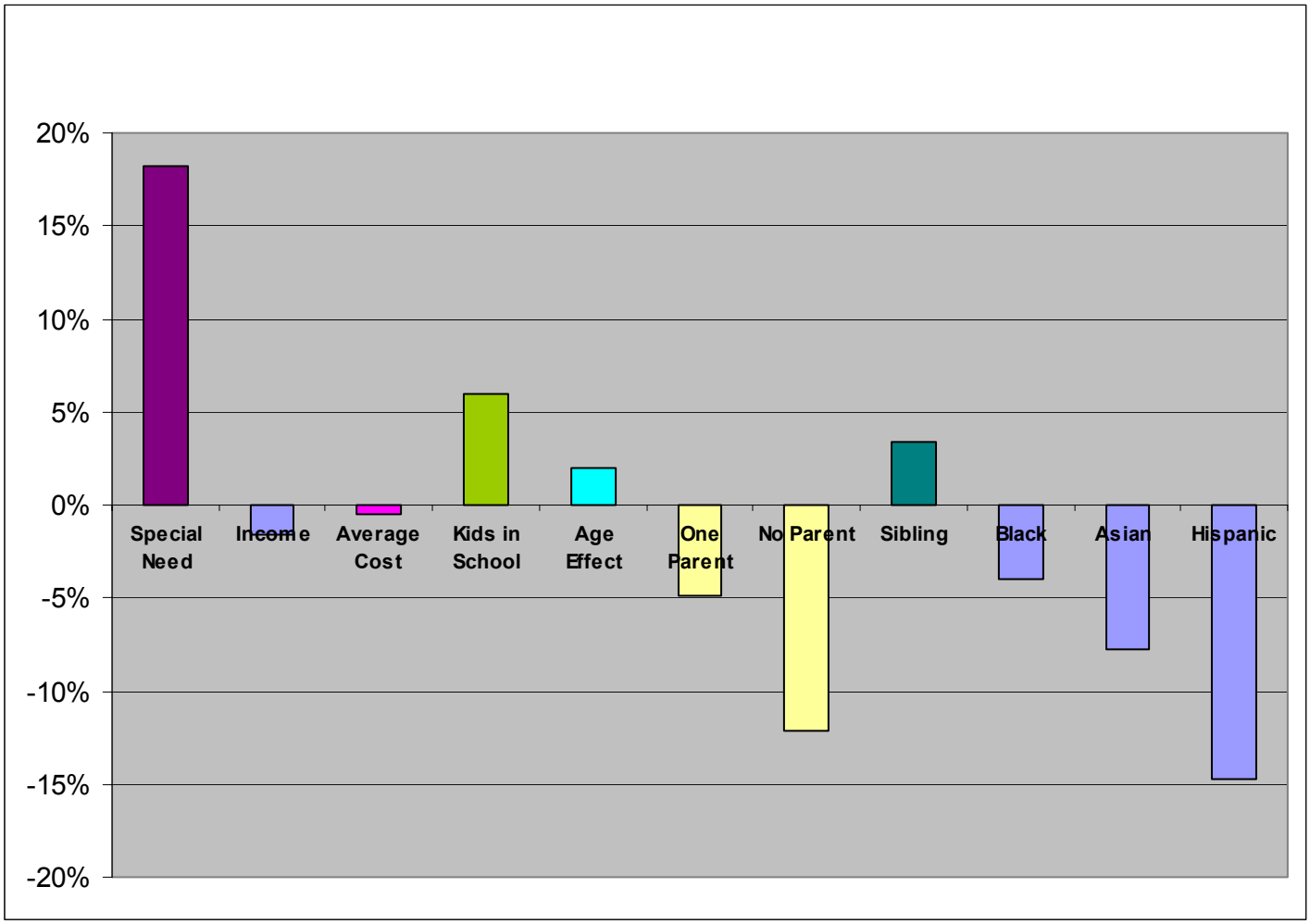


Table 1. Enrollment Duration Regression

	Model 1	Model 2	Model 3	Model 4	Model 5
Special Need	0.15833 (1230.25)	0.1584 (1230.71)	0.15835 (1230.66)	0.15697 (1210.66)	0.15702 (1211.05)
Income	-0.0000541 (263.11)	-0.0000509 (235.90)	-0.0000539 (262.58)	-0.0000349 (146.84)	-0.0000319 (123.37)
Urban-Rural	-0.0004967 (0.58)			-0.0006614 (1.03)	
6 Year Plus	0.12793 (1279.24)	0.12695 (1263.44)	0.12777 (1279.83)	0.1500 (1523.76)	
Sibling	0.02163 (133.27)	0.02168 (133.94)	0.02166 (133.77)		
Cost per Kid				-0.003724 (42.85)	-0.003714 (42.60)
One Parent	-0.04993 (161.83)		-0.04957 (161.66)	-0.05028 (164.71)	
Mom only		-0.04205 (111.40)			-0.04255 (113.48)
Dad only		-0.03617 (16.30)			-0.03714 (17.20)
No Parent	-0.10388 (21.11)	-0.09536 (17.81)	-0.10358 (21.00)	-0.08159 (13.12)	-0.07319 (10.56)
White	0.09015 (242.74)	0.09112 (249.52)	0.09043 (279.27)	0.08949 (239.31)	0.09073 (246.03)
Hispanic	-0.06296 (48.31)	-0.06104 (45.42)	-0.06228 (49.91)	-0.0623 (47.32)	-0.06038 (44.46)
Asian	-0.0049185 (0.12)	-0.0020277 (0.02)		-0.00590 (0.17)	
Black	0.04466 (55.03)	0.04356 (52.51)	0.04532 (63.77)	0.04524 (56.80)	0.04409 (53.81)
Intercept	2.35923 (6136.75)	2.34751 (68352.73)	2.35627 (71815.61)	2.37271 (60268.30)	2.3627 (60443.84)
Log Likelihood	-122800.933	-122824.71	-122801.274	-122846.90	-122870.83

Chi-Square statistics in parenthesis.

Figure 3. Simulated Effects of Enrollment Duration



References

Distance to Providers
Dutton, D. (1986). Financial, organizational and professional factors affecting health care utilization. *Social Science Medicine, 23*(7), 721-735.

Dutton, D.B., Gomby, D., & Fowles, J. (1985). Satisfaction with children's medical care in six different ambulatory settings. *Medical Care, 23*(7), 894-912.

Kasper, J.D. (1987). The importance of type of usual source of care for children's physician access and expenditures. *Medical Care, 25*(5), 386-398.

