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

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

State/Territory: ~~———~~:California
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

(Signature of Governor, or designee, of State/Territory, Date Signed)

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

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: ~~———~~John Ramey Position/Title: ~~———~~Executive Director, Managed Risk Medical Insurance Board
Name: Position/Title:
Name: Position/Title:

*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 80 hours 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, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, 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 and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- 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. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** 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. This section includes a list of potential eligibility standards the State can check off 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, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach 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. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children's Health Insurance**- 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). In this section States 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. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care**- This section includes 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 State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists 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. The section lists some of these tools. 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. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment**- 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, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- 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. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. 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.
- **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 March 31, 1997. Under this option, current Medicaid rules would apply.

  Medicaid Expansion- CHIP SPA Requirements
  In order to expedite the SPA 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)

  They will also be required to complete the appropriate program sections, including:
  - 4 (Eligibility Standards and Methodology)
  - 5 (Outreach)
  - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
  - 10 (Annual Reports and Evaluations).

  Medicaid Expansion- Medicaid SPA Requirements
  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 and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
  - 3 (Methods of Delivery and Utilization Controls)
  - 4 (Eligibility Standards and Methodology)
  - 6 (Coverage Requirements for Children's Health Insurance)
  - 7 (Quality and Appropriateness of Care)
  - 8 (Cost Sharing and Payment)
  - 11 (Program Integrity)
  - 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of 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 a Separate Program" would apply. 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.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR
———Not Applicable

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR
Not Applicable———

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))
Shortly after enactment of the federal Children's Health Insurance Program, Governor Pete Wilson developed a program for implementing the Initiative in California. He submitted his legislative package to the legislature in August of 1997 and the legislature worked with the Governor to enact the Healthy Families Program (HFP) in the last weeks of the 1997-98 legislative sessions.

Due to budget shortfalls in the intervening years, Governor Edmund G. Brown proposed to transition all HFP subscribers to Medi-Cal through the Medicaid Expansion. New enrollment was transitioned January 2013 and the last group of HFP subscribers was transitioned February 2014. Throughout this document, that group shall be known as Population 1.

California's program consists of the following pieces of legislation, which are included in the plan as Attachment 2.*

• Chapter 623 (AB 1126 -Villaraigosa) outlines the Healthy Families insurance program which provides affordable private health insurance plans for low-income children either through a health insurance purchasing pool or an insurance purchasing credit. The legislation details program

administration, eligibility criteria, monthly premiums, benefits, the program application process, and outreach activities;

*Attachment 1 is a glossary of terms used in the State Plan.

- Chapters 626 and 624 (AB 217 - Figueroa and SB 903 - Lee /Maddy) enact several provisions designed to improve access to Medi-Cal for Medi-Cal eligible children;
  - Chapter 625 (AB 1572 - Villaraigosa/ Gallegos) appropriates start-up funds for the Healthy Families program; and,
  - Chapter 28 (AB 1494 - Committee on Budget) transitions all HFP subscribers to Medi-Cal through a phased process.

Children in Population 1 will receive services through the Medi-Cal delivery system.

The Department of Health Care Services (DHCS) will be responsible for the administration of Population 1, including contracting with an Administrative Vendor to collect monthly premiums. DHCS will also be responsible for the administration of two yet to be described populations (Population 2 and Population 4) as well as for implementation of the outreach and Medicaid changes proposed in the Title XXI State Plan and the ongoing administration of the California Children's Services (CCS) and Child Health and Disability Prevention (CHDP) programs.

The Managed Risk Medical Insurance Board (MRMIB) will be responsible for administering the AIM program and overseeing the C-CHIP program until June 30, 2014. MRMIB has a strong commitment to providing affordable quality health care to Californians. MRMIB currently administers three health insurance programs: the Major Risk Medical Insurance Program (MRMIP), a program for medically uninsurable people; the Access for Infants and Mothers (AIM) Program, a program for uninsured pregnant women; and the County Children's Health Initiative Program (C-CHIP). All MRMIB programs will be transitioned to DHCS as of July 2014.

[Population 2]

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM (Population 3)

The AIM Program provides comprehensive health benefits for pregnant women with household incomes between 208 percent to 317 percent of the Federal Poverty Level (FPL). The program also guarantees coverage for the infants in either Population 1 or the DHCS AIM-Linked Infant and Children's Program (ALICP) for the first year of life based on the mother's FPL as long as the child is not enrolled in no cost Medi-Cal or Employer Sponsered Insurance (ESI). In addition, the program guarantees coverage for the second year of life for infants born to AIM mothers if the household income remains within AIM income guidelines.

The mothers in AIM will be hereafter labeled Population 3 and the infants and children in the DHCS

ALICP will be labled Population 4.

Pregnant women are not eligible for AIM if they are on no cost Medi-Cal or have ESI (unless the coverage has such high deductibles that the coverage is tantamount to being uninsured).

AIM serves pregnant women with incomes up to 317 percent of the FPL. Eligibility, enrollment, plan selection and benefit service delivery through the AIM Program remain for the pregnant woman. However, infants born to Population 3 will be enrolled in one of two programs based on the mother's FPL at the time of enrollment in AIM. If the mother's FPL was 261 percent or lower, the child will be enolled in Population1 for it's first year of life. If the mother's income was over 261 percent of the FPL, the child will be enrolled in the Population 4 for it's first year of life. An annual redetermination will be conducted prior to the child's first birthday to assure eligibility for the child's second year of life, and which Population that child will be in.

The legislature enacted language proposed by Governor Arnold Schwarzenegger in his 2003-04 Budget to enroll AIM children in the Healthy Families Program. California submitted a SPA to request federal approval for FFP, under Title XXI, up to 300 percent FPL for infants and children through age 2, born to mothers enrolled in the AIM Program and then enrolled in the Healthy Families Program. This SPA changes the FPL percentages based on the new Modified Adjusted Gross Income (MAGI) amounts and changes the program names iun which the children will be placed.

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM (C-CHIP) (Population 5)

AB495 (Diaz) (Chapter 648, statutes 2001) authorized the MRMIB to establish a mechanism to permit counties to utilize federal Title XXI (S-CHIP) funds not needed by the State for coverage of children or parents in Population 1. Funds will be used to expand coverage for uninsured children with incomes at or below 317 percent FPL and not eligible for no cost Medi-Cal or Population 1. California submited a SPA to implement the provisions of AB495 for Santa Clara, San Francisco, and San Mateo counties.

SB 36 (Simitian) (Chapter 416, statutes of 2011) authorized the MRMIB to expand coverage under C-CHIP to uninsured children with incomes at or below 400 percent FPL and not eligible for no cost Medi-Cal or Population 1. California submited a SPA to implement the provisions of SB 36 if so requested by C-CHIP counties.

