

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- Removed crowd-out language that had been added by the August 17 letter that later was repealed.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) indicating State

- **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, CHIP and Survey & Certification
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

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

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State’s Medicaid program). 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))

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))

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))

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)

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**

State Plan Amendment #2: Minor revisions to performance measures in approved XXI State Plan

Submitted: May 30, 2000

CMS Approved: September 11, 2000

State Plan Amendment #3: Increase enrollment cap to 19,800

Submitted: December 12, 2000

CMS Approved: March 9, 2001

State Plan Amendment #4 Compliance with final CHIP regulations and updated program descriptions

Submitted: July 31, 2002

CMS Approved: April 15, 2003

State Plan Amendment #5: Asset limit increase to \$10,000

Submitted: August 19, 2004

CMS Approved: November 10, 2004

Effective date: October 1, 2004

State Plan Amendment #6: Duration of eligibility period increased to 12 months

Submitted: May 16, 2006

CMS Approved: August 1, 2006

Effective Date: June 1, 2006

State Plan Amendment # 7: Unborn child expansion

Submitted: July 31, 2007
Approved: April 9, 2008
Effective: April 1, 2008

State Plan Amendment #8: Require SSN on application
Submitted: September 13, 2007
Approved: December 12, 2007
Effective: October 1, 2007

State Plan Amendment # 9: Transition the following targeted low income children from Section 1115 demonstration to the state plan: children ages 0 through 18 above 170 percent of the FPL up to 185 percent of the FPL.
Submitted: November 30, 2007
Approved: September 16, 2008
Effective: November 1, 2007

State Plan Amendment # 10: This amendment expands the income eligibility level for CHIP children through age 18 from 185 percent of the Federal poverty level (FPL) up to and including 300 percent of the FPL under the State's Healthy Kids initiative. This SPA is a companion amendment to the State's section 1115 title XXI demonstration amendment. This SPA also creates a new private insurance option, referred to as Healthy KidsConnect, specifically for children from 200 up to and including 300 percent of the FPL under Secretary-approved coverage under the CHIP state plan. In addition, this SPA institutes an Application Assistance Program to assist families applying for CHIP and other child health programs in the State as part of its Healthy Kids initiative, finances an outreach and enrollment grant program designed to provide culturally-specific and targeted outreach and direct application assistance to families in racial, ethnic and language minority communities living in geographic isolation or with additional access barriers, reduces the waiting period of uninsurance for CHIP coverage from 6 months to 2 months, and eliminates the asset test in CHIP This amendment will have a retroactive effective date of October 1, 2009, for the expansion of eligibility from 185 percent of FPL up to and including 200 percent of the FPL, as well as for the application assistance program, outreach and enrollment grant program, the waiting period reduction, and elimination of the asset test.

Submitted: July 27, 2009
Effective: October 1, 2009

This amendment will also have an effective date of January 1, 2010, for the expansion of eligibility above 200 percent of the FPL up to and including 300 percent of the FPL. However, the State must receive approval for its section 1115 demonstration amendment in order to permit children to enroll in its premium assistance programs.

Submitted: July 27, 2009

Approved: December 18, 2009
Effective: January 1, 2010.

State Plan Amendment #11: Expand Unborn population coverage to Benton, Clackamas, Hood River, Jackson and Lincoln counties.

Submitted: August 26, 2009

Effective: October 1, 2009

This amendment also closes the expansion in Lincoln County effective December 31, 2009.

Submitted: December 22, 2009

Approved: September 20, 2010

Effective: January 1, 2009

State Plan Amendment # 12: CHIPRA provisions related to those who have not met the 5 year waiting period for immigrant children.

Submitted: July 27, 2009

Approved: May 18, 2010

Effective: October 1, 2009

State Plan Amendment # 13: Designate express lane eligibility agencies as the Supplemental Nutritional Assistance Program (SNAP) and selected Department of Education, National School Lunch Program (NSLP).

Submitted: August 9, 2010

Approved: October 21, 2010

Effective: August 1, 2010

State Plan Amendment #14: Expand Unborn population coverage to Lane county.

Submitted: October 11, 2010

Effective: January 1, 2011

This Amendment also revises the budget month used for income eligibility

Approved: December 30, 2010

Effective: November 1, 2010

State Plan Amendment #15: withdrawn

State Plan Amendment #16: Expand Unborn population coverage to Columbia, Crook, Douglas, Josephine, Jefferson, Morrow, Union and Wasco county.