Kindig, D.A., Movassaghi, H., Cross Dunham, N., Zwick, D.I., & Taylor, C.M. (1987). Trends in physician availability in 10 urban areas from 1963-1980. *Inquiry, 24*, 136-146.

Yudkowsky, B.K., Cartland, J.D.C., & Flint, S.S. (1990). Pediatrician participation in Medicaid: 1978-1989. *Pediatrics, 85*(4), 567-577.

Immunization

Centers for Disease Control and Prevention. (1996). National, state, and urban area vaccination coverage levels among children aged 19-35 months-- United States, July 1994- June 1995. *Morbidity and Mortality Weekly Report, 45*, 508-513.

Centers for Disease Control and Prevention. (1997). Vaccination coverage by race/ethnicity and poverty level among children aged 19-35 months-- United States, 1996. *Morbidity and Mortality Weekly Report, 46*, 963-968.

Mayberry, R.M., Mili, F., & Ofili, E. (2000). Racial and ethnic differences in access to medical care. *Medical Care Research and Review, 57*(1), 108-145.

Moore, P., Hepworth, J.T., & Fenlon, N. (1996). Indicators of differences in immunization rates of Mexican American and white non-Hispanic infants in a Medicaid managed care system. *Public Health Nurse, 13*, 21-30.

Wood, D., Donald-Sherbourne, C., Halfon, N., Tucker, M.B., Ortiz, V., Hamlin, J.S., Duan, N., Mazel, R.M., Grabowsky, M., Brunell, P., & Freeman, H. (1995). Factors related to immunization status among inner-city Latino and African-American preschoolers. *Pediatrics, 96*, 295-301.

Income Factor

Horwitz, A. (1978). Family, kin, and friend networks in psychiatric help-seeking. *Social Science & Medicine, 12*, 297-304.

Newacheck, P.W. & Halfon, N. (1986). Access to ambulatory care services for economically disadvantaged children. *Pediatrics, 78*(5), 813-819.

Newacheck, P.W. & Halfon, N. (1986). The association between mother's and children's use of physician services. *Medical Care, 24(1)*, 30-38.

Newacheck, P.W. & Halfon, N. (1988). Preventive care use by school-aged children: Differences by socioeconomic status. Pediatrics, 82(2), 462-468.

