

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF DIRECTOR

**ACTION REFERRAL**

TO <i>Wells</i>	DATE <i>1-23-07</i>
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<b>DIRECTOR'S USE ONLY</b>	<b>ACTION REQUESTED</b>
1. LOG NUMBER <i>600476</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>Checked 1/24/07, Doc 809 #486</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>2-1-07</i>
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

From: "Andrea Maresca" <AMaresca@aphsa.org>  
Date: 1/22/2007 12:12:40 PM  
Subject: NASMD SCHIP Shortfall Survey

Dear Medicaid and SCHIP Directors:

In response to requests for information from some states, NASMD has developed a brief eight question online survey to track recent updates on projected SCHIP shortfalls. We will disseminate the aggregate information and use the aggregate data to inform our efforts to educate Members of Congress and their staff. We encourage you complete the online survey by Friday, February 9, 2007. To access the survey, follow this link: <http://www.surveymonkey.com/s.asp?u=88923155566>

If you have any questions about the survey or related to federal SCHIP issues please contact Andrea Maresca at 202-682-0100 x292 or [amaresca@aphsa.org](mailto:amaresca@aphsa.org)

Andrea Maresca, MPH

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*Do you Wells  
"Agree - Sign"*

*\* Please have lobby  
review before  
submitting*

*Thanks!  
lm  
1/22*

**RECEIVED**

JAN 22 2007

Department of Health & Human Services  
OFFICE OF THE DIRECTOR

## SCHIP Shortfall Survey

[Exit this survey >>](#)

### 1. SCHIP Shortfall Survey

NASMD is tracking states with SCHIP shortfalls. We will disseminate this information and use the aggregate data to inform our efforts to educate Members of Congress and their staff. Please take a moment to complete the following questions. We ask that you complete the survey by Friday, February 9, 2007.

**\* 1. Please provide the following information:**

Name  
Title  
State  
Phone  
Email  
Type of CHIP program (standalone, Medicaid expansion, combination)

**\* 2. Based on the most recent data available, does your state anticipate a funding shortfall for the remainder of FY2007?**

**3. If yes, please indicate approximately when you expect the shortfall to occur and the estimated shortfall amount.**

Anticipated date  
Estimated shortfall amount

**4. Please indicate whether your most recent anticipated shortfall date and amount differs from CMS estimates.**

**5. How is your state planning to address the shortfall?**

- State legislature is likely to appropriate additional funding for SCHIP.  
 The state is likely to shift some SCHIP enrollees into the Medicaid program  
 The state is likely to make cuts to eligibility and/or services.

Other (please specify)

**6. Please elaborate on your response(s) above. (i.e. will the legislature act to avert the entire expected shortfall? What cuts to eligibility and services or changes in cost sharing rules are likely to be implemented? Etc.)**

**7. Is your state working with your Congressional delegation to address the SCHIP shortfall issue? Please elaborate if so.**

**8. Has your state received guidance from CMS regarding how to address your projected shortfall? If yes, please elaborate.**

**Next >>**