C-CHIP enrolled children will receive health coverage from a health plan that has a contract with the county to provide the services and participated in the former Healthy Families Program (now the Optional Targeted Low Income Program). Health benefits are the same as in theCA Medicaid Program, except for the specialized services carved out for California Children's Services (CCS). Children with certain complicated medical conditions will receive treatment of those conditions through California's highly regarded CCS program. Similarly, children with serious emotional disturbances will receive treatment of their condition from county mental health departments. Under the C-CHIP model, children diagnosed with an eligible CCS condition will be referred to the CCS program for a full eligibility determination, including financial eligibility. In C-CHIP, children that do not meet all the CCS

eligibility criteria will have all their medical needs met by the health plan as occurs today under the California State Employees coverage that served as the benchmark coverage. Children enrolled in the C-CHIP will also receive comprehensive dental and vision coverage patterned after the CA Medicaid Program.

C-CHIP will be administered by the counties. Application screening to assure children are not eligible for no-cost Medi-Cal or Population 1 will be done via application assistants who are already trained in Medi-Cal criteria. Enrollment into C-CHIP will occur by the health plan staff. To assure consistency among all the public programs, eligibility criteria are the same as in the Medi-Cal programs except that C-CHIP covers income at or below 317 percent FPL.

MRMIB is responsible for review and ongoing monitoring of each of the C-CHIP expansions to assure compliance with federal Title XXI regulations and California's approved state plan. DHCS takes over that responsibility as of July 1, 2014.

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

Not Applicable

1.2. ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

[no text in old SPA]

1.3. ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

[no text in old SPA]

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: July 1, 1998

Implementation Date: ~~———~~July 1, 1998

SPA ~~#———~~#20 Purpose of SPA: ~~———~~HFP Transition to Medicaid Expansion
Proposed effective date~~:———~~:January 1, 2014

Proposed implementation date: ~~———~~February 1, 2014

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.
The Managed Risk Medical Insurance Board worked in collaboration with the Department of Health Care Services, the administering state agency for California's Medicaid Program, as detailed SPA Section 2.3-TC Tribal Consultation Requirements.~~———~~
TN No: Approval Date Effective Date

Section 2. **General Background and Description of Approach to Children's Health Insurance Coverage and Coordination**

Guidance: The demographic information requested in 2.1. 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.

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. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified , by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

According to the California Health Interview Survey (CHIS) data analyzed by the UCLA Center for Health Policy Research, just over half of Californians aged 0 to 64 were insured all year in 2012

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through either employment based insurance or individually purchased insurance. Additionally, nearly a quarter of nonelderly Californians were insured all year in 2012 through Medi-Cal, Healthy Families, or another public program. This leaves just over 20 percent, or 6,736,000, of nonelderly Californians that were uninsured for some or all of 2012.

According to the Census Bureau's March Supplement to the Current Population Survey (the CPS Annual Social and Economic Supplement or ASEC) as analyzed by the Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, 75 percent of uninsured nonelderly Americans in 2012 had household incomes at or below 250 percent FPL, half of which are at or below 100 percent FPL. In addition, the report noted that less than 18 percent of nonelderly Americans were uninsured during 2012, compared to the over 20 percent of nonelderly Californians.

Public Health Care Programs for Children. As was noted above, most California children obtain their coverage through private means. However, a significant number are served through public programs. The public programs under which children may get coverage include the following:

Medi-Cal. California's largest public health insurance program serving children is Medicaid (known in California as Medi-Cal).

- Most children are served under the categorically needy categories (SSI/SSP and AFDC/TANF recipients).
- The Medically Needy program under Title XIX, Section 1902(a)(10)(C) provides benefits to children under age 21 who meet resource requirements and who are determined otherwise eligible.
- The Federal Poverty Level programs under Title XIX, Section 1902(l) provides benefits to children under age 19 who are determined otherwise eligible. The FPL programs are as follows:

- For infants up to age one: family income must be at or below 200 percent of FPL, the income (between 185 percent and 200 percent) and the resources of the parents and child are disregarded.
- For children age one and under age six: family income must be at or below 133 percent of FPL.

- Presently, resources are counted for children ages 1 to 19 in the FPL program. However, state legislation has just been enacted to disregard the resources of the parents and child in the FPL program which will expand Medi-Cal coverage under Title XXI

California Health Care for Indigents Program (CHIP). CHIP provides funding to large counties for uncompensated hospital, physician, and other health service costs.

To be eligible for CHIP funds, counties must meet their Maintenance of Effort (MOE), and provide or arrange for follow-up medical treatment for children with health problems and/or medical disorders detected through the CHDP program.

Rural Health Services (RHS). RHS provides funding to small rural counties for uncompensated hospital, physician, and other health services costs. This is not the same as the Rural Health Demonstration Project.

To be eligible, counties must participate in the County Medical Services Program, meet their Maintenance of Effort (MOE), and provide or arrange for follow-up medical treatment for children with health problems and/or medical disorders detected through the CHDP program.

The program contracts with the State Office of County Health Services for the rural counties' obligation to provide follow-up treatment for the conditions identified in CHDP screens.

Expanded Access to Primary Care (EAPC) Program. EAPC provides financial assistance to primary care clinics serving medically-underserved areas or populations. EAPC is funded through Proposition 99 tobacco tax monies and serves individuals at or below 200 percent of the poverty level on a sliding scale basis.

Seasonal Agricultural and Migratory Workers Health Program. This program provides financial and technical assistance to primary care clinics serving the needs of seasonal, agricultural, and migratory workers and their families. Individuals pay on a sliding scale.

California Children's Services (CCS). CCS provides funding for medical care for eligible low-income families with children with serious medical problems, such as critical acute illnesses, chronic illnesses, genetic diseases, physical handicaps, major injuries due to violence and accidents, congenital defects, and neonatal and pediatric intensive care unit level conditions. It provides physician, hospital, laboratory, X-ray, rehabilitation services, medications, and medical case management.

To be eligible, individuals must be under twenty-one years of age, have a medical condition covered by CCS, be a resident of the county, have an adjusted gross family income below $40,000 or a projected out-of-pocket medical cost greater than twenty percent of the family income.

Major Risk Medical Insurance Program (MRMIP): MRMIP provides subsidized health coverage to individuals, including children, who are denied coverage by private carriers or offered coverage at rates higher then those offered in MRMIP. People who are eligible for Medicaid or Medicare cannot enroll in this program. Approximately 6% of the program subscribers are children.

Direct health services are frequently provided through community health centers, school based health centers, and voluntary practitioner programs.

Access for Infants and Mothers (AIM): The AIM program is a public-private partnership which offers creditable coverage to pregnant women with incomes between 208 percent and 317 percent of FPL. [For infants born to mothers enrolled in AIM prior to July 1, 2004, the AIM program provided coverage through the first two years of life. For infants born to mothers enrolled in AIM on or after July 1, 2004, and registered prior to February 2014, the infants were enrolled in the Healthy Families program. For infants born to mothers enrolled in AIM on or after July 1, 2004, and registered on or after February1, 2014, the infants were enrolled in either Population 1 or 4, based on the mother's FPL at time of application. AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. To cover the full cost of care, California uses Proposition 99

tobacco tax monies to subsidize subscriber co-payments and contributions, while the subscriber pays two percent of their average annual income if enrolled prior to July 1, 2004 and 1.5% of their average annual income if enrolled on or after July 1, 2004. As of December 2013, AIM has provided access to comprehensive health benefits for 145,067 women.

