

**THIS DOCUMENT WAS SENT TO GOVERNORS' REPRESENTATIVES, STATE  
MEDICAID DIRECTORS AND OTHER INTERESTED PARTIES ON SEPTEMBER  
15, 1997**

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Attached for your review and comment, as well as assistance, is a draft of the model application template, (zipped WP 6.1 format, 35,982 bytes) and instructions, (zipped WP 6.1 format, 46,439 bytes) that are being developed to assist states in submitting a child health plan under Title XXI of the Social Security Act.

This draft model application template outlines the types of information that are likely to be included in the state child health plan required under Title XXI. It has been designed to reflect many of the requirements that will be necessary for state plans under Title XXI. It is not intended to be comprehensive or final. We provide it for preliminary guidance as well as to solicit additional information from states and other interested parties on the appropriate content.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like benefits definitions, maintenance of effort provisions, collection of baseline data, and methods for preventing substitution of new Federal funds for existing state and private funds. As such guidance becomes available, the model application template will be revised and finalized. We will work to distribute it in a timely fashion to provide assistance as states submit their state plans.

Assistance from the states, advocates and other interested parties, in the form of comments and input on the attached documents, is greatly appreciated and all suggestions will be taken into consideration.

Please note that under the law, a state must have an approved state plan for a fiscal year in order to receive an allotment that year. In order for the Department to determine allotments for FY 98, state plan applications should be submitted as soon as possible. The length of time from submission to approval will vary depending upon the quality of the plan and the extent to which requirements under the law are met. We cannot guarantee that we will be able to approve plans submitted after July 1 before the close of the fiscal year. Therefore, the sooner a state submits its plan, the more quickly Health Care Financing Administration (HCFA) will be able to approve it, and the sooner states will have access to their allotments. For States with approved plans, the allotment under Title XXI is available for up to three years.

Comments on the template may be submitted to the HCFA at the following address:

Center for Medicaid and State Operations  
Health Care Financing Administration  
7500 Security Blvd  
Baltimore, Maryland 21244  
Attn: Family & Children's Health Programs Group  
Mail Stop - C4-14-16

We hope that you find this information helpful in the development of the State Children's Health Insurance Program. If you need further assistance or have questions regarding this information, please contact your HCFA regional office or Rick Fenton in HCFA's Family and Children's Health Programs Group at 410- 786-5920.

*Note:* This page includes links to specialized data and multimedia files. Viewing these files requires the use of a third-party plug-in or viewer. For more information or to test whether your computer can read these files, visit our [File Formats and Plug-Ins](#) page.

**INSTRUCTIONS FOR COMPLETING  
The Draft Model Application Template for  
State Child Health Plan Under Title XXI of the Social Security Act  
State Children's Health Insurance Program**

**Preamble.** This draft model application template outlines the types of information that are likely to be included in the state child health plan required under Title XXI. It has been designed to reflect many of the requirements that will be necessary for state plans under Title XXI. It is not intended to be comprehensive or final. We provide it for preliminary guidance as well as to solicit additional information from states and other interested parties on the appropriate content.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like benefits definitions, maintenance of effort provisions, collection of baseline data, and methods for preventing substitution of new Federal funds for existing state and private funds. As such guidance becomes available, the model application template will be revised and finalized. We will work to distribute it in a timely fashion to provide assistance as states submit their state plans.

**Disclosure.** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

**Introduction.** The purpose of the new State Children's Health Insurance Program (Title XXI) is to provide Federal matching funds to states to enable them to initiate and expand coverage to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. States are able to use Title XXI funds for: (1) obtaining health benefit coverage, (2) expanding Medicaid coverage, or (3) a combination of both.

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**Requirement to Submit a State Plan.** In order to be eligible for payment under this new legislation, each state must submit a Title XXI plan for approval by the Secretary that details how the state intends to use the funds and fulfill other requirements under the law. Under the law, a state plan is considered approved in 90 days unless the Secretary notifies the state in writing that the plan is disapproved or that specified additional information is needed. If a state wishes to use Medicaid to expand coverage through Title XXI, it must submit a Medicaid plan amendment for an eligibility expansion in addition to submitting a state plan for Title XXI. The Title XXI plan should encompass all of the child health assistance being provided using Title XXI funding. The Department will be working with states to facilitate and expedite the application and approval process.

Any items that require a description may be addressed in the form of an attachment or in the space provided. It is expected that any attachments will be brief and limited to one page, unless more space is needed for an accurate description.

The application template includes the following sections:

1. General Description and Purpose of the State Child Health Plans
2. General Background and Description of State Approach to Child Health Coverage
3. General Contents of State Child Health Plan
4. Eligibility Standards and Methodology
5. Outreach and Coordination
6. Coverage Requirements for Children's Health Insurance
7. Quality and Appropriateness of Care
8. Cost Sharing and Payment
9. Strategic Objectives and Performance Goals for the Plan Administration
10. Annual Reports and Evaluations
11. Glossary

**Statement of Purpose.** This model application template and instructions may be employed by states for the purpose of submitting a state plan. The instructions have been designed to complement the model application template and to facilitate completion of the template. States should use the instructions in conjunction with the template for guidance regarding what issues should be addressed in the narrative sections of the state plan.

With regard to Sections 9 and 10 on performance goals and annual reporting requirements, we plan on developing national standards for performance measures, in conjunction with the states, advocacy groups, Congress, evaluators, and other interested parties, subsequent to the implementation of this legislation. We believe that, by developing national standards with the states, with advocates and with others, we will insure the ability to review and evaluate the impact of the program in a way that will be most useful to the public, while limiting the reporting burdens on the states, and ensuring accountability and effectiveness of State programs.

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**Program Options.** As mentioned above, the law allows states to expand coverage for children through a separate child health insurance program, through the Medicaid program, or through a combination of these programs. States have the following options under Title XXI:

**Option to Expand Medicaid.** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under state rules in effect as of April 15, 1997. Under this option, current Medicaid rules would apply.