Submitted: March 28, 2011

Effective: July 1, 2011

Approved: May 26, 2011

State Plan Amendment #17: (a) Expand Unborn population coverage to Umatilla county. (b) Provisions implementing temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor or FEMA declared disaster areas. In the event of a natural disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or FEMA declared disaster areas. (c) This amendment also closes the expansion in Josephine county effective July 1, 2011.

Submitted: March 29, 2012

Effective: April 1, 2012

Approved: April 30, 2012

State Plan Amendment # 18: This amendment is to provide federal funding for the Oregon Poison Center (OPC) under a health services initiative.

Submitted: May 4, 2012

Effective: April 1, 2012

Approved: September 27, 2012

State Plan Amendment # 19: Children currently enrolled in Healthy KidsConnect with incomes between 200 and 300% FPL will be converted to CHIP direct coverage. Expand OHP Plus direct coverage to children to at or below 300% and reduce the period of uninsurance from 2 months to zero.

Submitted: 8/29/13

Effective: 8/23/13

This Amendment also expands the unborn population coverage statewide.

Submitted: 8/29/13

Effective: 10/1/13

Approved: 11/22/13

State Plan Amendment # 20 (13-0120) ACA MAGI elig. Form CS15

Adds new subsection 4.3.4, CS13 adds new subsection 4.3.5. CS7, CS8 supersede section 4.1.1, 4.1.2 and 4.1.3.

Submitted: 11/12/13

Effective: 1/1/14

Approved: 2/10/14

State Plan Amendment # 21 (13-0121) ACA elig process. Form CS24 supersedes

section 4.3 & 4.4.
Submitted: 11/12/13
Effective: 1/1/14
Approved: 5/5/14

State Plan Amendment # 22 (13-0122) ACA established 2101(f). Form CS14 adds new subsection 4.1. 10.
Submitted: 11/12/13
Effective: 1/1/14
Approved: 2/3/14

State Plan Amendment # 23 (13-0123) ACA Non financial elig. Form CS17 superseded section 4.1.5. CS18 superseded section 4.1.0, 4.1-LR; 4.1.1-LR. CS19 supersedes section 4.1.9. CS21 supersedes section 8.7. CS27 supersedes section 4.1.8 and CS28 supersedes section 4.4.3.
Submitted: 11/12/13
Effective: 1/1/14
Approved: 2/10/14

State Plan Amendment # 24 (13-0124) ACA Chip to XXI Medicaid. Form CS3 supersedes section 4.0.
Submitted: 11/12/13
Effective: 1/1/14
Approved: 2/3/14

- 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 State uses the consultation process as outlined in section 2.3 of this State plan. Specific to this Amendment. The OHA distributed information to the ‘770’ Tribal distribution list on 7/29/13 with additional details distributed on 8/1/13. Tribal entities are given an opportunity to ask questions or to comment prior to the SPA submission.

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))

Prior to implementation of CHIP in 1998, approximately 870,000 children in the state of Oregon were under the age of 19. About 92 percent of them, 800,000, had health insurance coverage of some form. Children of Hispanic or racial minority origin are more likely than their Caucasian counterparts to be uninsured. Fourteen percent of Hispanic children and 9 percent of other minority children are uninsured, compared with only 7 percent of Caucasian children. Most uninsured children live in households earning less than \$25,000 per year, while median household income for all children in the state is more than \$40,000 per year.

The economic conditions of the state and nation reflect an increase in the number of uninsured. The 2006 Oregon Population Survey (OPS) shows 12.6% of children under age 19 lacked health insurance coverage last year compared to 13% in 2004 and 10.6% in 2002. The table below compares number of uninsured children by Federal Poverty Level (FPL).