Covered California. Covered California is a new, easy-to-use marketplace where Californians may get financial assistance to make coverage more affordable and where theywill be able to compare and choose health coverage that best fits their needs and budget. Coverage began January 2014 and the application also screens individuals for Medi-Cal. Financial assistance is available on a sliding scale, with more support for those who earn less

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Uninsured Children. The CHIS data shows that since 2001, the percentage of nonelderly Californians uninsured for some or all of the year has been decreasing slowly, although the decrease was slowed by the Great Recession. In addition, the percentage of nonelderly Californians covered all year by employment based insurance has fallen below 50 percent and has not improved as quickly as the unemployment rate has, indicating employers were not providing insurance as readily as in previous years. However, with the implementation of the Patient Protection and Affordable Care Act (ACA) of 2010, many previously uninsured Californians now qualify for Medi-Cal or a premium subsidy through Covered California. In addition, Californians that do not qualify for the premium subsidy are still required to have credible coverage and many are purchasing it through Covered California or the private insurance market.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. **Health Services Initiatives**- Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

[2.2 and 2.3 of old SPA talk about different issues . . .]

2.3-TC **Tribal Consultation Requirements**- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

California's Title XXI program follows the same tribal consultation process as the California Medicaid Program. This process is identified in the Medicaid approved State Plan Amendment (SPA) 10-018, effective October 1, 2010, which was approved by CMS on March 16, 2011, and further amended in the Medicaid approved SPA 12-002, effective January 1, 2012, and approved on June 15, 2012.

The Managed Risk Medical Insurance Board (MRMIB) participates in the Tribal Consultation activities jointly with DHCS, the administering state agency for California's Medicaid Program. MRMIB participates in the scheduled annual Tribal Consultation meetings, presenting CHIP matters affecting these tribal organizations. While DHCS directs all communications as it relates to Medicaid, MRMIB takes responsibility for following the Tribal Consultation Plan protocols for written communications, webinars, face-to-face meetings and stakeholder teleconference lines for CHIP-specific matters.

Section 3. Methods of Delivery and Utilization Controls

☐ 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.

Guidance: In Section 3.1., discussion may include, but is not 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.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s)

complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to the CMS Regional Office servicing them for review and approval.

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 a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: 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. (42CFR 457.490(a))

3.1. **Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

———Population 2: The Medi-Cal Program, administered by DHCS, provides services through contracts with various health plans as well as a fee for service environment with payments made directly to providers of service. Population 2 will receive coverage through the Medi-Cal Program (California's Medicaid Program).

Population 3: The AIM program provides creditable coverage to pregnant women (who do not qualify for no-cost Medi-Cal) with incomes between 208 percent and 317 percent of FPL and their newborn children (if the woman was enrolled in AIM prior to July 1, 2004) through the first two years of life. Eligibles from confirmed pregnancy through birth will receive coverage through the AIM program.

AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. Because Medi-Cal currently serves infants under 1 year of age through 208 percent of FPL, infants through age 1 up to 261 percent of poverty served by AIM fall within the income range of targeted low income children.

Delivery System. MRMIB will offer access to health plans through a subsidized consumer choice purchasing system. The pool is built around the concepts used successfully by organized purchasers such as the California Public Employees Retirement System (CalPERS) -- price competition among

managed care health plans, choice of plans, performance based contracts with plans, and reliance on existing private sector delivery systems. In the purchasing pool, some of the same health plans and networks available in the employer market will be available to beneficiaries, providing broad access to health care providers. Most of the plans participating will be health maintenance organizations (HMOs), but it is possible that one or more preferred provider organizations (PPOs) will also participate. PPO's participate in several of MRMIB's programs and are a particularly effective means of providing coverage in areas with little or no penetration by HMO's.

Plan Contracting. MRMIB is authorized to contract with licensed health plans and health insurers as well as Local Initiatives approved by DHCS to provide service to Medi-Cal beneficiaries, County Organized Health Systems (COHS), and federal Health Insuring Organization demonstration projects such as Santa Barbara's COHS. Participating plans will be under the regulatory authority of California's Department of Insurance or Department of Managed Health Care (DMHC), and subscribers will be able to take any benefit grievances to those regulators. Eligibility grievances are appealable to MRMIB. DHCS will take over these responsibilities from MRMIB on July 1, 2014.

To assure that health care providers currently serving low income families are given the opportunity to participate in the program:

- MRMIB will encourage private managed care plans to subcontract with safety net providers and require them to report annually on the number of subscribers selecting these providers.
- MRMIB will allow the health plan in each county that has the highest percentage of traditional and safety net providers in its provider network to charge a discounted premium.
- County managed care systems (county organized health systems and Local Initiatives) are allowed to participate in the pool and, in the case of COHS's, given two years to obtain licensure as private health plans.
- MRMIB will give priority in contracting to plans with significant numbers of providers who serve uninsured children.

Plan Contracting Process. The process that MRMIB will use to contract with health plans will be the process it uses to contract with health plans under its existing programs. MRMIB first adopted (emergency) regulations detailing the eligibility, benefits and appeals process for the program. It then issued model contracts, one for the administrative function, and one for health plans, which specify MRMIB's contracting requirements. The model contracts issued by MRMIB serve as the basis of negotiations with all vendors. These contracts will contain numerous requirements, ranging from quality standards, participation of safety net providers, communication standards, grievance procedures, and manner of payment.][Many of the provisions will be aimed at developing a medical home for children. These provisions include:

- Performance standards regarding provision of health promotion service, such as immunizations;
- Requirements that families receive ID cards, evidence of coverage documents, and physician and hospital directories on the effective date of coverage;
- Requirement to report on grievances; and
- Requirements to publish materials in specified languages.]

MRMIB traditionally contracts with health plans for two years. It continually refines and improves the requirements of the contract prior to each new contracting period. It will be able to incorporate in subsequent contracts the indicators of a high quality medical home once such measures have been developed.

Both the regulations and the model contracts have been adopted in public session by MRMIB after the public has had the opportunity to testify on them. Once the model contracts are adopted, MRMIB staff meets with any and all potential contractors. Those interested in participating are required to submit signed contracts, together with their price for services, at a certain time. MRMIB staff reviews contracts for compliance with requirements and MRMIB selects contractors offering the state the best value. MRMIB can select as few or as many health, dental, and vision plans as it deems appropriate and is not constrained to select the lowest bidder(s).

MRMIB has a reputation for expeditious implementation of the programs it administers. Each of the three existing MRMIB programs opened for enrollment within nine months of enactment of authorizing legislation. Mindful of the urgent needs of California's uninsured children, MRMIB adopted a similarly aggressive schedule for enrollment to the pool.

Administration. The purchasing pool components of the program will be privately administered under the oversight of MRMIB. Applications can be mailed or faxed to the Administrative Vendor or are forwarded from the Single Statewide Application system, known as California's Healthcare Eligibility, Enrollment and Retention System (CalHEERS), and eligibility determinations are completed within an estimated ten days. The application is designed to determine the income eligibility of families and to screen them for access to employer sponsored coverage as well as coverage under no cost Medi-Cal. Income eligibility is verified electronically through CalHEERS or with valid income documentation.