**Option to Create or Expand a Separate Program.** States electing to use their available Title XXI funds to establish or expand a separate child health insurance program will be subject to new cost-sharing and benefit rules in the law. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid. The law requires that any state that lowers its Medicaid eligibility standards for children below the June 1, 1997 levels be denied access to the new child health funds.

**Combination of Options.** The new law allows states to elect to use a combination of the Medicaid program and a separate child health insurance program to increase health coverage for children. For example, a state may cover children in families with incomes of up to 133% of poverty through Medicaid and a targeted group of children above that level through a separate program. For the children the state chooses to cover under Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the state chooses to cover under a separate program, the provisions outlined above in “Option to Create or Expand a Separate Program” would apply.

In order to expedite the application process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete **Sections 1 (General Description), 2 (General Background), 5 (Outreach and Coordination), 9 (Strategic Objectives and Performance Goals for the Plan Administration), and 10 (Annual Reports and Evaluations)**. States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX state plans. These states may complete the first check-off for Sections 3 (General Contents of State Health Plan), 4 (Eligibility Standards and Methodology), 6 (Coverage Requirements for Children's Health Insurance), 7 (Quality and Appropriateness of Care), and 8 (Cost Sharing and Payment) indicating that the description of the requirements for these sections are incorporated by reference through their state Medicaid plans. States wishing to use a combination of approaches will be required to complete the Title XXI state plan and the necessary state plan amendment under Title XIX. Completed state plans for Title XXI should be submitted to the Health Care Financing

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Administration at the following address:

Administrator  
Health Care Financing Administration  
7500 Security Blvd  
Baltimore, Maryland 21244

Attn: Family & Children's Health Programs Group  
Center for Medicaid and State Operations  
Mail Stop - C4-14-16

The state should submit an original package and 10 copies. In addition, state plan amendments for Medicaid expansions should also be sent to this address. Plans may be submitted on computer disk, formatted using WordPerfect 6.1. An electronic version of the model application template can be obtained by contacting HCFA . The template and instructions are viewable on the HCFA website ([Http://www.hcfa.gov](http://www.hcfa.gov)). Questions regarding this process may be submitted to the Family & Children's Health Programs Group or the state may contact its servicing Health Care Financing Administration regional office. The contacts and addresses for the regional offices are as follows:

<u>HCFA Regional Office Administrators</u>			
<u>Regional Office</u>	<u>Administrator</u>	<u>Address</u>	<u>Phone</u>
Atlanta	Rose Crum Johnson Regional Administrator	HCFA - Atlanta RO 101 Marietta Tower Rm. 701 Atlanta, Georgia 30323	404/331-2329
Boston	Sidney Kaplan Regional Administrator	HCFA - Boston RO JFK Federal Building Room 2325 Boston, MA 02203	617/565-1188
Chicago	Dorothy Burke Collins Regional Administrator	HCFA - Chicago RO 105 W. Adams Street 15th & 16th Floors Chicago, IL 60603	312/886-6432
Dallas	Ed Lessard Acting Regional Admin.	HCFA - Dallas RO 1200 Main Street, Ste. 2000 Dallas, TX 75202-4348	214/767-6427

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Denver	Mary Kay Smith Regional Administrator	HCFA - Denver RO Federal Office Bldg. 1961 Stout Street, Room 522 Denver, CO 80294-3538	303/844-2111
Kansas City	Joe Tilghman Regional Administrator	HCFA - Kansas City RO Richard Bolling Federal Bldg. 601 East 12th Street, Room 235 Kansas City, MO 64106-2808	816/426-5233
New York	Alberta Leone Acting Regional Admin.	HCFA - New York RO 26 Federal Plaza, Room 3811 New York, NY 10278	212/264-4488
Philadelphia	Maurice Hartman Regional Admin.	HCFA - Philadelphia RO 3535 Market Street, Rm. 3100 Philadelphia, PA 19104	215/596-1351
San Francisco	Beth Abbott Regional Administrator	HCFA - San Francisco RO 75 Hawthorne Street, 4th Floor San Francisco, CA 94105-3903	415/744-3507
Seattle	Nancy Dapper Regional Administrator	HCFA - Seattle RO 2201 Sixth Ave. Mail Stop RX 40 Seattle, WA 98121-2500	206/615-2306

**SECTION SPECIFIC INSTRUCTIONS (For attached model application template)**

**Section 1. General Description and Purpose of the State Child Health Plans**

**Introduction**

An approved state child health plan is required in order for a state to be eligible for payment under Title XXI. This plan must set forth how the state intends to use the funds provided under Title XXI by indicating that child health assistance shall be provided primarily through one of the three options listed in Section 2101(a) of the Social Security Act (the Act).

**Guidance**

**Section 1.1.** Check here if child health assistance shall be provided primarily through the development of an independent insurance program that meets the requirements of Section 2103, which details coverage requirements and the other applicable requirements of Title XXI.

**Section 1.2.** Check here if child health assistance shall be provided primarily through providing expanded eligibility under the state's Medicaid program (Title XIX).

**Section 1.3.** Check here if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the state's Medicaid program).



**Section 2. General Background and Description of State Approach to Child Health Coverage**

**Introduction**

This section is designed to solicit general information related to the special characteristics of each state. The information being sought concerns the extent and manner to which children in the state currently have creditable health coverage, current health state efforts to provide or obtain creditable health coverage for uncovered children and how the plan is designed to be coordinated with current health insurance or public health efforts. This information will provide a health insurance baseline in terms of the status of the children in a given state and the state programs currently in place.

**Guidance**

**Section 2.1.** The demographic information requested in 2.1. in the form of an attachment can be used for state planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT. The numbers used to determine the allotment of funds under Title XXI will be those provided each year by the U.S. Bureau of the Census.