	<100%	100-135%	135-150%	150-185%	186-200%	>200%
Age 0-4 Total	35,817	13,567	9,226	15,195	11,668	148,695
Age 0-4 insured	32,021	12,129	8,248	13,584	10,431	132,934
Age 0-4 uninsured	3,797	1,438	978	1,611	1,237	15,762
Age 5-9 Total	37,076	14,044	9,550	15,729	12,078	153,923
Age 5-9 insured	33,146	12,555	8,538	14,062	10,798	137,608

	<100%	100-135%	135-150%	150-185%	186-200%	>200%
Age 5-9 uninsured	3,930	1,489	1,012	1,667	1,280	16,316
Age 10-14 Total	38,818	14,704	9,999	16,468	12,645	161,155
Age 10-14 insured	34,704	13,145	8,939	14,723	11,305	144,073
Age 10-14 Uninsured	4,115	1,559	1,060	1,746	1,340	17,082
Age 15-17 Total	23,556	8,923	6,067	9,993	7,673	97,792
Age 15-17 insured	21,059	7,977	5,424	8,934	6,860	87,426
Age 15-17 Uninsured	2,497	946	643	1,059	813	10,366

Sources: Population Research Center, Portland State University data for July 2008, Bureau of Labor Statistics/ U.S. Census; Current Population Survey (CPS)

The primary source of health coverage for most children is an employer-based policy, most often sponsored by a parent’s employer. In 1998 Employer-based coverage accounted for 82 percent of all children’s health insurance coverage in the state, while public sources made up 13 percent and the remaining 5 percent was from other sources. In 2007 Employer-based coverage decreased as the unemployment rate increased.

During Oregon’s 2009 Legislative Session, HB 2116 created the Healthy Kids initiative. Healthy Kids provides coverage for uninsured children through age 18 in the State. The objective of Healthy Kids is to provide options for children at all income levels, remove barriers to accessing health care coverage and build on existing programs already available to Oregon families. HB 2116 increases the FPL from 185 percent of FPL up to and including 300 percent of FPL for children.

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 457.1005.

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)

Oregon will use CHIP funds, within the 10 percent federal administrative expenditures cap allowed for states, to support the Oregon Poison Center (OPC). The OPC provides emergency telephone treatment advice, referral assistance, and information to manage exposures to poisonous and hazardous substances. The OPC answers poisoning emergency calls from the general public as well as health care providers needing assistance 24 hours a day, 365 days each year at no charge. At all times, Specialists in Poison Information, Certified Specialists in Poison Information, and toxicologists are available to manage cases. The service is provided via a toll-free telephone number to all communities throughout Oregon, including under-served, low income, and indigent populations. Services are available by use of an interpreter in over 150 languages and via telecommunications devices for the deaf and hearing impaired (TTY).

The OPC provides public education programs directed towards pediatric accidental poisoning as well as targeted “at-risk” populations. Educational materials and teaching curricula are distributed throughout the state, free of charge. Materials are also available in Spanish, Vietnamese and Russian. The OPC participates in a variety of community injury prevention including health fairs.

The OPC receives approximately 46,000 calls from Oregonians annually involving individuals exposed to poisons or hazardous substances. Sixty-four percent of all poisoning exposure calls received involve children under age 19. For CHIP eligible children, over 38 percent of the total calls relate to poisoning exposures of children in families whose annual household incomes is \$44,700 or less (200% FPL for a family of 4 in 2011). In addition to calls regarding exposures, the OPC receives over 7,800 calls each year from Oregonians requesting information about poison prevention, effective use of chemicals, drug identification, substance abuse and other medical questions. These calls are considered preventive.

OPC intervention resulted in over 92 percent of the exposure calls (in children under age 19) being handled in the home so the children did not have to use an emergency department or need a 911 call and response.

The Authority has no special funding arrangement with the providers for these services and they retain 100% of the approved reimbursement from the state. Providers do not return any portion of the payments to the state.

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 (IHCA). 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.

The Division of Medical Assistance Programs, within the Oregon Health Authority (OHA) has regular quarterly meetings with the nine federally recognized Tribes, Urban Indian Programs and Indian Health Service (IHS) representatives. The agenda's are mainly driven by the Indian communities of Oregon, Urban Indian Programs and Indian Health Service (IHS) representatives and are constructed by requesting topic's to be discussed at the meeting. These meetings are referred to in Oregon as Senate Bill 770 in reference to the legislation authoring the meeting. The OHA may engage the tribal and urban program representatives outside of the meeting setting through correspondence in the event a policy change is needed more quickly than the next 770 meeting will support. Each Tribe and Indian Organization selects its representative to the meetings based on whom the Tribe or Indian Organization feels is best to represent their needs.

The Division discusses proposed State Plan Amendments, waiver amendments, demonstration project proposals. Policies or rule-making that may have a direct impact on American Indians, Tribal entities and urban Indian programs or IHS in the SB 770 quarterly meetings.