Short, P.F. & Lefkowitz, D.C. (1992). Encouraging preventative services for low-income children: The effect of expanding Medicaid. *Medical Care, 30*(9), 766-780.

Wood, D.L., Hayward, R.A., Corey, C.R., Freeman, H.E., & Shapiro, M.F. (1990). Access to medical care for children and

adolescents in the United States. *Pediatrics, 86*(5), 666-673.

Use of Service

Cafferata, G.L., & Kasper, J.D. (1985). Family structure and children's use of ambulatory physician services. *Medical Care, 23*(4), 350-360.

Cornelius, J.L. (1993). Barriers to medical care for white, black, and Hispanic American children. *Journal of the National Medical Association, 85*(4), 281-288.

Fleischer, A.B., Feldman, S.R., & Bradham, D.B. (1994). Office-based physician services provided by dermatologists in the United States in 1990. *Journal of Investigative Dermatology, 102,* 93-97.

Flores, G., Bauchner, H., Feinstein, A.R., & Nguyen, U.-S.D.T. (1999). The impact of ethnicity, family income, and parental education on children's health and use of health services. *American Journal of Public Health, 89*, 1066-1071.

Guendelman, S., & Schwalbe, J. (1986). Medical care utilization by Hispanic children: How does it differ from black and white peers? *Medical Care, 24*(10), 925-940.

Hahn, B.A. (1995). Children's health: Racial and ethnic differences in the use of prescription medications. *Pediatrics, 95*, 727-732.

Halfon, N., Newacheck, P.W., Wood, D.L., & St, P.R.F. (1996). Routine emergency department use for sick care by children in the United States. *Pediatrics, 98*, 28-34.

Horwitz, S.M., Morgenstern, H., & Berkman, L.F. (1985). The impact of social stressors and social networks on pediatric medical care use. *Medical Care, 23*(8), 946-959.

Kasper, J.D. (1987). The importance of type of usual source of care for children's physician access and expenditures. *Medical Care, 25*(5), 386-398.

Kleinman, J.C., Gold, M., & Makuc, D. (1981). Use of ambulatory medical care by the poor: Another look at equity. *Medical Care, 19*(10), 1011-1021.
Lewin-Epstein, N. (1991). Determinants of regular source of health care in black, Mexican, Puerto Rican, and non-Hispanic white populations. *Medical Care, 29*(6), 543-557.

Mayberry, R.M., Mili, F., & Ofili, E. (2000). Racial and ethnic differences in access to medical care. *Medical Care Research and Review, 57*(1), 108-145.

Moore, P., & Hepworth, J.T. (1994). Use of perinatal and infant health services by Mexican-American Medicaid enrollees. *Journal of the American Medical Association, 272*, 297-304.

Newacheck, P.W. (1992). Characteristics of children with high and low usage of physician services. *Medical Care, 30*(1), 30-42.

Yamamoto, L.G., Zimmerman, K.R., Butts, R.J., Amaya, C., Lee, P., Miller, N.L., Shirac, L.K., Tanaka, T.T., Leung, F.K. (1995). Characteristics of frequent pediatric emergency department users. *Pediatrics Emergency Care, 11*, 340-346.

CAHPS Responses and Claims Data

Introduction:

The Consumer Assessment of Health Plans Survey (CAHPS) was used to assess aspects of Medicaid plan performance in Alabama for families of children covered by the Patient First program. The survey consisted of 93 questions about client perceptions of medical access, health care quality, self-perceptions of health status, and demographic information about the respondent. CAHPS is the leading survey used by health plans and state agencies to measure access and quality.

CAHPS respondents were randomly drawn from Medicaid and PeachCare enrollment files in order to be representative of the populations of those programs statewide. Over 50% of those selected from Medicaid surveyed responded, and nearly 70% of those selected from PeachCare responded. Therefore, the results from the CAHPS survey, are representative of the opinions of Georgia's Medicaid and PeachCare recipients.

The GHPC concentrated on five areas of the CAHPS Survey in relation to Medicaid Data.