Factors that the state may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. To the extent practicable, the state should make a distinction between creditable coverage under public health insurance programs (e.g., Medicaid and state-only child health insurance) and public-private partnerships, and describe its information sources and the assumptions it uses for the development of its description. (A suggested format for describing this information can be found in Section 10 of the template).

**Section 2.2.** A state child health plan must include an overview of current efforts made by the state through child related programs (e.g., Medicaid, the Maternal and Child Health Block Grant, Title V, WIC, community and migrant health centers, or special state programs for child health care) to provide health care services or obtain creditable health coverage for uncovered children by identifying and enrolling all uncovered children.

- 2.2.1. Briefly describe the steps being taken by the state to identify and enroll all uncovered children who are eligible to participate in **public** health insurance programs (e.g., Medicaid and state-only child health insurance). This information may include a description of the state's outreach efforts through Medicaid and state-only programs.

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- 2.2.2. Briefly describe the steps being taken by the state to identify and enroll all uncovered children eligible to participate in health insurance programs that involve a *public-private* partnership. The state may also address the coordination between the public-private outreach and the public health programs that is occurring statewide.

**Section 2.3.** This item requires a brief overview of how new Title XXI efforts -- particularly new enrollment outreach efforts -- will be coordinated with and improve upon existing state efforts described in Section 2.2.

To help understand the strategy of the state plan to accomplish the intent of Title XXI, states need to describe the efforts they are making to coordinate the Title XXI plan with the Medicaid program. **Under Title XXI children identified as Medicaid-eligible are required to be enrolled in Medicaid.** Therefore, the state should describe how its Title XXI program will closely coordinate the enrollment with Medicaid.

### Section 3. General Contents of State Child Health Plan

#### Introduction

The state child health assistance plan must describe the type of child health assistance to be provided under the plan (2102(a)(4)). This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers.

**\*\*Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan may check the appropriate box and proceed to Section 4.**

#### Guidance

**Section 3.1.** In describing the methods of delivery of the child health assistance using Title XXI funds, the state should address the choice of financing the insurance products and the methods for assuring delivery of the insurance product(s) to children. These may include, but are not necessarily limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The state should describe any variations based upon geography, as well as the state methods for establishing and defining the delivery systems.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(a)(2)). Describe which, if any, of these methods will be used.

Examples of the above may include: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding.

If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services.

**Section 3.2.** In describing the utilization controls under the child health assistance using Title XXI, note that utilization control systems are those administrative mechanisms that are designed to ensure that children use only that health care that is appropriate, medically necessary, and/or approved by the state or its subcontractor.

Examples of utilization control systems include, but may not be limited to, the following: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the state should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and state developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner.

## Section 4. Eligibility Standards and Methodology

### Introduction

The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Included on the template is a list of potential eligibility standards. Please check off the standards that will be used by the state and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, describe how they will be applied and under what circumstances they will be applied.

**\*\*Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan may check the appropriate box and proceed to Section 5.**

### Guidance

**Section 4.1.** Check all standards that will apply to the state's plan.

- 4.1.1. If eligibility criteria will vary based on geography within the state, check and explain.
- 4.1.2. Identify and explain the state's age standards.
- 4.1.3. Identify the state's income standards, including the definition of household and family income, deductions, disregards, and methods for evaluating family income.
- 4.1.4. Identify the state's resource standards and describe spend down and disposition of resources, if applicable.
- 4.1.5. Identify the state's residency requirements.
- 4.1.6. Identify how disability status affects eligibility.
- 4.1.7. Identify how access to or coverage under other health coverage affects eligibility.
- 4.1.8. Specify the duration of eligibility.
- 4.1.9. Identify and describe other standards for or affecting eligibility.

**Section 4.2.** Assurances. The state must assure that its eligibility standards do not discriminate on the basis of diagnosis; within a defined group of covered targeted low-income children, the standards do not cover children of higher income families without covering children with a lower family income; and the standards do not deny eligibility based on a child having a pre-existing medical condition. Check the appropriate boxes to make the necessary assurances. The state should review its policies and maintain state records necessary to explain how it may make these assurances.

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**Section 4.3.** Methodology. Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, whether the state uses the same application form for Medicaid and/or other public benefit programs.

**Section 4.4.** This section addresses eligibility screening and coordination with other health coverage programs. States must describe how they will assure:

- 4.4.1. only targeted low-income children are furnished child health assistance under the plan;
- 4.4.2. children found through the screening to be eligible for medical assistance under the state Medicaid plan are enrolled for assistance under such plan;
- 4.4.3. the insurance provided under the state child health plan does not substitute for coverage under group health plans;
- 4.4.4. the provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)); and
- 4.4.5. coordination with other public and private programs providing creditable coverage for low-income children.

Describe the state's eligibility screening process in a way that addresses the five assurances specified above. The state should consider including in this description important definitions, the relationship with affected Federal, state and local agencies, and other applicable criteria that will describe the state's ability to make assurances.

## Section 5. Outreach and Coordination

### Introduction

This section is designed for the state to fully explain its outreach and coordination activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in such a program.

### Guidance

**Section 5.1.** Describe how the outreach program will be used to target children in the state who would be eligible and enable those children to enroll, utilize and stay in the health care system including those served through other child-related programs (e.g., MCH Block Grant, WIC, and community and migrant health centers).

Outreach and enabling services may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other Federal, state or local health assistance program.

This section may also include discussions of the following:

- How the outreach program will take advantage of the outreach strategies and experience of traditional safety net providers.
- Coordination of the outreach program with other public and private health services, other social services, day care programs, and school-based or school-linked services.
- Special outreach efforts that will target families of migrants, homeless children, other children with special health care needs, or those in rural or frontier areas.
- Further outreach efforts the state will require of health plans or providers who receive Title XXI funds.