The administrative contractor is responsible for eligibility determinations, premium collection, transmission of enrollment information to health plans, and printing and mailing of program materials.

In addition, an application assistance payment will be made to entities able to refer large numbers of children to the program. The types of entities anticipated to be authorized by MRMIB for receipt of the fee include state maternal and child health contractors, school districts, parent-teacher associations, Healthy Start sites, county health departments, county welfare offices, licensed day care operators, and insurance agents or brokers. A flat fee of $50 will be paid to the referring entity for every family that is determined to be eligible for and enrolled in the program.

Quality Oversight. Consistent with its administration of its existing programs, the MRMIB looks to the state regulatory entities to assure the basic quality of health plans with regard to financial stability, adequacy of network, and appropriateness of medical policy. In addition, to ensure that a health plan becomes a child's medical home, the best practices available for quality improvement and monitoring will be adopted. Such performance standards could include assuring the accessibility of services (such as wait time for appointments) and the delivery of preventive treatments (such as improvements in the percentage of children that are fully immunized by age two).

Coordination with Other Programs. MRMIB encourages all plans to develop protocols to screen and refer children needing services beyond the scope of the program's benefit package to public programs providing such services and to coordinate care between the plan and the public programs. This could include the regional centers for the developmentally disabled, county substance abuse programs and local education agencies.

MRMIB also coordinates eligibility with the state Medi-Cal program by forwarding applicants who appear to be eligible for Medi-Cal to the county.

The application assistance fee, which MRMIB pays for referrals of eligible children, is another feature which facilitates coordination with public and private entities. MRMIB specifies those agencies and persons in regulation after public hearing, but anticipates authorizing a wide range of entities including insurance agents, PTA's and county maternal and child health contractors.]

Outreach Efforts. Statewide outreach efforts are launched to inform parents about the child health services offered through programs such as Covered CA and Medi-Cal. The outreach program uses mass media, toll free phone lines, community based organizations, and coordination with other state and local programs to deliver messages that are culturally and linguistically appropriate. (See Section 5 for a more detailed description of the outreach activities.)]

Nine health care service plans participate in AIM, which offers statewide coverage, and the vast majority of all beneficiaries are offered a choice of two plans in each region (three in Los Angeles County).

Population 4: The Medi-Cal Program, administered by DHCS, provides services through contracts with various health plans as well as a fee for service environment with payments made directly to providers of service. Population 4 will receive coverage through the Medi-Cal Program.

Population 5: Delivery System. Service delivery for Population 5 will be provided by health plans contracted by the county. These health plans are health maintenance organizations and previously contracted with MRMIB to participate what is now Population 1.

Administration. Population 5 will be administered by the county. The health plans are directly responsible for final eligibility determinations, enrollment in the LI or COHS, distribution of written materials including correspondence, billing statements, Evidence of Coverage booklet, and premium collection, etc. MRMIB oversees program activities to assure compliance with federal Title XXI regulations and DHCS takes over the responsibilities as of July 1, 2014. MRMIB has reviewed the following materials to provide this assurance:

- The application, to assure that all necessary data is collected.
- Policies and procedures for determining eligibility (including citizenship/immigration status) and enrollment, documentation requirements, appeals processes, and enrollee protections such as continued enrollment during an appeal.

• All template correspondence to be used in communicating with the applicants.

☐ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS Regional Office for review and approval. (Section 2103(f)(3))

——[???]

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: 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. (42CFR, 457.490(b))

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42CFR 457.490(b))

——Population 2: Medi-Cal services provided under Title XXI will be provided in accordance with the routine utilization review procedure used in the Medi-Cal program consistent with the Title XIX state plan.

Population 3: MRMIB will contract with both HMOs and PPOs which will receive a specified amount per enrollee per month and a lump sum once the program is informed of a delivery outcome.

All of the plans will be regulated by DMHC under a body of law - the Knox-Keene Act - established specifically for managed care plans.1 The Knox-Keene Act prescribes rules for the organization of health maintenance organizations and other managed care entities. It specifies plan standards, marketing rules, and consumer disclosure requirements. It also establishes fiscal solvency requirements and quality assurance standards. Specific Knox-Keene requirements include:

• Medical decision making. The Knox-Keene Act requires medical services to be sufficiently

separate from administrative and fiscal management so that medical decisions are not unduly influenced by fiscal concerns. DMHC conducts an onsite medical survey at least every three years. Plans have physician medical directors responsible for medical decision making and directing quality assurance programs.

• Basic health care services. Knox-Keene plans must provide the following basic services: physician services, inpatient and outpatient services, diagnostic and therapeutic lab and radiologic services, home health care, preventive health care, and emergency health care, including ambulance and out-of-area coverage. In addition, there are a number of statutory mandates to provide or offer specific benefits.

• Accessibility of services. DMHC must review and approve provider networks and contracts. Primary care services must be within 30 minutes or 15 miles of the enrollees' residence or workplace. Regulations require at least one primary care provider (FTE) for every 2,000 enrollees as guideline. DOC may require more providers depending on the area, population density, and other factors. Different requirements may apply in rural or medically underserved areas. DOC assures reasonable access to ancillary services and tertiary care.

• Quality assurance. Plans must have quality assurance programs to review quality of care, which includes as one component a utilization review system. Regulations require a program directed by health providers to review the quality of care being provided, and to identify, evaluate and remedy problems related to access, continuity and quality of care, utilization and monitoring of plan providers.

• Financial viability. Plans must file quarterly and annual financial statements and other financial reports. Plans must meet "tangible net equity" requirements and a financial and administrative audit is conducted at least every three years to monitor plan financial viability.

• Consumer protection. Plans must maintain internal grievance procedures for plan enrollees and appeals may be made to DMHC if grievances are not resolved to the enrollees' satisfaction. DMHC reviews and approves plan contracts, disclosure forms, marketing materials and advertising to be sure that consumers receive fair and accurate information.]

In addition to the Knox-Keene statutory and regulatory requirements for all health plans, MRMIB developed a number of features for its programs to assure that enrollees are receiving needed health care. A number of these are discussed in Section 7. However, two features associated with the purchasing pool should be pointed out here:

• Purchasing Pool Structure. MRMIB uses a purchasing pool structure under which applicants can choose from at least two health plans available in their area.

• Risk Assessment/Risk Adjustment. MRMIB is one of the country's leaders in developing and operating a risk assessment/risk adjustment (RARA) mechanism. One of the purposes of RARA is to provide fiscal relief to plans that have attracted a

disproportionate share of higher risk enrollees. This mitigates the incentives that a health plan may have to avoid (or provide inadequate treatment to) a higher risk person or population because they will be high cost. Stated alternatively, it seeks to assure that plans with a higher than average risk mix of enrollees have the resources needed to serve their population.

Population 4: Medi-Cal services provided under Title XXI will be provided in accordance with the routine utilization review procedure used in the Medi-Cal program consistent with the Title XIX state plan.