1. CAHPS as a Measure of Health Care Access

2. The effectiveness of PCP care

3. Identifying Children with Special Health Care Needs with CAHPS

4. Differences between Medicaid and Peachcare

5. Validating the CAHPS survey by comparing survey responses to claims data.

I. USING CAHPS TO MEASURE ACCESS TO CARE:

1. Identifying Child's PCP

Access to care is measured in CAHPS by a number of different indicators. The first we examined was a parent's knowledge of their child's Primary Care Provider (PCP). CAHPS asks the question "Do you have one person you think of as your child's personal doctor or nurse?" At enrollment, every Medicaid and PeachCare child is assigned a PCP. If the communication between Medicaid/PCK and parents were perfect, 100% of parents should be able to identify their child's PCP via this question. Via CAHPS, 69% of Medicaid parents and 81% of PCK parents answered yes to the question above. Whites were over 2 ½ times as likely to identify a PCP in the CAHPS survey as nonwhites ($p < .01$), children with CAHPS identified special health care needs were over twice as likely to identify their PCP ($p < .01$). Interestingly parents of children identified as CSHCN through diagnosis only were no more or less likely to identify their PCP than other children.

2. Seeing the Doctor

CAHPS also asks parents how many times their child saw a doctor in the last year. Due to different medical needs of different children, it is difficult to determine what is an appropriate number of times for a child to see a doctor. However, pediatric care guidelines [(1)] indicate that even children in perfect health children should have at least one office visit per year. CAHPS does not ask this question directly, instead it asks whether respondents have seen a doctor in the last 6 months. The CAHPS survey indicates, that 78% of recipients (87% of MC, 74% of PCK) visited a doctor at least once in the past six months. To test whether this 22% who did not see a doctor was due to time contraits on the survey, or to poor access, we evaluated claims data for the past 12 months. This evaluation indicated that according to this measure, only a small problem existed for enrolled DMA clients. According to claims data, 94% of respondents (96% of MC, 93% of PCK) received some doctor care in the 12 months preceeding the CAHPS questionnaire. While the goal of perfect care is still 100%, the fact that 94% of clients have seen the doctor in the past year should be considered a success.

3. Seeing a Dentist

Dental care can be seen as similar to normal pediatric care, although there is less direct evidence and consensus regarding the need for periodic dental checkups. In a general sense the American Dental Association seems to advise at least yearly dental examinations for children over two years of age. The CAHPS survey asks whether a child has visited a dentist in the last six months. For those families with children over two years of age, 49% reported visiting the doctor at least once in the last six months (58% of MC, 44% of PCK). Interestingly, claims data indicate that 52% of Medicaid children and 64% of PCK children over the age of 2 had visited a dentist in the past 12 months. This highlights a problem in dental access for both MC and PCK children. However, the claims data indicates a much higher rate of dental access for PCK children than the CAHPS data. This is a potential area for further study.

4. Seeing a Specialist

CAHPS attempt to capture whether or not they were able to see specialists that they or their PCPs thought they needed to see. Only 23% of CAHPS respondents said that they needed specialty care, but of those, it appears that some had trouble accessing specialists. According to CAHPS, of those who said they needed to see a specialist, 72% felt satisfied that they were able to. The difference between MC and PCK patients was large. 87% of PCK patients who needed to see a specialist were able to see one as compared to only 64% of MC patients. This information is very difficult to gather from claims data for two reasons. First, from administrative claims, it is impossible to know for certainty who needed to see a specialist and who did not. Second, because many specialty doctors also practice primary care medicine, it is difficult to determine from administrative codes which patients are seeing specialists for advanced care, and which patients are simply going for primary care. The CAHPS survey reveals that there appears to be access issues for MC children who require specialty services.

5. Getting Needed Care

Another area in which CAHPS is superior to claims data is in assessing whether clients are getting the care they think they need. Although, as seen above many clients felt they were unable to get specialty care they or their doctors thought was warranted. However, when asked specifically if they were able to get care they or their doctor thought was "needed" respondents from both MC and PCK overwhelmingly said yes. Nearly all patients (98%) felt they were able to get the care they needed.

We analyzed our five access measures to determine if their were differences in access between MC and PCK children and Children with and without special health care needs. We found that on the whole,

PCK children do better on access measures than MC children, and that children with special health care needs (CSHCN) do better on access measures than children without. PCK/MC differences could be attributable to higher education levels and income levels of PCK parents, as both higher education and income are associated with better access. It also may have to do with issues of racial disparities. A much higher proportion of MC children the PCK children are black, and this could attribute to access differentials. CSHCN may do better than those without due to their greater health requirements which may lead their parents to become more savvy consumers of public health insurance services.

Who Does better on Access Measures?