**Section 5.2.** Describe how children who are determined to be eligible for Medicaid or another state-only children's health insurance program will be referred to and enrolled into that program.

Describe how Medicaid eligibility workers will refer non-Medicaid eligible children to the new Children's Health Insurance Program.

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Finally, describe how the outreach efforts described above will be coordinated with current outreach efforts for the Medicaid or other state-only children's health insurance program, and how outreach and enrollment efforts for the Children's Health Insurance Program will be coordinated with the state's current efforts to provide outstationed eligibility services at Federally Qualified Health Centers and Disproportionate Share Hospitals (as required by Section 1902(a)(55) of the Social Security Act).



## Section 6. Coverage Requirements for Children's Health Insurance

### Introduction

Regarding the required scope of health insurance coverage in a state plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage).

Identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions.

**\*\*Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan may check the appropriate box and proceed to Section 7.**

### Guidance

**Section 6.1.** Check all that apply in terms of the coverage to be offered to eligible children.

- 6.1.1. **Benchmark coverage** is equivalent to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, state employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If this box is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked and an attached description provided.
  - 6.1.1.1. Check here if the benchmark benefit package to be offered by the state is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. If checked, attach a copy of the plan.
  - 6.1.1.2. Check here if the benchmark benefit package to be offered by the state is state employee coverage, meaning a coverage plan that is offered and generally available to state employees in the state. Identify the specific state plan and attach a copy of the benefits description.
  - 6.1.1.3. Check here if the benchmark benefit package to be offered by the state is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. Identify the specific HMO coverage plan and attach a copy of the benefits

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description.

- 6.1.2. **Benchmark-equivalent coverage** must meet the following requirements: the coverage includes benefits for items and services within each of the categories of basic services described in Section 2103(c)(1): inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age-appropriate immunizations; the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, state employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 2103(c)(2): coverage of prescription drugs, mental health services, vision services and hearing services.

If this box is checked, a signed actuarial memorandum must be attached. Sufficient information should be provided so that any actuary could review and replicate the results of the state's actuary.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the Actuarial Standards Board for such reports. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the state child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a state to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the state child health plan that results from the limitations on cost sharing under such coverage.

- 6.1.3. **Existing comprehensive state-based coverage** is only applicable to New York, Florida and Pennsylvania. If this box is checked, an attached description of the benefits package, administration and date of enactment must be attached.

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A state approved under this provision, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If “existing comprehensive state-based coverage” is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached.

Also, the fiscal year 1996 state expenditures for “existing comprehensive state-based coverage” must be described in the space provided for all states.

- 6.1.4. **Secretary-approved coverage** refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state.

**Section 6.2.** The term “child health assistance” means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the services and products listed in this section of the template (Section 2110(a)). All forms of coverage that the state elects to provide to children in its plan must be checked. The state should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations.

- 6.2.1. - 6.2.28. Check each box the state elects to provide coverage for in its child health assistance plan.

The following are clarifications of certain types of services:

- 6.2.14. Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.
- 6.2.15. Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.
- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by state law and only if the service is:  
1) prescribed by or furnished by a physician or other

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licensed or registered practitioner within the scope of practice as prescribed by state law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a state or local government or is licensed under state law and operating within the scope of the license.

- 6.2.27. Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

**Section 6.3.** There are two types of waivers that states may request that address additional purchase options in Title XXI: waivers authorized for cost effective alternatives and waivers for the purchase of family coverage.

Review and approval of the waiver application(s) will be separate and distinct from the state plan approval process.

- 6.3.1. Check here if the state is requesting a **waiver for a cost-effective alternative**. Such a waiver allows the state to waive the 10% limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(d)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the state must demonstrate that payments in excess of the 10% limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the state to administer the plan.

- 6.3.1.1. If a waiver for cost-effective alternatives is sought, coverage provided to targeted low-income children through

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such expenditures meet the coverage requirements as stated above and describe the coverage provided by the alternative delivery system in an attachment.

- 6.3.1.2. If a waiver for cost-effective alternatives is sought, the cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described in 6.4.1., and describe the cost of such coverage on an average per child basis in an attachment.
- 6.3.1.3. If a waiver for cost-effective alternatives is sought, describe the community based delivery system in an attachment.
- 6.3.2. Check here if the state is requesting a **waiver to purchase family coverage under a group health plan**. Any state desiring such a waiver will need to attach information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child.
  - 6.3.2.1. Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children in an attachment.
  - 6.3.2.2. Describe how the family coverage would not otherwise substitute for health insurance that would be provided to such children but for the purchase of family coverage.

## Section 7. Quality and Appropriateness of Care

### **Introduction**

State child health plans must include a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for states' use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. Listed below are some of the methods which states may consider using. In addition to methods, there are a variety of tools available for state adaptation and use with this program. A list of some of these tools is provided below. States also have the option to choose who will conduct these activities. As an alternative to using staff of the state agency administering the program, states have the option to contract out with other organizations for this quality of care function.

### **Methods for Evaluating and Monitoring Quality**

Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the state or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the state or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies could include the establishment of quality improvement goals for the plan or the state and provider education. Other strategies includes specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

**Tools for Evaluating and Monitoring Quality**

Tools and types of information available include QARI (Medicaid's Quality Assurance Review Initiative), QISMC (The Quality Improvement System for Managed Care) which is under development by HCFA and will replace QARI, HEDIS (Health Employer Data Information Set) measures, FACCT (Foundation for Accountability) measures, CAHPS (Consumer Assessments of Health Plans Study), vital statistics data, and state health registries (e.g., immunization registries).

Quality monitoring may be done internally by appropriate staff of the state agency administering the child health insurance program or may be contracted out to a variety of entities including state Health Departments, external quality review organizations, PROs (Professional Review Organizations), and others with appropriate skills and expertise. Establishing grievance measures is also an important aspect of monitoring.