Population 5:
Health Plan Regulatory Oversight. These plans are regulated by DMHC under the Knox-Keene Act. The Knox-Keene Act, as previously stated, prescribes rules for the organization of health maintenance organizations and other managed care entities. It specifies plan standards, marketing rules, and consumer disclosure requirements. It also establishes fiscal solvency requirements and quality assurance standards.

Specialized Services.

California Children's Services Program. Children who are enrolled in the C-CHIP and diagnosed with an eligible CCS condition will be referred to the CCS Program for an eligibility determination based on CCS eligibility criteria: CCS eligible condition, residence within the county, and income within CCS financial guidelines. Children not eligible for CCS services shall receive their medically necessary services via the health plan delivery system like the California State Employees system that serves as the benchmark. C-CHIP eligible children do not have deemed financial eligibility for CCS services; AB495 and SB36 requires that expansion services be provided without state expense.]

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Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. ☒ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group:
California covers the following Optional Targeted Low-Income children (OTLIC) with Title XXI funds under its Medicaid Program (Population 1):

- Infants from age 0 up to age 1 above 208 percent of the Federal Poverty Limit (FPL)* up to and including 261 percent of the FPL;
- Children from age 1 up to age 6 from above 142 percent of the FPL up to and including 261 percent of the FPL; and,
- Children from age 6 up to age 19 above 108 percent of the FPL up to and including 261 percent of the FPL.

* All FPLs do not include a 5 percent standard disregard.

4.1. ☒ **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.
Populations 2 and 3: Applicants are not required to provide a Social Security Number (SSN) or proof of citizenship or immigration status. Applicants must only be residents of the State and intend on staying in the State through the end of the pregnancy. When the child is born in the State, the child will be a citizen.

Population 4: During the registration process, a Social Security Number (SSN) is requested. If provided, the Administrative Vendor, MAXIMUS, utilizes the DHCS Medi-Cal Eligibility Data System (MEDS) for the electronic Social Security Administration (SSA) verification. If no SSN is provided, MAXIMUS includes that information on the transmittal for submission to the Couty Welfare Department (CWD). The county must follow federal Deficit Reduction Act (DRA) procedurtes and allow for a reasonable opportunity period of discovery.

Population 5: Applicants must prove citizenship or immigration status at the time of application and again if previously provided proof has expired. Applicants may provide a SSN which will be electronically verified. Applicants may also provide unexpired citizenship and immigration documents.

4.1.1 ☒ Geographic area served by the Plan if less than Statewide:
Populations 2, 3 and 4 are served statewide.
Population 5 is only served in threee counties (Santa Clara, San Francisco, and San Mateo).

4.1.2 ☒ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

California covers the following Targeted Low-Income Children (TLIC) with Title XXI funds under its Separate CHIP:

Conception to birth (Population 2): Children from conception to birth from 0 up to and including 208 percent of the FPL. This program is referred to as "Medicaid look-alike," and described in section [blank] of the CHIP state plan. This population receives the same coverage as pregnant women in the Medicaid state plan.

Conception to birth (Population 3): Children from conception to birth above 208 percent of the FPL up to and including 317 percent of the FPL. This population receives coverage under the Access for Infants and Mothers (AIM) program as described in section [blank] of the CHIP state plan.

Children from birth up to age 2 (Population 4): A subset of Population 3 remains in CHIP from birth until age 2 above 261 percent of FPL up to and including the 317 percent of the FPL based on the guarantee in the State Statute that authorizes the AIM Program.

County Children's Health Insurance Program (C-CHIP) (Population 5): Children from age 0 up to age 19 with income above 261 percent of the FPL up to and including 317 percent of the FPL in three counties (Santa Clara, San Francisco, and San Mateo) counties.

4.1.2.1-PC ☒ Age: ~~———~~:Conception through birth (SHO #02-004, issued November 12, 2002)

4.1.3 ☒ Income of each separate eligibility group (if applicable):

Conception to birth (Population 2): Children from conception to birth from 0 up to and including 208 percent of the FPL. This program is referred to as "Medicaid look-alike," and described in section [blank] of the CHIP state plan. This population receives the same coverage as pregnant women in the Medicaid state plan.

Conception to birth (Population 3): Children from conception to birth above 208 percent of the FPL up to and including 317 percent of the FPL. This population receives coverage under the Access for Infants and Mothers (AIM) program as described in section [blank] of the CHIP state plan.

Children from birth up to age 2 (Population 4): A subset of Population 3 remains in CHIP from birth until age 2 above 261 percent of FPL up to and including the 317 percent of the FPL based on the guarantee in the State Statutes that authorize the AIM Program.

County Children's Health Insurance Program (C-CHIP) (Population 5): Children from age 0 up to age 19 with income above 261 percent of the FPL up to and including 317 percent of the FPL in three counties (Santa Clara, San Francisco, and San Mateo) counties.

4.1.3.1-PC ☒ 0% of the FPL (and not eligible for Medicaid) through ~~———%~~

317% of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 ☐ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

———Not Applicable

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state):

———Populations 2 and 3 require the applicant to be a resident of the State of California and intend on staying in the State through the end of the pregnancy. Residency is proven though the residence address provided by the applicant and printed on any supporting documentation recevied by the programs. For Population 3, the application includes a declaration regarding the applicant's intent to stay in the State for the legnth of the pregnancy.

Populations 4 and 5 require the child to be a resident of the State and to be a US citizen, US national, or a lawfully residing alien. Residency is proven though the residence address provided by the applicant and printed on any supporting documentation recevied by the programs. Citizenship and immigration status verification is described in Section 4.1.0.

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

———Not Applicable

4.1.7 ☒ Access to or coverage under other health coverage:

———Individuals are ineligible for coverage under the Separate CHIP populations if they are eligible for (no cost) Medicaid or Medicare coverage.

4.1.8 ☒ Duration of eligibility, not to exceed 12 months:

———Population 2: Eligibility begins on the first day of the month in which the applicant is determined eligible and continues through the last day of the month in which the 60th day following the end of the pregnancy occurs. Applicants may request and receive retroactive coverage of services received for the unborn child.

Population 3: Coverage begins 10 calendar days after eligibility has been determined and continues through the last day of the month in which the 60th day following the end of the pregnancy occurs.

Population 4: Coverage begins once the program is notified of the birth of the child and may be retro-actively applied up to 11 months back to the date of birth. Coverage continues until a redeterminination is made prior to the first birthday. If the household income remains within guidelines, the child will be covered for an additional 12 month period. If not, the case will be reviewed for eligibility for any other child health assistance program. Prior to the second birthday, a redetermination will be made to see if the child qualifies for any other child health assistance program.

Population 5: Coverage begins 10 calendar days after eligibility has been determined

and continues for 12 months at a time. Annualy, a redetermination will be made to continue eligibility.

4.1.9 ☒ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Population 2: No other standards.

Population 3: • Individuals are ineligible if they are eligible for any California Public Employees' Retirement System Health Benefits Program(s) (CalPERS), unless the employer contribution is less than $10 per family per month. If a paystub indicating CalPERS membership is received, the AIM then determines or solicits additional information if needed to determine the employer's contribution towards benefits to ensure that this individual is truly eligible for Population 3.