(Based on regression analysis controlling for age, parent education, and urban rural status)

Measure	MC/CHIP	SHCN/No SHCN
PCP	CHIP p < .05	SHCN p < . 01
Doctor Visit	CHIP p < .01	SHCN p < . 01
Seeing the Dentist	CHIP p < .01	Not Significant
Needed Specialist Care	Not Significant	Not Significant
Problem getting "needed" care	Not Significant	No SHCN p < . 01
Odds of reporting "Good" or better health	CHIP p < .01	No SHCN p < . 01

II. THE EFFECT OF IDENTIFYING A PCP

Using ordinary least squares regression, and logistic regression analysis, we examined the effect of a patient's ability to identify their PCP on different utilization and access measures, controlling for patient's race, MC/PCK status, CSHCN status, age, and gender.

Service Category	Effect	P value
Total Cost	None	.95
Outpatient Cost	None	.68
Outpatient Visits	None	.19
Inpatient Costs	None	.13
Inpatient Days	None	.15
ER Costs	None	.72
ER Visits	None	.52
Prescription Costs	None	.97
Number of Prescriptions	None	.18

****

RESPONSE NON-RESPONSE DIFFERENCES:

Question 1. How do CAHPS Repondents Differ from Non-Respondents?

A1. Service Use for Medicaid CAHPS Nonrespondents and Respondents

Service Category	Non-Respondents	Respondents	P value
Total Cost	1080	1179	.05
Outpatient Cost	788	1181	.01
Outpatient Visits	8.2	11.9	.01
Inpatient Costs	218	205	.88
Inpatient Days	.04	.05	.41
ER Costs	56	70	.05
ER Visits	.59	.69	.05
Prescription Costs	17	15	.72
Number of Prescriptions	6.47	10.73	.01

For Medicaid survey responders have many differences from nonreponders

B1. Service Use for PeachCare CAHPS Nonrespondents and Respondents

Service Category	Non-Respondents	Respondents	P value
Total Cost	668	771	.19
Outpatient Cost	589	702	.17
Outpatient Visits	7.67	10.07	.01
Inpatient Costs	2	6	.59
Inpatient Days	.03	.03	.79
ER Costs	65	51	.34
ER Visits	.50	.45	.53
Prescription Costs	11	13	.59
Number of Prescriptions	7.94	9.91	.56

For PeachCare, responders and nonresponders are mostly alike

C1. Service Use for PeachCare and Medicaid children regardless of Response status

Service Category	PeachCare	Medicaid	P value
Total Cost	740	1255	.01
Outpatient Cost	670	965	.05
Outpatient Visits	9.34	9.86	.39
Inpatient Costs	5	212	.01
Inpatient Days	.03	.05	.17
ER Costs	55	62	.34
ER Visits	.46	.63	.01
Prescription Costs	12	16	.55
Number of Prescriptions	9.31	8.39	.10

PeachCare Children cost less even though their units of service are the same.

This is perhaps due to higher sickness in the Medicaid population, as Children with Special Health Care Need Cost More.

Question 2. What are the utilization and SHCN differences beetween PeachCare and Medicaid Children?

A2. Number, Percent, Mean & Median Cost of Children with completed CAHPS Surveys who are Identified as having a Special Health Care Need Through Different Methods

Status	Number	Percent	Mean Cost	Median Cost
No SHCN	1037	64	583 (30)	315
Administratively Identified SHCN	253	16	2445 (308)	1202
CAHPS Identified SHCN	140	9	1078 (256)	478
Administrative and CAHPS Identified SHCN	199	12	3934 (720)	1559

But as Tables B and C show, Medicaid Children Cost more regardless of there Special Need Category. Perhaps this is because Medicaid children are diagnosed with more severe illnesses?

B2. Number, Percent, Mean & Median Cost of MEDICAID Children with completed CAHPS Surveys who are Identified as having a Special Health Care Need Through Different Methods

Status	Number	Percent	Mean Cost	Median Cost
No SHCN	726	64	545	233
Administratively Identified SHCN	196	17	2746	1118
CAHPS Identified SHCN	69	6	1426	362
Administrative and CAHPS Identified SHCN	12	12	4564	1845

C2. Number, Percent, Mean & Median Cost of PEACHCARE Children with completed CAHPS Surveys who are Identified as having a Special Health Care Need Through Different Methods

Status	Number	Percent	Mean Cost	Median Cost
No SHCN	311	62	467	236
Administratively Identified SHCN	57	11	1419	692
CAHPS Identified SHCN	71	14	720	519
Administrative and CAHPS Identified SHCN	62	12	1761	1061