States are also expected to comply with any national quality measures developed in the future as discussed on page 2. Any standards that are adopted will be developed in conjunction with the states, advocacy groups, and other interested parties.

**\*\*Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan may check the appropriate box and proceed to Section 8.**

**Guidance**

**Section 7.1.** Provide a brief description of methods to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care and immunizations provided under the plan. The state must also specify the qualifications of entities that will provide coverage and the conditions of participation.

- 7.1.1.-7.1.4. Check each of the tools listed that the state plans to utilize to assure quality.

**Section 7.2.** Provide a brief description of methods to be used to assure access to covered services, including emergency services. The state should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care.

## Section 8. Cost-Sharing and Payment

### Introduction

This section addresses the requirement of a state child health plan to include a description of its proposed cost sharing for enrollees. Cost-sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost-sharing imposed. The cost-sharing requirements provide protection for lower income children in the state's cost-sharing plan, ban cost-sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions.

**\*\*Note: States electing to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan may check the appropriate box and proceed to Section 9.**

### Guidance

**Section 8.1.** Indicate if the state's Title XXI plan will implement any sort of cost-sharing.

- 8.1.1. Check here if the state's Title XXI plan will implement any sort of cost-sharing in the form of premiums, deductibles, coinsurance or other cost-sharing.
- 8.1.2. Check here if the state's Title XXI plan will *not* implement any sort of cost-sharing. If there is no cost-sharing, proceed to question 8.5.

**Section 8.2.** This section asks for a description of the cost-sharing under the state plan. It is important to note that, for families below 150% of poverty, the same limitations on cost-sharing that are under the Medicaid program apply (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50-.59). For families with incomes of 150% of poverty and above, cost-sharing for all children in the family cannot exceed 5% of a family's income per year.

**Section 8.3.** Provide a brief description of how beneficiaries and the public will be able to obtain information on cost-sharing requirements.

**Section 8.4.** To ensure that protection will be provided for lower income children and that preventive services will not be subject to cost-sharing, the state must assure that the following are descriptive of its plan. The state should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

- 8.4.1. Under Title XXI, cost-sharing cannot favor children with higher incomes



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over those with lower incomes. Please indicate if the state's plan follows this requirement.

- 8.4.2. Under Title XXI, state plans are not allowed to have cost-sharing on well-baby and well-child care, including age appropriate immunizations. Please indicate if the plan follows this requirement.
- 8.4.3. The state must comply with cost-sharing limitations as described in 1916(b)(1).
- 8.4.4. Funds provided by the Federal government are not eligible for use as the state match. In addition, services assisted by or subsidized to any great extent by the Federal Government may not be used for state match either. Please confirm that non-Federal funds will only be used for the state match.
- 8.4.5. Premiums and cost-sharing from beneficiaries are not eligible for use as part of the state match. Please confirm that no cost-sharing funds will be used toward the state match. Please note that if a state collects cost-sharing funds, this revenue will be offset by reducing the amount of expenditures eligible for state match by the amount of the cost-sharing revenue.
- 8.4.6. To prevent duplicative payments, no payment will be made to a state if a private insurer (as defined by the Secretary by regulation and including a group health plan -- as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974 -- a service benefit plan, and an HMO) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided health assistance under the plan. Please confirm that this requirement is incorporated into the state plan.

The following assurance must be made regarding the maintenance of effort requirements:

- 8.4.7. Under the child health program, a state may not implement income and resource standards and methodologies for determining Medicaid eligibility that are more restrictive than those in use as of June 1, 1997. Please indicate if the state's Medicaid eligibility standards have changed since June 1, 1997.

The following assurances must be made regarding limitation of services for abortion under child health:

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- 8.4.8. Appropriated funds may not be used to pay for health coverage that includes abortion or to assist in the direct purchase of abortion services except if necessary to save the life of the mother or if the pregnancy is the result of rape or incest. Please confirm that the state's plan follows this requirement.
- 8.4.9. Payments shall not be made to a state under this section for any amount expended under the state plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion (except as described in 8.5.5.). (Note that nothing in Title XXI should be construed as affecting the expenditure for any abortion or for health benefits coverage that includes coverage of abortion by a state, locality, or private person or entity of state, local or private funds.) Please confirm that the state's plan follows this requirement.

The state should be able to demonstrate upon request its rationale and supporting justification regarding the assurances addressed above.

**Section 8.5.** Cost-sharing on children from families with incomes equal to or greater than 150% of poverty cannot exceed 5% of family income a year. Please provide a description of the methods that will be used to ensure that families in this income range will not be charged more than allowed.

**Section 8.6.** Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the state provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.3.2. of the template), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the state is contracting with a group health plan or provides benefits through group health coverage, please describe briefly any limitations on pre-existing conditions.

## **Section 9. Strategic Objectives and Performance Goals for the Plan Administration**

### **Introduction**

The section addresses the strategic objectives, the performance goals, and the performance measures the state has established for providing child health assistance to targeted low-income children under the plan for maximizing health benefits coverage for other low-income children and children generally in the state.

States are also expected to comply with any national performance measures developed in the future as discussed on page 2. Any standards that are adopted will be developed in conjunction with the states, advocacy groups, and other interested parties.

### **Guidance**

- Section 9.1.** Identify and list the specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children. It is suggested the state identify a minimum of 5, but no more than 10 strategic objectives.
- Section 9.2.** Specify at least one performance goal and performance measure for each strategic objective. We plan on developing, in conjunction with the states, advocacy groups, and other interested parties, national standards for performance measures. We will be working with states to develop the most useful measures. In the interim, we are proposing examples that may be useful for states in designing their performance measures. In the hope of consistent reporting among states, and for the aggregation of national results, we suggest that each performance goal and performance measure be described as reflected in Section 9.3.
- Section 9.3.** Briefly describe how the plan's performance will be measured objectively and independently. Check all appropriate measures the state will be utilizing.