• To be eligible, the complete application must be received at the program before the end of the 30th week of pregnancy as determined by the Estimated Date of Delivery (EDD).

Population 4: • Children are ineligible if they are eligible for any California Public Employees' Retirement System Health Benefits Program(s) (CalPERS), unless the employer contribution for dependent coverage is less than $10 per family per month. If a paystub indicating CalPERS membership is received, the program then determines or solicits additional information if needed to determine the employer's contribution towards dependent children's benefits to ensure that these children are truly eligible for Population 4. In addition, if an applying child is an inmate in a public correctional institution, or if they are a patient in an institution for mental illness, they are also ineligible.

• Children must be linked to a Population 3 subscriber's coverage.

Population 5: Children are ineligible if they are eligible for any California Public Employees' Retirement System Health Benefits Program(s) (CalPERS), unless the employer contribution for dependent coverage is less than $10 per family per month. If a paystub indicating CalPERS membership is received, the county then determines or solicits additional information if needed to determine the employer's contribution towards dependent children's benefits to ensure that these children are truly eligible for Population 5. In addition, if an applying child is an inmate in a public correctional institution, or if they are a patient in an institution for mental illness, they are also ineligible. The application includes a declaration that must be signed addressing all the above eligibility exceptions.

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed

newborns.

4.1.9.1 ☐ States should specify whether Social Security Numbers (SSN) are required.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☐ Continuous eligibility

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.
~~———~~Not Applicable

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1) "lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☒ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C.

§1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:
  (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
  (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
  (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
  (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
  (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
  (vi) Aliens currently in deferred action status; or
  (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☒ Elected for children under age ——19

4.1.1-LR ☒ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same

manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS ☐ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

Not Applicable

4.2. **Assurances** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(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. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS ☐ These standards do not discriminate on the basis of diagnosis.

4.2.2-DS ☐ 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-DS ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

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, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Population 2: Eligibility will be established and enrollment continued in a manner

that is consistent with the state's Title XIX plan. The state would utilize the standard Medi-Cal program application process, using the single streamline application and redetermination process for this group with Modified Adjusted Gross Income (MAGI) eligibility determinations. Applications are screened through the California Healthcare Eligibility and Enrollment Retention System (CalHEERS) for all Medi-Cal programs prior to a determination.

Population 3: Application: The program can receive applications in several ways. The AIM application is a 4 page document that is available online and can be received by mail, fax, or in person delivery to the Administrative Vendor (MAXIMUS). The program will also accept the Covered California application. When Covered California receives an electronic or paper application, and it contains a pregnant woman applying for coverage who appears to qualify for Population 3, it will be sent to the program for evaluation.

Eligibility Determination: When an application is received, the program will access the interface with the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS)* for an income eligibility determination based on a Modified Adjusted Gross Income (MAGI) FPL calculation. The CalHEERS interface will also provide the family size determination based on the information on family members provided on the application. If an application was forwarded to the County Welfare Department (CWD) due to being screened as Medi-Cal eligble, and is returned to the program, a Notice of Action (NOA) is required. If the NOA is not provided with the returned application, the program will request the applicant to send a copy of the NOA.

Birth Outcome Notification: Prior to the EDD, subscribers are reminded to notify the program when the pregnancy ends. Provided with the application and several of the regular communications are the Infant Registration Form (IRF) and the Early End of Pregnancy Form which can be mailed or faxed to the program. In addtion, the subscriber's health plan can also inform the program of the birth outcome. Notification of the birth outcome triggers the disenrollment date of the subscriber. Disenrollment occurs on the last day of the month following the 60th day after the end of the pregnancy.

Population 4: Registration: When the AIM program receives the IRF, the program notes the AIM subscriber's FPL. Depending on the FPL, the infant will be forwarded to the county for enrollment into Population 1 or enrolled in Population 4.

Year 1 Redetermination: Prior to the child's first birthday, the program will perform an annual redetermination. If the child's household income and family size remain within Population 4 guidelines, coverage will continue for an additional year. If the income has fallen to Population 1 guidelines, the case will be forwarded to the county for enrollment. If the household income of a Population 1 child that was born to a Population 3 subscriber is determined to be within Population 4 guidelines at the first birthday, they will be enrolled in the Population 4 program for the following year.

Year 2 Redetermination: Prior to the child's second birthday, the [county/program?] will perform a review of the case to determine if the child is eligible for any other child health assistance programs.

Population 5: Santa Clara, San Francisco and San Mateo Counties will contract with the Local Initiative (LI) or County Organized Health System (COHS) to administer the local insurance expansion programs. Since the LI or COHS health plan is the only health plan available in each C-CHIP project, there are no issues related to steerage. The LI and COHS staff are responsible for program enrollment, premium collection, and distribution of health plan materials.

Application: To assure compliance with the federal screen and enroll requirement, the C-CHIP uses One-e-App. In using One-e-App, certified application assistants working with the local C-CHIPs will enter the data. Once this is completed, One-e-App has a calculation feature that includes a Medi-Cal or C-CHIP eligibility screening. The eligibility rules used in One-e-App are the same as those used by the counties. When children are preliminary screened to Medi-Cal, the certified application assistant presses the submit key and the application is electronically submitted to the CWD. One-e-App also generates a fax cover sheet for the applicant to use when faxing their income documentation. When children are preliminary screened to the local C-CHIP, the family can elect to submit the application for the State to do a final eligibility determination or print the application as evidence that an acceptable screen and enroll assessment was made so that the children can be enrolled in the local C-CHIP. The C-CHIPs have established their own applications, although most resemble the one used by the counties. Applications are processed and an eligibility determination made within thirty (30) days.

Eligibility Determination: [interim solution - 3 suggestions made to CMS]

Annual Redetermination: Coverage is approved in 12 month periods. Prior to the end of the 12 month period, a redetermination is made.

* The CalHEERS interface is an interim process until the full integration of the AIM Application has been completed.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

If the MRMIB determines that sufficient funds are not available to cover the estimated cost of program expenditures and it is necessary to limit enrollment, MRMIB will place children on a waiting list until adequate funding becomes available to resume enrollment. This determination will be made in a public meeting, pursuant to State law. The MRMIB will notify the Center for Medicare and Medicaid Services prior to implementation of a waiting list in writing (by email, fax, letter or other appropriate means).