D2. Prevalence Rates of SCHN Conditions for PeachCare and Medicaid Children that responded to the CAHPS Survey

Disease	Percentage of PeachCare	Percentage of Medicaid
Malignant Neoplasms	.4	0
HIV	0	.09
Benign Neoplasm	.2	0
Diabetes	.4	.27
Anemia	0	.53
Mental Health	13.57	16.67
Retardation	0	.44
Cerebral Palsy	0	1.77
Epilepsy	.8	1.86
Blindness	1.8	1.6
Heart Valve Problems	0	.18
Asthma	10.18	11.52
Kidney, or Renal Difficulty	0	.09
Spinabifuda	0	.53

Congenital Abnormalities	.8	1.24
Severe Burns	.6	.62
Physical Abuse	0	.89
Perinatal Complications	.2	.44

E2. Percentage of PeachCare and Medicaid Children that responded to the CAHPS survey with Multiple Numbers of SHCN Conditions

Number of Special Need Conditions	Percentage of PeachCare	Percentage of Medicaid
0	75	69
1	21	25
2	3	5
3 or more	.4	1.51

Question 3. How do children differ in their use of services based on their ability to identify a PCP?

A3. Service Use for Medicaid Patients Who Did not and Did Identify their Assigned PCP

Service Category	Did Not ID PCP	Did ID PCP	P value
Total Cost	1263	1616	.31
Outpatient Cost	1087	1252	.56
Outpatient Visits	9.46	12.95	.01
Inpatient Costs	99	272	.11
Inpatient Days	.03	.07	.05
ER Costs	64	75	.38
ER Visits	.66	.70	.63
Prescription Costs	12	17	.01
Number of Prescriptions	8.30	11.85	.42

B3. Service Use for PeachCare Patients Who Did not and Did Identify their Assigned PCP

Service Category	Non-Respondents	Respondents	P value
Total Cost	661	808	.27
Outpatient Cost	590	737	.23
Outpatient Visits	8.05	10.66	.05
Inpatient Costs	0	7.04	.54
Inpatient Days	0	.04	.47
ER Costs	62	50	.55
ER Visits	.46	.45	.91
Prescription Costs	10	14	.24
Number of Prescriptions	7.54	10.55	.05

1. Pediatric preventive care: health assessments and anticipatory guidance. Kaiser Permanente Health Plan, Inc. Mid-Atlantic Permanente Medical Group. 1997 May 21.

Although we are just halfway through August, already the monthly total number of children who have applied for PeachCare via the Internet application is higher than it has ever been.

In order to find successful mechanisms for soliciting applications, it is important to understand what has caused this sudden jump in applications.

Since the Internet application was introduced in April 2001, 3680 complete applications have been submitted. These applications have sought coverage for 7736 children.

According to survey respondents, applicants heard about PeachCare from a friend or family member more often than any other source (30%).

Survey respondents also indicated that most people apply because they believe PeachCare is affordable and wish to have insurance for their children (76%). However, 10% of respondents indicated their primary reason for applying was because they have a sick child.

73% of respondents indicated that they would have applied that month even if the application were not available on the computer.

The majority of survey respondents filled out the application at home (63%). Most of the remainder indicated that they filled out their application in an "other" location. Since "workplace" was not given as an option, this probably comprises most of the applications filled out in an "other" location. Another possible location may be a school (either child's or parent's school).

A very small percentage of respondents needed help completing the application (4%).

Almost half of those surveyed had completed some college. The next largest group was those who had completed any amount of high school. Few were at the extremes - less than high school, or college graduates.

August applicants differ from earlier applicants in several respects. First, August applicants applied for coverage for an average of 2.61 children per application. This is higher than the overall average number of children per application (2.10 children). The higher number of children per application is in part responsible for the dramatic increase in child applications for PeachCare during August.

Many more August applicants heard about PeachCare from an "other" source than did earlier applicants (43% versus 25%). This difference is statistically significant. Perhaps the "other" source includes the child's school. Since many school systems start in August, and schools often require check-ups and shots for their students, timing suggests that schools may be a source of information about PeachCare.

August applicants also differ from earlier applicants with respect to the health status of their children. About 5% of August respondents indicated that they had a sick child, compared to over 10 % of earlier applicants. This statistically significant difference also suggests that more of the August applicants are motivated by access to routine care or well-visits, as would required before starting school.