**It is acceptable for the state to include performance measures for population subgroups chosen by the state for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.**

**HEDIS (Health Employer Data and Information Set) 3.0 measures directly relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 3.0 manual published by the National Committee on Quality Assurance. So that state HEDIS results are**

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consistent and comparable with national and regional data, states should check the HEDIS 3.0 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care. HEDIS 3.0 is a set of standardized performance measures designed for managed care plans, including plans that enroll Medicaid beneficiaries. HEDIS is intended to focus on areas of health important to individual consumers and patients, providers, and purchasers, and is being used by over 300 managed care plans to report performance experience for the reporting year 1996. Results by plan and summary results (national and regional) will be available in early fall 1997.

The following is an example of how the State could provide an objective measure.

**HEDIS 3.0 Reporting Set Measures Relevant to Children and Adolescents**

<b>HEDIS Domain /Measure</b>	<b>Rough definition of Measure</b>
<i>Effectiveness of Care</i>	
<b>Childhood immunization status</b>	<b>% of children in plan who have received appropriate immunizations by their 2nd birthday</b>
<b>Adolescent immunization status</b>	<b>% of 13-year-olds in plan who received all appropriate immunizations by their 13th birthday</b>
<b>Treating children's ear infections</b>	<b>How often a non-preferred antibiotic was given to children with uncomplicated acute otitis media</b>
<i>Access/Availability of Care</i>	
<b>Children's access to primary care providers</b>	<b>% of Medicaid enrolled children age 12 months through 24 months and age 25 months through 6 years who had a visit with a health plan primary care provider during the reporting year, and the % of Medicaid enrolled children age 7 through 11 years who had a visit with a health plan primary care provider during the reporting year or the year preceding the reporting year.</b>
<i>Satisfaction with the Experience of Care</i>	
<b>CAHPS -child health module</b>	
<i>Use of Services</i>	
<b>Well-child visits in the first 15 months of life</b>	<b>% of members who turned 15 months old during the reporting year and who received either zero, one, two, three, four, five, or six or more well-child visits with a primary care provider during their first 15 months of life.</b>
<b>Well-child visits in the Third, Fourth, Fifth and Sixth Year</b>	<b>% of enrolled members who were 3, 4, 5, or 6 years old during the reporting year and who received one or more well-child visit(s) with</b>

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<b>of Life</b>	<b>a primary care provider during the reporting year.</b>
<b>Adolescent well-care visits</b>  <sup>1</sup> States receiving funds would be required to cover, and thus to use, this quality measure, only for children less than 19.	<b>% of members who were age 12 through 21 years<sup>1</sup> during the reporting year who have had at least one comprehensive well-care visit with a primary care provider during the reporting year.</b>
<b><i>Health Plan Descriptive Information</i></b>	
<b>Pediatric physician specialists</b>	<b>% of each that has completed residency training or fellowship training in their respective specialties and/or are board certified, reported separately for each payer.</b>
<b>Pediatric mental health services</b>	<b>A narrative description of the health plan's pediatric mental health provider network, including the number and types of MH providers specially trained to treat children and adolescents (including, but not limited to, child psychiatrists, child psychologists and social workers, counselors, marriage and family therapists and nurses with special education and training in child and adolescent mental health). If the plan subcontracts for this service, it is required to describe any special requirements included in the subcontracts.</b>

**Section 9.4.** Assure that the state will provide reports to the Secretary as requested.

**Section 9.5.** Briefly describe the state's plan for annual assessment and evaluation. (See section 10 and sections 2108 (a) and (b) of the Act.) Some questions to consider and to assist the state in describing the state's plan for annual assessment include:

For the annual assessment:

- How will the state calculate the baseline number of uncovered low-income children?

For the evaluation:

- Who will perform the evaluation?
- What constitutes "effectiveness"?
- How will the state measure the "quality of health coverage"? What data elements will the state track? How will this information be collected? By whom?
- How are the performance goals and proposed measures the state identified in section 9.3 related to the required elements of the evaluation? Are there information systems in place to track these performance goals? Who is responsible for monitoring progress?
- How will the state identify "changes and trends in the state" affecting

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the provision of health insurance for children?

- Section 9.6.** Self-explanatory
- Section 9.7.** As stated above, national performance standards will be developed in conjunction with states, advocates, and other interested parties. This assurance verifies that the states will participate in the collection and evaluation of data when the measures are developed.
- Section 9.8.** Assure that the state applies sections of this Act in the same manner as they apply under Title XIX as listed in Title XXI, Section 2107(e). Check all that apply.
- Section 9.9.** Briefly describe the process and document the activity used to involve the public, including community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program.
- Section 9.10.** Submit the budget for this program including details on the planned use of funds and sources of the non-Federal share of plan expenditures. This budget must be updated periodically as necessary.
- A form for the budget is being developed, with input from all interested parties, to assist in addressing this requirement.

## **Section 10. Annual Reports and Evaluations**

### **Introduction and Guidance**

Section 2108(a) requires the state to assess the operation of the State Child Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uncovered low-income children. The report is due by January 1, following the end of the Federal fiscal year. The report will cover a Federal Fiscal Year: the first report, covering Federal Fiscal Year 1998, is due January 1, 1999.

By March 31, 2000, each state participating in the program must submit to the Secretary an evaluation report addressing the elements set forth in section 2108(b).

States are also expected to comply with any national reporting measures developed in the future as discussed on page 2. Any standards that are adopted will be developed in conjunction with the states, advocacy groups, and other interested parties.

In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box.

**Section 10.1.** These assurances address the annual assessment.

- Chart. Complete the chart using the performance measures the state have developed for analyzing the state's Title XXI program. A chart is included in subsection 10.1. listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

**Section 10.2.** State evaluations and assurances. Complete this section verifying that the state's annual report will address these areas.