Impacts that are considered to have direct affects on Native Americans, Urban Indian programs or IHS are changes that would impact eligibility determinations, changes that reduce payment rates or changes in payment methodologies, reductions in covered services, changes in provider qualifications/requirements, and proposals for demonstrations or waivers.

Process:

Thirty (30) days prior to a State Plan submission to the Centers for Medicare and Medicaid Services (CMS), the Division distributes documents describing a proposed State Plan Amendments (SPA). This is normally discussed in a scheduled quarterly SB 770 meeting. Approximately ten (10) days prior to the quarterly 770 meeting the Division distributes the agenda and documents describing a proposed SPA. This is distributed through the Tribal

Liaison to the nine federally recognized Tribes, Tribal Urban Indian programs and Indian Health Service (IHS) representatives. The types of entities on the distribution list includes, but is not limited to:

- a. Oregon Tribal Governments (i.e. Tribal Executive Council, Tribal Business Council, etc.)**
- b. Tribal Chairman or Chief or their designated representative(s)**
- c. Tribal Health Clinic Executive Directors of Oregon’s 638/FQHC providers**
- d. IHS representatives**
- e. Tribal Organizations established to represent IHS and Tribal health programs and such as the Northwest Portland Indian Health Board**
- f. Urban Indian program(s) Executive Director(s) or designee(s)**

In instances where a SPA would need to be submitted prior to a regularly scheduled ‘770’ meeting the Division would utilize electronic mail or schedule conference calls.

The Division may also utilize an expedited process in the event a deadline is outside the control of the Division, or in severely time limited situations. The expedited process includes at a minimum, 10 days in advance of the change the Division provides written notification with the proposed change; anticipated impact; method for providing comments/questions; timeframe for feedback; and an opportunity for a face-to-face meeting or conference call if requested.

Tribal, Urban Indian program and IHS designees are invited to attend all Divisions’ Rule Advisory Committee meetings to provide additional input on rule concepts and language.

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 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))

- 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))

CHIP OHP Plus coverage: Health care services for CHIP clients are primarily provided through the managed care delivery system already established for the OHP Medicaid 1115 Waiver Demonstration.

The Division of Medical Assistance Programs (DMAP), within the Oregon Health Authority (OHA), manages the Medicaid Demonstration Project, and has primary responsibility for operation of CHIP. The State started to transform its delivery system through a shift to the delivery of care from current specialized MCEs to Coordinated Care Organizations (CCOs) beginning in August 2012. Initially, CCOs are required to provide both medical and behavioral health services (formerly provided under different MCEs). Dental services must be merged into the CCO by July 2014. The State's contracting with the CCO will phase out of Fully Capitated Health Plan (FCHP), Physician Care Organization (PCO), and Mental Health Organization (MHO) contracts by July 1, 2014 and CCOs must have a formal contractual relationship with any Dental Care Organization (DCO) in its service area by July 2014. The CCOs initially will be phased into the delivery system over four monthly cycles (or "waves") beginning in August 2012 and ending in November 2012.

. As part of OHP Medicaid and CHIP policy all plans are encouraged to incorporate safety net providers in their delivery system and most FQHCs, rural health clinics and local health departments that provide primary care are incorporated into plan networks.

CHIP enrollees have the same choice of CCO plans as OHP Medicaid enrollees in their area. CHIP clients are required to enroll in a CCO. If no managed care plan is available, a managed fee-for-service (FFS) network is available. DMAP monitors plan provider capacity quarterly and we track enrollment monthly. If it is determined that there is insufficient capacity in a geographic area, CHIP clients are not required to enroll in a managed care plan and may receive services on a fee for service basis. refer to waiver number: 21-W-00013/10 and 11-W-00160/10 for additional details on the CCO delivery system.

PC-Unborn option:

This population is exempt from managed care enrollment. The preferred service delivery system is Primary Care Management (PCM) providers. Services continue through labor and delivery, the day after pregnancy ends, eligibility for medical services for the mother ends unless they are found eligible for a Medicaid or CHIP eligibility category. The following services are not covered for the prenatal period: Postpartum care beyond the global payment; Sterilization; Abortion; Death with dignity services; Hospice.

Reimbursement for Professional fees for labor and delivery are paid with a global

fee, unless the client changes obstetricians during the pregnancy. In that case, one physician may bill for the actual antepartum visits and the other would bill only for the delivery.