Lastly, the average age of August child applicants is 1.42 years greater than that of earlier applicants. This difference is statistically significant. Additionally, the proportion of applicants with a school age child (age 5 and above) was statistically significantly higher in August than in earlier months (83% versus 70%). The presence of a higher proportion of school age children among applicants further suggests that the return to school is generating PeachCare Internet applications.

rmance of Internet Application - April to Mid August

	APRIL COUNT	APRIL PCT	MAY COUNT	MAY PCT	JUNE COUNT	JUNE PCT	JULY COUNT	JULY PCT	AUGUST COUNT	AUGUST PCT	TOTAL T COUNT
er of Kids Applying Via Internet	322	4%	1213	16%	1719	22%	2100	27%	2382	31%	7736
er of Internet Applications Submitted	178	5%	667	18%	970	26%	953	26%	912	25%	3680
er of Kids with Completed Surveys	187	6%	662	20%	925	27%	1111	33%	504	15%	3389
er of Applications With Completed Surveys	100	6%	372	21%	516	29%	542	31%	242	14%	1772
ge Kids Per Day	10.73		39.13		57.30		67.74		183.23		57.30
ge Applications Per Day	5.93		21.52		32.33		30.74		70.15		27.26
ge Surveys Per Day	3.33		12.00		17.20		17.48		18.62		13.13
ge Number of Kids Per Application	1.81		1.82		1.77		2.20		2.61		2.10

Percentages sum horizontally.

	APRIL	MAY	JUNE	JULY	AUGUST	TOTAL
ge Age in Years During Month of Application	7.64	7.23	6.97	7.30	8.53	7.61

pplication Survey Responses - By Month

you hear about PCK?	APRIL COUNT	APRIL PCT	MAY COUNT	MAY PCT	JUNE COUNT	JUNE PCT	JULY COUNT	JULY PCT	AUGUST COUNT	AUGUST PCT	TOTA COUN
ment	22	22%	63	17%	119	23%	119	22%	40	17%	3
seworker/Outreach worker	8	8%	35	9%	35	7%	36	7%	13	5%	1
Other Health Care Provider	20	20%	59	16%	69	13%	86	16%	29	12%	2
Family	23	23%	128	34%	160	31%	168	31%	57	24%	5
	27	27%	87	23%	133	26%	133	25%	103	43%	4

	APRIL	APRIL	MAY	MAY	JUNE	JUNE	JULY	JULY	AUGUST	AUGUST	TOTA

s the most important reason you applied?	COUNT	PCT	COUNT	PCT	COUNT	PCT	COUNT	PCT	COUNT	PCT	COUN
ffordable, and Id like my child to be insured.	82	82%	278	75%	385	75%	414	76%	191	79%	13
ommended to me.	11	11%	43	12%	69	13%	73	13%	39	16%	2
y easy to apply.	1	1%	4	1%	4	1%	7	1%	0	0%	
s sick and needs healthcare.	6	6%	47	13%	58	11%	48	9%	12	5%	1

u have applied this month if an	APRIL COUNT	APRIL PCT	MAY COUNT	MAY PCT	JUNE COUNT	JUNE PCT	JULY COUNT	JULY PCT	AUGUST COUNT	AUGUST PCT	TOTA COUN
	22	22%	101	27%	139	27%	144	27%	72	30%	4
	78	78%	271	73%	377	73%	398	73%	170	70%	12

e you filling out this application?	APRIL COUNT	APRIL PCT	MAY COUNT	MAY PCT	JUNE COUNT	JUNE PCT	JULY COUNT	JULY PCT	AUGUST COUNT	AUGUST PCT	TOTA COUN
	0	0%	1	0%	0	0%	2	0%	0	0%	
ce	1	1%	1	0%	0	0%	2	0%	1	0%	
	4	4%	6	2%	6	1%	3	1%	2	1%	
	69	69%	229	62%	326	63%	343	63%	152	63%	11
	1	1%	3	1%	4	1%	2	0%	1	0%	
	2	2%	13	3%	17	3%	20	4%	13	5%	
	22	22%	118	32%	158	31%	167	31%	71	29%	5
utreach Worker	1	1%	1	0%	5	1%	3	1%	2	1%	

eed help filling out the application?	APRIL COUNT	APRIL PCT	MAY COUNT	MAY PCT	JUNE COUNT	JUNE PCT	JULY COUNT	JULY PCT	AUGUST COUNT	AUGUST PCT	TOTA COUN
	95	95%	351	94%	494	96%	526	97%	238	98%	17
	5	5%	21	6%	22	4%	16	3%	4	2%	

e highest level of school you completed?	APRIL COUNT	APRIL PCT	MAY COUNT	MAY PCT	JUNE COUNT	JUNE PCT	JULY COUNT	JULY PCT	AUGUST COUNT	AUGUST PCT	TOTA COUN
nt of High School	30	30%	130	35%	178	35%	164	30%	72	30%	5
l College	7	7%	51	14%	74	14%	83	15%	37	15%	2
High School	5	5%	11	3%	17	3%	24	4%	16	7%	
lege	58	58%	180	48%	247	48%	271	50%	117	48%	8

SAS output of statistical significance tests.