**Section 10.3.** Self-explanatory

**Section 10.4.** Specify that the state agrees to the assurance that it will comply with all Federal laws and regulations, including grant administration and reporting rules.

**GLOSSARY**

*Adapted directly from SEC. 2110. DEFINITIONS.*

**CHILD HEALTH ASSISTANCE-** For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

- (1) Inpatient hospital services.
- (2) Outpatient hospital services.
- (3) Physician services.
- (4) Surgical services.
- (5) Clinic services (including health center services) and other ambulatory health care services.
- (6) Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
- (7) Over-the-counter medications.
- (8) Laboratory and radiological services.
- (9) Prenatal care and pre-pregnancy family planning services and supplies.
- (10) Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
- (11) Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
- (12) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
- (13) Disposable medical supplies.
- (14) Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
- (15) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
- (16) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.



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- (17) Dental services.
- (18) Inpatient substance abuse treatment services and residential substance abuse treatment services.
- (19) Outpatient substance abuse treatment services.
- (20) Case management services.
- (21) Care coordination services.
- (22) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- (23) Hospice care.
- (24) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
  - (A) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
  - (B) performed under the general supervision or at the direction of a physician, or
  - (C) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
- (25) Premiums for private health care insurance coverage.
- (26) Medical transportation.
- (27) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
- (28) Any other health care services or items specified by the Secretary and not excluded under this section.

**TARGETED LOW-INCOME CHILD DEFINED-** For purposes of this title--

- (1) **IN GENERAL-** Subject to paragraph (2), the term 'targeted low-income child' means a child--
  - (A) who has been determined eligible by the State for child health assistance under the State plan;
  - (B)(I) who is a low-income child, or
    - (ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
  - (C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).
- (2) **CHILDREN EXCLUDED-** Such term does not include--
  - (A) a child who is a resident of a public institution or a patient in an institution for

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mental diseases; or

(B) a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

(3) SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.

(4) MEDICAID APPLICABLE INCOME LEVEL- The term `medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under section 1902(1)(2) for the age of such child.

ADDITIONAL DEFINITIONS- For purposes of this title:

(1) CHILD- The term `child' means an individual under 19 years of age.

(2) CREDITABLE HEALTH COVERAGE- The term `creditable health coverage' has the meaning given the term `creditable coverage' under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).

(3) GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms `group health plan', `group health insurance coverage', and `health insurance coverage' have the meanings given such terms in section 2191 of the Public Health Service Act.

(4) LOW-INCOME CHILD - The term `low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.

(5) POVERTY LINE DEFINED- The term `poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

(6) PREEXISTING CONDITION EXCLUSION- The term `preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

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- (7) STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms `State child health plan' and `plan' mean a State child health plan approved under section 2106.
- (8) UNCOVERED CHILD- The term `uncovered child' means a child that does not have creditable health coverage.'

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**DRAFT MODEL APPLICATION TEMPLATE FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

**Preamble**

This draft model application template outlines the types of information that are likely to be included in the state child health plan required under Title XXI. It has been designed to reflect many of the requirements that will be necessary for state plans under Title XXI. It is not intended to be comprehensive or final. We provide it for preliminary guidance as well as to solicit additional information from states and other interested parties on the appropriate content.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like benefits definitions, maintenance of effort provisions, collection of baseline data, and methods for preventing substitution of new Federal funds for existing state and private funds. As such guidance becomes available, the model application template will be revised and finalized. We will work to distribute it in a timely fashion to provide assistance as states submit their state plans.

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**MODEL APPLICATION TEMPLATE FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: \_\_\_\_\_  
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

\_\_\_\_\_  
(Signature of Governor of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

**According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.**

Proposed Effective Date \_\_\_\_\_

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**Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)**

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1.  Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2.  Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3.  A combination of both of the above.

**Section 2. General Background and Description of State Approach to Child Health Coverage**  
(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

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2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

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2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:  
(Section 2102)(a)(3)

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**Section 3. General Contents of State Child Health Plan** (Section 2102)(a)(4)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)

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3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

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**Section 4. Eligibility Standards and Methodology.** (Section 2102(b))

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))

- 4.1.1.  Geographic area served by the Plan: \_\_\_\_\_
- 4.1.2.  Age: \_\_\_\_\_
- 4.1.3.  Income: \_\_\_\_\_
- 4.1.4.  Resources (including any standards relating to spend downs and disposition of resources): \_\_\_\_\_
- 4.1.5.  Residency: \_\_\_\_\_
- 4.1.6.  Disability Status (so long as any standard relating to disability status does not restrict eligibility): \_\_\_\_\_
- 4.1.7.  Access to or coverage under other health coverage: \_\_\_\_\_
- 4.1.8.  Duration of eligibility \_\_\_\_\_
- 4.1.9.  Other standards (identify and describe):  
\_\_\_\_\_

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))

- 4.2.1.  These standards do not discriminate on the basis of diagnosis.
- 4.2.2.  Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3.  These standards do not deny eligibility based on a child having a pre-existing medical condition.