The public will be notified of a potential waiting list through the MRMIB's Board meetings. MRMIB will hold a Board meeting to facilitate public discussion of the insufficient funds

for the estimated program expenditures. The Board will also notify the public of insufficient funds and institute a waiting list. MRMIB Board meeting dates and agenda items are posted on the MRMIB website and made available to the public ten (10) days in advance, to comply with California public meeting law requirements. In addition, the MRMIB website is updated to reflect any program changes and newsletter articles are updated for our community partners. Each new applicant family affected by the waiting list will receive notification in writing.

a. When a waiting list is implemented, the program will continue to receive new applications; however, no eligibility determinations will be made until adequate funding is available. Placement on the waiting list is only for new applications to the HFP. New applications will be screened at the Single Point of Entry (SPE) for Medi-Cal, California's Title XIX Medicaid program and the State's SPE will forward these applications to the applicant's local county welfare department for a Medi-Cal eligibility determination. Siblings and newborns of current enrollees and children formerly eligible for No-Cost Medi-Cal who apply for the HFP are considered new applicants and are subject to the waiting list. Each new applicant family whose child is placed on the waiting list will be notified by letter. In addition, the notification letter will contain information about where the family may apply for other potential coverage (e.g., Medi-Cal).

b. If the State is using a waiting list, children will be placed on the waiting list in the order in which their applications were received based on the date the application was received. If MRMIB determines that sufficient funds are available to cover some or all children on the waiting list, the Healthy Families Program will review the applications for children on the waiting list in the order their application was received.

c. When children are removed from the waiting list, each family will receive a notification letter, informing them that sufficient funding is now available for the enrollment of their child and requesting that the family complete a pre-printed application, updating any changes and information to determine eligibility for enrollment into the Healthy Families Program. When the pre-printed application and other updated documentation is received, the State's Single Point of Entry will screen the application based upon income eligibility to either the Healthy Families Program or the state's Medi-Cal program. If the family does not reply within seventeen (17) calendar days, as noted on the pre-printed application, the application will be denied for being incomplete. If the family submits the information after the requested due date the child may be placed back onto the waiting list, in the order in which the new application is received.

If the MRMIB further determines that establishing a waiting list is insufficient to ensure operation within allotted expenditures, the MRMIB will make this determination at a public meeting and will announce that it is necessary to disenroll subscribers from the Healthy Families Program at the end of the month of their anniversary date, following their Annual Eligibility Review (AER). MRMIB Board meeting dates and agenda items

are posted on the MRMIB website and made available to the public ten (10) days in advance, to comply with California public meeting law requirements. In addition, the MRMIB website is updated to reflect any program changes and newsletter articles are updated for our community partners. Each family affected by AER disenrollments will receive notification in writing thirty (30) days prior to disenrollment. These subscribers will also be placed on the waiting list until sufficient funding is available to cover program expenditures. The subscriber child's effective date on the waiting list will be the date of his or her disenrollment from the HFP. However, children with chronic conditions through California Children's Services (CCS) who are CCS eligible solely by virtue of their HFP eligibility are exempt from AER disenrollment and will continue their enrollment in the HFP.

If MRMIB later determines sufficient funds are available to cover some or all eligible subscriber children, the Healthy Families Program will stop disenrolling children during the AER process and begin enrolling subscriber children back into the program in the following manner: The Healthy Families Program will first reassess eligibility of the applications of children who were disenrolled at their AER, in the order of their effective dates on the waiting list, starting with those who have the earliest effective date. When all children who were disenrolled at their AER have been removed from the waiting list, eligibility will then be assessed for the additional waitlisted children, in the order of their effective dates on the waiting list.

If only a waiting list is implemented, children who have current enrollment in the Healthy Families Program will remain enrolled, so long as they continue to meet all eligibility criteria and remain current with premium payments.

☐ Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. ☐ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Not Applicable

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility ☐ Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not

apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including 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. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

4.4.2. ☒ children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))

Population 2: Eligibility for this group is determined at the CWD, therefore, if an applicant applies for this group and is found eligible for a Medicaid program, the CWD will enroll that applicant.

Population 3: When an application is received at the program and has been screened as Medi-Cal eligible, that application is sent by overnight mail to the CWD for processing. The program will also send notification to the applicant that their application has been forwarded to the CWD.

Population 4: When an IRF is received at the program, the Population 3 subscriber's FPL is notated in the child's case file. If the AIM FPL is within Population 1 guidelines, that child will be forwarded to the CWD for enrollment. If additional income documentation is received with the IRF that lowers the FPL below Population 4 guidelines, that child will be forwarded to the CWD for processing. The program will also send notification to the applicant that their application has been forwarded to the CWD.

Population 5: Eligibility for this group is determined at the CWD, therefore, if an applicant applies for this group and is found eligible for a Medicaid program, the CWD will enroll that applicant.

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Population 2: Eligibility for this group is determined at the CWD, therefore, if an applicant applies for a Medicaid program and is found ineligible, the CWD will enroll that applicant.

Population 3: If an applicant applies for Medi-Cal and is denied for income too high, the applicantion will be forwarded to the AIM program for processing.

Population 4: ???

Population 5: Eligibility for this group is determined at the CWD, therefore, if an applicant applies for a Medicaid program and is found ineligible, the CWD will enroll

that applicant.

4.4.4. ☒ the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)

Population 2 applicants may have other coverage, but the Medi-Cal coverage is the payer of last resort.

If an application for Population 3 indicates that the applicant has coverage through an employer, that application is not approved, unless the employer provides a separate maternity only deductible or copayment greater than $500.

If an application or redetermination for Populations 4 or 5 indicates that the applicant has coverage through an employer, that application is not approved.

[CMS wants language regarding monitoring the stats of applications received indicating the child has or had ESI. Noted language should contain trigger threshold percentages at which a waiting period would be implemented.]

4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

Not Applicable

4.4.5. ☒ Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

California has made significant efforts to educate entities , clinics, stte Certified Application Assistants, and the general population regarding available health coverage for children through CHIP and Medicaid, including targeted outreach to the AI/AN population in the past years. These efforts have been statewide, and as such are also made on behalf of Population 5.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the Federal

poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

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

Pending review

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

Pending review

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

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5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

Pending review

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

Guidance: Outreach strategies 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 private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

5.3. **Strategies** Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

Pending review

Section 6. Coverage Requirements for Children's Health Insurance

☐ 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 proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal 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 box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below 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. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)
Pending review

Guidance: Check box below 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. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
Pending review

Guidance: Check box below 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. (Section 2103(b)(3) (42 CFR 457.420(c)))

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.)
Pending review

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- 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 42 CFR 457.430:
    - coverage of prescription drugs,
    - mental health services,
    - vision services and
    - hearing services.

  If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

  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 American Academy of Actuaries. 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. **(**Section 2103(a)(2))

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.
Pending review

Guidance: A State approved under the provision below, 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. (Section 2103(a)(3))

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide 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. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Pending review

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. ☐ Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☐ Coverage the same as Medicaid State plan

Pending review

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver

Pending review

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

Pending review

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in 457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

Pending review

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Pending review

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial

equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)
Pending review

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☐ Other (Describe)
Pending review

Guidance: 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. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

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)) (42CFR 457.490)
Pending review

6.2.1. ☐ Inpatient services (Section 2110(a)(1))
Pending review

6.2.2. ☐ Outpatient services (Section 2110(a)(2))
Pending review

6.2.3. ☐ Physician services (Section 2110(a)(3))
Pending review

6.2.4. ☐ Surgical services (Section 2110(a)(4))
Pending review

6.2.5. ☐ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
Pending review

6.2.6. ☐ Prescription drugs (Section 2110(a)(6))
Pending review

6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))
Pending review

6.2.8. ☐ Laboratory and radiological services (Section 2110(a)(8))
Pending review

6.2.9. ☐ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
Pending review

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))
Pending review

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)
Pending review

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))
Pending review

6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))
Pending review

Guidance: 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.