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))

Oregon Administrative rules for quality assurance and quality improvement review process require DMAP contracted coordinated care organizations to have an internal utilization review infrastructure and to specifically monitor utilization of preventive care, the operation and outcome of referral procedures, and persistent or significant DMAP member complaints. DMAP staff annually reviews health plan compliance with utilization and quality assurance requirements to ensure appropriate utilization of health care services. The quality improvement process ensures services provided are appropriate and medically necessary, and approved by the state. The following are examples of administrative mechanisms required of the managed care plans in the Oregon Health Plan Medicaid Demonstration Project, which are also required under CHIP to ensure CHIP children receive appropriate and medically necessary health care.

- **Plans must provide 24-hour-a-day, 7 day-a-week appropriate urgent, emergent, and triage services. Plans are required to have written policies and procedures that they communicate to providers, and plans are required to review their policies and procedures annually.**
- **Plans must ensure and monitor the availability of an after-hours call-in system to triage urgent and emergent call from clients.**
- **Plans must assure access to services according to the following time standards:**
 - **Immediately for emergency medical services. Within 24 hours for emergency dental, mental health, or chemical dependency services.**

- Within 48 hours for urgent medical, mental health, or chemical dependency services. Within one to two weeks for urgent dental services.
- Within four weeks, or within the community standard, for well care for preventive or non emergent medical services.
- Within two weeks of patient request for intake assessment for mental health or chemical dependency services.
- Within twelve weeks, or the community standard, for dental services.

For CHIP services provided on a FFS basis, all utilization review requirements of Title XIX and the 1115 Demonstration apply. The Quality Improvement Organization (QIO) contractor reviews inpatient hospital services. DMAP requires prior authorization for certain services according to OHP Medicaid FFS protocols and claims are subject to SURS post-payment review.

Section 4. Eligibility Standards and Methodology

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

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. Eligibility for Medicaid Expansion Program

Eligibility for Medicaid Expansion Program	CS3
42 CFR 457.320(a)(2) and (3)	

Income eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards:

There should be no overlaps or gaps for the ages entered.

4.0.1. Ages of each eligibility group and the income standard for that group:

From Age	To Age	Above (% FPL)	Up to & including (% FPL)
0	1	133	185
6	19	100	133

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.
Oregon uses a match with the SSA to verify citizenship in an overnight process. A new citizenship verification field was added to the system used by eligibility staff. The new citizenship code field uses SSA data to confirm the individual meets medical program U.S. citizenship documentation requirements. In cases where the data match does not confirm the individual is a U.S. citizen, the eligibility worker sends the applicant a notice requesting citizenship/identity documentation. Individual's who do not provide the U.S. citizenship documentation in the time frame allowed will have their medical assistance closed.

4.1.1 Geographic area; 4.1.2 Age; 4.1.3 Income standards; 4.1.2.1-PC are superseded by ACA form CS7 & CS9.

Separate Child Health Insurance Program	
Eligibility - Targeted Low-Income Children	CS7
2102(b)(1)(B)(v) of the SSA and 42 CFR 457.310, 315 and 320	

Targeted Low-Income Children - Uninsured children under age 19 whose household income is within standards established by the state.

The CHIP Agency operates this covered group in accordance with the following provisions:

Age: Must be under age 19.

Income Standards:

Income standards are applied statewide. Yes No

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? Yes No

Statewide Income Standards:

Please note that the lower bound for CHIP eligibility should be the highest standard used for Medicaid poverty level children for the same age group or groups entered here.

From Age	To Age	Above (% FPL)	Up to & including (% FPL)
0	1	185	300
1	19	133	300

Special Program for Children with Disabilities:

Does the state have a special program for children with disabilities? Yes No

Separate Child Health Insurance Program Eligibility - Coverage From Conception to Birth	CS9
42 CFR 457.10	

Coverage From Conception to Birth - Coverage from conception to birth when the mother is not eligible for Medicaid.

The CHIP Agency operates this covered group in accordance with the following provisions:

Age Standard: **From conception through birth.**

Does the state have an additional age definition or other age-related conditions?

Yes No

Income Standards:

Income standards are applied statewide. Yes No

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? Yes No

Statewide Income Standard

The statewide income standard is: From zero up to **185** % FPL

Exempted from requirement of providing or applying for a Social Security Number.