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4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2))

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4.4. Describe the procedures that assure:

4.4.1. Through intake and followup screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))

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4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))

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4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))

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4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))

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4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

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**Section 5. Outreach and Coordination** (Section 2102(c))

Describe the procedures used by the state to accomplish:

- 5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))
- 

- 5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))
-

**Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)**

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

6.1. The state elects to provide the following forms of coverage to children:  
(Check all that apply.)

- 6.1.1.  Benchmark coverage; (Section 2103(a)(1))
  - 6.1.1.1.  FEHBP-equivalent coverage; (Section 2103(b)(1))  
(If checked, attach copy of the plan.)
  - 6.1.1.2.  State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
  - 6.1.1.3.  HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.) \_\_\_\_\_
- 6.1.2.  Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.**
- 6.1.3.  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."  
\_\_\_\_\_
- 6.1.4.  Secretary-Approved Coverage. (Section 2103(a)(4))

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6.2. The state elects to provide the following forms of coverage to children:  
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))

- 6.2.1.  Inpatient services (Section 2110(a)(1))
- 6.2.2.  Outpatient services (Section 2110(a)(2))
- 6.2.3.  Physician services (Section 2110(a)(3))
- 6.2.4.  Surgical services (Section 2110(a)(4))
- 6.2.5.  Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6.  Prescription drugs (Section 2110(a)(6))
- 6.2.7.  Over-the-counter medications (Section 2110(a)(7))
- 6.2.8.  Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9.  Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10.  Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11.  Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12.  Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13.  Disposable medical supplies (Section 2110(a)(13))
- 6.2.14.  Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15.  Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16.  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17.  Dental services (Section 2110(a)(17))
- 6.2.18.  Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19.  Outpatient substance abuse treatment services (Section 2110(a)(19))

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- 6.2.20.  Case management services (Section 2110(a)(20))
- 6.2.21.  Care coordination services (Section 2110(a)(21))
- 6.2.22.  Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23.  Hospice care (Section 2110(a)(23))
- 6.2.24.  Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25.  Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26.  Medical transportation (Section 2110(a)(26))
- 6.2.27.  Enabling services (such as transportation, translation, and outreach services) (See instructions) (Section 2110(a)(27))
- 6.2.28.  Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3. **Waivers - Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. **To be approved, the state must address the following:** (Section 2105(c)(2) and(3))

6.3.1.  **Cost Effective Alternatives.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. **Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** (Section 2105(c)(2)(B)(i))

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii))

6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** (Section 2105(c)(2)(B)(iii))

- 6.3.2.  **Purchase of Family Coverage.** Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3))
- 6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A))
- 6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B))



**Section 7. Quality and Appropriateness of Care**

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))

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Will the state utilize any of the following tools to assure quality?  
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1.  Quality standards
- 7.1.2.  Performance measurement
- 7.1.3.  Information strategies
- 7.1.4.  Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))

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**Section 8. Cost Sharing and Payment** (Section 2103(e))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1.  YES

8.1.2.  NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:  
(Section 2103(e)(1)(A))

8.2.1. Premiums: \_\_\_\_\_

8.2.2. Deductibles: \_\_\_\_\_

8.2.3. Coinsurance: \_\_\_\_\_

8.2.4. Other: \_\_\_\_\_

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: \_\_\_\_\_

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))

8.4.1.  Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))

8.4.2.  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))

8.4.3.  No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4.  No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))

8.4.5.  No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))

8.4.6.  No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.  
(Section 2105(c)(6)(A))

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- 8.4.7.  Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1))
- 8.4.8.  No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B))
- 8.4.9.  No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A))
- 8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: (Section 2103(e)(3)(B))
- 
- 8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:
- 8.6.1.  The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**
- 8.6.2.  The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:
-

**Section 9. Strategic Objectives and Performance Goals for the Plan Administration** (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2))

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9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3))

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9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A),(B))

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Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- 9.3.1.  The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2.  The reduction in the percentage of uninsured children.
- 9.3.3.  The increase in the percentage of children with a usual source of care.
- 9.3.4.  The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5.  HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6.  Other child appropriate measurement set. List or describe the set used.
- 9.3.7.  If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
  - 9.3.7.1.  Immunizations
  - 9.3.7.2.  Well child care
  - 9.3.7.3.  Adolescent well visits
  - 9.3.7.4.  Satisfaction with care
  - 9.3.7.5.  Mental health
  - 9.3.7.6.  Dental care
  - 9.3.7.7.  Other, please list: \_\_\_\_\_

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- 9.3.8.  Performance measures for special targeted populations.
- 9.4.  The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1))
- 9.5.  The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))  
\_\_\_\_\_
- 9.6.  The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))
- 9.7.  The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

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9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e))

- 9.8.1.  Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2.  Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3.  Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4.  Section 1115 (relating to waiver authority)
- 9.8.5.  Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
- 9.8.6.  Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7.  Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8.  Section 1128A (relating to civil monetary penalties)
- 9.8.9.  Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10.  Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c))

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9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

A financial form for the budget is being developed, with input from all interested parties, for states to utilize.

**Section 10. Annual Reports and Evaluations (Section 2108)**

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))

10.1.1.  The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2.  Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

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Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

<u>Attributes of Population</u>	<u>Number of Children with Creditable Coverage</u> <u>XIX</u> <u>OTHER CHIP</u>	Number of Children without Creditable Coverage	<b>TOTAL</b>
<b>Income Level:</b>			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
<u>Age</u>			
0 - 1			
1 - 5			
6 - 12			
13 - 18			
<u>Race and Ethnicity</u>			
American Indian or Alaskan Native			
Asian or Pacific Islander			
Black, not of Hispanic origin			
Hispanic			
White, not of Hispanic origin			
<u>Location</u>			
MSA			
Non-MSA			



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- 10.2.  State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: **(Section 2108(b)(A)-(H))**
- 10.2.1.  An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
- 10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:
- 10.2.2.1.  The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
- 10.2.2.2.  The quality of health coverage provided including the types of benefits provided;
- 10.2.2.3.  The amount and level (including payment of part or all of any premium) of assistance provided by the state;
- 10.2.2.4.  The service area of the state plan;
- 10.2.2.5.  The time limits for coverage of a child under the state plan;
- 10.2.2.6.  The state's choice of health benefits coverage and other methods used for providing child health assistance, and
- 10.2.2.7.  The sources of non-Federal funding used in the state plan.
- 10.2.3.  An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

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- 10.2.4.  A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5.  An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6.  A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7.  Recommendations for improving the program under this Title.
- 10.2.8.  Any other matters the state and the Secretary consider appropriate.
- 10.3.  The state assures it will comply with future reporting requirements as they are developed.
- 10.4.  The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.