6.2.14. ☐ Home and community-based health care services (Section 2110(a)(14))
Pending review

Guidance: 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.

6.2.15. ☐ Nursing care services (Section 2110(a)(15))
Pending review

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)
Pending review

6.2.17. ☐ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
Pending review

6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
Pending review

6.2.19. ☐ Outpatient substance abuse treatment services (Section 2110(a)(19))
Pending review

6.2.20. ☐ Case management services (Section 2110(a)(20))
Pending review

6.2.21. ☐ Care coordination services (Section 2110(a)(21))
Pending review

6.2.22. ☐ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
Pending review

6.2.23. ☐ Hospice care (Section 2110(a)(23))
Pending review

Guidance: 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 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.

6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))
Pending review

6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))
Pending review

6.2.26. ☐ Medical transportation (Section 2110(a)(26))
Pending review

Guidance: 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.

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))
Pending review

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))
Pending review

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☐ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

Pending review

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- ☐ State-developed Medicaid-specific
- ☐ American Academy of Pediatric Dentistry
- ☐ Other Nationally recognized periodicity schedule
- ☐ Other (description attached)

Pending review

6.2.2-DC ☐ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

Pending review

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

Pending review

6.2.2.3-DC ☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

Pending review

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must

receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: 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 6.4.2.), 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, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.3. The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☐ The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ 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 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:
Pending review

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

6.4. **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 option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ **Cost Effective Coverage**- Payment may be made to a State in excess of the 10 percent 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 (42CFR 457.1005(a)):

6.4.1.1. 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)) (42CFR 457.1005(b))

Pending review

6.4.1.2. 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; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

Pending review

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent 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(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent 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. (42CFR, 457.1005(a))

6.4.1.3. 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(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

Pending review

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include 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. (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2. ☐ **Purchase of Family Coverage**- Describe the plan to purchase 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)) (42CFR 457.1010)

Pending review

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

Pending review

6.4.2.2. 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)) (42CFR 457.1010(b))

Pending review

6.4.2.3. The State assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Pending review

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☐ Yes
☐ No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

Pending review

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

Pending review

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

Pending review

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan**.**

Pending review

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

Pending review

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

Pending review

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

Pending review

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

Pending review

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in

CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

Pending review

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

Pending review

6.4.3.5-PA **Purchasing Pool**- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

☐ Yes
☐ No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

Pending review

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

Pending review

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

Pending review

6.4.3.6-PA **Notice of Availability of Premium Assistance**- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

Pending review

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

Pending review

Section 7. Quality and Appropriateness of Care

Guidance: **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 (e.g., CAHPS) 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 should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

☐ 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.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

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. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)
Pending review

7.1.1. ☐ Quality standards
Pending review

7.1.2. ☐ Performance measurement
Pending review

7.1.2 (a) ☐ CHIPRA Quality Core Set
Pending review

7.1.2 (b) ☐ Other
Pending review

7.1.3. ☐ Information strategies
Pending review

7.1.4. ☐ Quality improvement strategies
Pending review

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. 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 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))
Pending review

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))
Pending review

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex,

or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

Pending review

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Pending review

Section 8. Cost-Sharing and Payment

☐ 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? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☐ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☐ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent 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 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. ☐ Premiums:
Pending review

8.2.2. ☐ Deductibles:
Pending review

8.2.3. ☐ Coinsurance or copayments:
Pending review

8.2.4. ☐ Other:
Pending review

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and

dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:
Pending review

8.2.2-DS ☐ Deductibles:
Pending review

8.2.3-DS ☐ Coinsurance or copayments:
Pending review

8.2.4-DS ☐ Other:
Pending review

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))
Pending review

Guidance: 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. The State assures that it has made the following findings with respect to the cost sharing in 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)) (42CFR 457.530)

8.4.2. ☐ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☐ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

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 income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))
Pending review

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)
Pending review

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))
Pending review

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title

XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
Pending review

8.7.1.2. ☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
Pending review

8.7.1.3. ☐ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
Pending review

8.7.1.4 ☐ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))
Pending review

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☐ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☐ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☐ 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)) (42CFR 457.626(a)(1))

8.8.4. ☐ 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)) (42CFR 457.622(b)(5))

8.8.5. ☐ 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)) (42CFR 457.475)

8.8.6. ☐ 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)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

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)) (42CFR 457.710(b))

Pending review

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Pending review

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

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) 2008 contains performance measures 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 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 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.

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))

(42CFR 457.710(d))

Pending review

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.

Pending review

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 childcare
- **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, list:

Pending review

9.3.8. ☐ Performance measures for special targeted populations.

Pending review

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)) (42CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. ☐ The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

Pending review

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 or audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. ☐ The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

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)) (42CFR 457.135)

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 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of 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 or public forums used to discuss changes to the State plan.

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 ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))
Pending review

9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))
Pending review

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).
Pending review

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.
Pending review

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child

health initiatives, and evaluation; and

- Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
- All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1 Pending review

CHIP Budget

STATE: CA	**FFY Budget**
Federal Fiscal Year	
State's enhanced FMAP rate	
Benefit Costs	
Insurance payments	
Managed care	
per member/per month rate	
Fee for Service	
Total Benefit Costs	
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	

STATE: ——CA	FFY Budget
General administration	
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	
Other	
Total Administration Costs	
10% Administrative Cap	
Cost of Proposed SPA Changes	
Federal Share	
State Share	
Total Costs of Approved CHIP Plan	

NOTE: Include the costs associated with the current SPA.
Pending review——
The Source of State Share Funds: Pending review——

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

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)) (42CFR 457.750)

10.1.1. ☐ The progress made in reducing the number of uninsured 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

10.2. ☐ The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☐ 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.

10.3-DC ☐ The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

☐ 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 to Section 12.

11.1. ☐ The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. 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)) (42CFR 457.935(b)) (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)

- **11.2.1.** ☐ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- **11.2.2.** ☐ Section 1124 (relating to disclosure of ownership and related information)
- **11.2.3.** ☐ Section 1126 (relating to disclosure of information about certain convicted individuals)
- **11.2.4.** ☐ Section 1128A (relating to civil monetary penalties)
- **11.2.5.** ☐ Section 1128B (relating to criminal penalties for certain additional charges)
- **11.2.6.** ☐ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

12.1. **Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.
Pending review

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. **Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.

Pending review

12.3. **Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Pending review

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices				
CMS Regional Offices	**States**		**Associate Regional Administrator**	**Regional Office Address**
Region 1-Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2-New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3-Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4-Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5-Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6-Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7-Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8-Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9-San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103
Region 10-Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

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 prepregnancy 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.
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 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(l)(2) for the age of such child.
5. TARGETED LOW-INCOME PREGNANT WOMAN.—The term ‘targeted low-income pregnant

woman' means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

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)).
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. UNINSURED CHILD- The term 'uninsured child' means a child that does not have creditable health coverage.