Exempted from requirement of verifying citizenship status

4.1.4 Resources of each separate eligibility group (including any standards

relating to spend downs and disposition of resources): **No asset limit**

4.1.5 Residency –superseded by form CS17

Separate Child Health Insurance Program Non-Financial Eligibility – Residency	CS17
42 CFR 457.320	

Residency

The CHIP Agency provides CHIP to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

A child is considered to be a resident of the state under the following conditions:

A non-institutionalized child, if capable of indicating intent and who is emancipated or married, if the child is living in the state and:

1. Intends to reside in the state, including without a fixed address, or
2. Has entered the state with a job commitment or seeking employment, whether or not currently employed.

A non-institutionalized child not described above and a child who is not a ward of the state:

1. Residing in the state, with or without a fixed address, or
2. The state of residency of the parent or caretaker, in accordance with 42 CFR.435.403(h)(1), with whom the individual resides.

An institutionalized child, who is not a ward of the state, if the state is the state of residence of the child's custodial parent or caretaker at the time of placement, or

A child who is a ward of the state regardless of where the child lives, or

A child physically located in the state when there is a dispute with one or more states as to the child's actual state of residence.

If the state covers pregnant women, a pregnant woman is considered to be a resident under the following conditions:

A non-institutionalized pregnant woman who is living in the state and:

1. Intends to reside in the state, including without a fixed address, or if incapable of indicating intent, is living in the state, or
2. Entered with a job commitment or seeking employment, whether or not currently employed.

An institutionalized pregnant woman placed in an out-of-state-institution, as defined in 42 CFR 435.1010, including foster care homes, by an agency of the state, or

An institutionalized pregnant woman residing in an in-state-institution, as defined in 42 CFR 435.1010, whether or not the individual established residency in the state prior to entering the institution, or

A pregnant woman physically located in the state when there is a dispute with one or more states as to the pregnant woman's actual state of residence.

The state has in place related to the residency of children and pregnant women (if covered by the state): One or more interstate agreement(s). Yes No

A policy related to individuals in the state only for educational purposes Yes No

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:
A child must be uninsured at the date of eligibility for the CHIP program.

4.1.8 Duration of eligibility- refer to 4.1.9.2.

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:

Although eligibility is retroactive to date of CHIP application, if the client does not include selection of a CCO in mandatory managed care areas they are auto assigned to a CCO for OHP Plus coverage. This is the same as the current rule applied to OHP Medicaid non-categorical members. The twelve-month eligibility period for Healthy KidsConnect members begins on the date of application approval. Plan enrollment will be no earlier than the first of the month following eligibility approval. Enrollment in HKC plans is the first of the month following application approval, if application approval occurs on or before the 25th of the approval month. If application approval is the 26th or after in the approval month, enrollment will be the first of the next month.

The office of Private Health Partnerships (OPHP) is abolished effective 1/1/2014. Redeterminations and new applications received on or after 8/23/13 will be enrolled in OHP direct coverage. Children currently enrolled in Healthy KidsConnect with incomes above 200% up to and including 300% of FPL will be converted to CHIP direct coverage on or before 1/1/14.

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 Social Security number- superseded by ACA form CS19

Separate Child Health Insurance Program	
Non-Financial Eligibility - Social Security Number	CS19
42 CFR 457.340(b)	

Social Security Number

As a condition of eligibility, the CHIP Agency must require individuals who have a social security number or are eligible for one as determined by the Social Security Administration, to furnish their social security number, or numbers if they have more than one number.

- The CHIP Agency requires individuals, as a condition of eligibility, to furnish their social security number(s), with the following exceptions:
 - Individuals refusing to obtain a social security number (SSN) because of well established religious objections, or
 - Individuals who are not eligible for an SSN, or
 - Individuals who are issued an SSN only for a valid non-work purpose.
- The CHIP Agency assists individuals, who are required to provide their SSN, to apply for or obtain an SSN from the Social Security Administration if the individual does not have or forgot their SSN.
- The CHIP Agency informs individuals required to provide their SSN:
 - By what statutory authority the number is solicited; and
 - How the state will use the SSN.
- The CHIP Agency provides assurance that it will verify each SSN furnished by an applicant or beneficiary with the Social Security Administration, not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by the Social Security Administration and that the state's utilization of the SSNs is consistent with sections 205 and 1137 of the Social Security Act and the Privacy Act of 1974.

The state may request non-applicant household members to voluntarily provide their SSN, if the state meets the requirements below.