Is the average age of August applicant kids different from the age of earlier applicants?
Variable: AGEYRS

AUGUST	N	Mean	Std Dev	Std Error	Variances	T	DF	Prob>|T|
0	5352	7.20032711	5.42020790	0.07408971	Unequal	-10.1309	4685.1	0.0001
1	2382	8.52767445	5.27392397	0.10805951	Equal	-10.0250	7732.0	0.0000

For H0: Variances are equal, F' = 1.06 DF = (5351,2381) Prob>F' = 0.1186

Is the proportion of applicants with school age kids (5 and over) higher in August?
Variable: OVER4

AUGUST	N	Mean	Std Dev	Std Error	Variances	T	DF	Prob>|T|
0	2768	0.70014451	0.45827726	0.00871054	Unequal	-8.8142	1889.3	0.0001
1	912	0.83333333	0.37288248	0.01234737	Equal	-7.9520	3678.0	0.0000

For H0: Variances are equal, F' = 1.51 DF = (2767,911) Prob>F' = 0.0000

Is the proportion of surveyed applicants who heard of PCK from an "other" source higher in

August?
Variable: OTHER

AUGUST	N	Mean	Std Dev	Std Error	Variances	T	DF	Prob>|T|
0	1530	0.24836601	0.43220647	0.01104957	Unequal	-5.2579	301.8	0.0001
1	242	0.42561983	0.49546138	0.03184946	Equal	-5.8054	1770.0	0.0000

For H0: Variances are equal, F' = 1.31 DF = (241,1529) Prob>F' = 0.0037

Is the proportion of surveyed applicants with a sick kid lower in August?
Variable: SICK

AUGUST	N	Mean	Std Dev	Std Error	Variances	T	DF	Prob>|T|
0	1530	0.10392157	0.30525855	0.00780409	Unequal	3.3929	408.3	0.0008
1	242	0.04958678	0.21753961	0.01398398	Equal	2.6637	1770.0	0.0078

For H0: Variances are equal, F' = 1.97 DF = (1529,241) Prob>F' = 0.0000

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002(10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage

B. Employer sponsored insurance buy-in

C. 1115 waiver

D. Eligibility including presumptive and continuous eligibility

E. Outreach

F. Enrollment/redetermination process

G. Contracting

H. Other -- PeachCare for Kids has submitted a State Plan Amendment that would allow children who had voluntarily cancelled private insurance with premiums in excess of 5% of the household income to be exempt from the three month waiting period to become eligible for enrollment in PeachCare for Kids, should all other eligibility criteria be met.

---

[1] In order to be eligible, family income must be less than or equal to 235% of the federal poverty level, which is $35,000 for a family of 3 and $42,000 for a family of 4.

[2] Special health care need is said to be met if one or more of the following diagnoses is present: HIV, malignant and benign neoplasms, diabetes, anemia, mental illness, mental retardation, cerebral palsy,epilepsy, blindness and hearing loss, diseases of mitral and aortic valves, asthma, kidney disorders, rheumatoid arthritis, spina bifida, congenital anomalies, fractures and burns, abuse, perinatal complications, and muscular dystrophy. This criterion was devised by Florida's Institute for Child Health Policy, in collaborations with Pediatric Department of the University of Florida's College of Medicine.

[3] SAS Proc Lifereg (version 8) with Weibull distribution assumption was used.

[4] There seems to be an inconsistency between the positive coefficients of the six year plus variable and the negative coefficients of the average premium cost variable. However, given that enrollment decision is made at the family level, and the process requires only one form to enroll all children in the family, the result need not be contradictory.

[5] One cannot rule out the possibility that such change in policy may deter some from joining the program because such policy may create the perception that SCHIP is a n welfare program. Answering this question would require a multistate comparative evaluation with states that used the zero premium plus copay approach.