The state requests non-applicant household members to voluntarily provide their SSN. Yes No

- When requesting an SSN for non-applicant household members, the state assures that:
 - At the time such SSN is requested, the state informs the non-applicant that this information is voluntary and provides information regarding how the SSN will be used; and

- The state only uses the SSN for determination of eligibility for CHIP or other insurance affordability programs, or for a purpose directly connected with the administration of the state plan

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

4.1.9.2 Continuous eligibility

Eligibility is for 12 continuous months, unless one of the following events occurs before the annual renewal: 1) moves out of state; 2) obtains other health insurance; 3) a child turns age 19; 4) the family requests cancellation; 5) the family applies for Medicaid and the child is determined eligible for Medicaid or 6) if the child is enrolled in a HKC plan and does not pay the premium. Families with HKC children will have a minimum 30 days to pay their portion of the premium before being disenrolled. People in HKC are billed by OPHP each month for their portion of the premium. OPHP combines the member’s portion with the subsidy and pays the insurance carrier. Individuals who fail to pay their premium will be disenrolled. Members are billed approximately 45 days in advance of the date premiums are due to the carrier. Members are provided a premium grace period of at least 30 days from the billing date. Reminder notices are mailed mid-way through this grace period. Subsidy cancellation notices outlining the program’s intent to terminate, are mailed at the end of the grace period. Terminated individuals can be reinstated on a one time exception basis. Once terminated for non payment of premium members are able to re-enroll in the program.. Eligibility is redetermined every twelve months for State Plan children . No limit to duration of eligibility if all conditions are met. The PC-Unborn population is eligible for CHIP benefits while in utero and redetermined at birth.

4.1.10 Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

Child Health Insurance Program
Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards CS27
Section 2101(f) of the ACA and 42 CFR 457.310(d)

Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

- The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be

subject to this provision.

- The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

- The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.
- The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.
- The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.
_____ % FPL
- The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.
- Other.

Describe the benefits provided to this population:

- This population will be provided the same benefits as are provided to children in the state's Medicaid program.

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.

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 other words, a State that chooses to cover pregnant women under this option must otherwise cover pregnant women under their State plan as described in 4.1.11. 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 and 4.1.1-LR Lawfully Residing Option

Separate Child Health Insurance Program	
Non-Financial Eligibility – Citizenship	CS18
Sections 2105(c)(9) and 2107(e)(1)(J) of the SSA and 42 CFR 457.320(b)(6), (c) and (d)	

Citizenship

The CHIP Agency provides CHIP eligibility to otherwise eligible citizens and nationals of the United States and certain non-citizens, including the time period during which they are provided with reasonable opportunity to submit verification of their citizenship, national status or satisfactory immigration status.

The CHIP Agency provides eligibility under the Plan to otherwise eligible individuals:
Who are citizens or nationals of the United States; or

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), and 1902(ee) of the Act, and 42 CFR 435.406, 407, 956 and 457.380.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation,

or the agency needs more time to complete the verification process.

Yes No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

The date benefits are furnished is:

The date of application containing the declaration of citizenship or immigration status.

The date the reasonable opportunity notice is sent.

Other date, as described:

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3).

Yes No

Otherwise eligible children means children meeting the eligibility requirements of targeted low-income children with the exception of non-citizen status.

The CHIP Agency provides assurance that lawfully residing children are also covered under the state's Medicaid program.

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible pregnant women, lawfully residing in the United States, as provided in Section 214 of CHIPRA 2009, P.L. 111-3. The state may not select this option unless the state also elects to cover lawfully residing children. A state may not select this option unless the state also covers Targeted Low- Income Pregnant Women.

Yes No

An individual is considered to be lawfully residing in the United States if he or she is lawfully present and meets state residency requirements.

An individual is considered to be lawfully present in the United States if he or she is:

1. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);
2. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));
3. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;
4. A non-citizen who belongs to one of the following classes:
 - (i) Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively;

- (ii) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;
 - (iii) Granted employment authorization under 8 CFR 274a.12(c);
 - (iv) Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;
 - (v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;
 - (vi) Granted Deferred Action status;
 - (vii) Granted an administrative stay of removal under 8 CFR 241;
 - (viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;
5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8

U.S.C.1231,or under the Convention Against Torture, who:

- (i) Has been granted employment authorization; or
 - (ii) Is under the age of 14 and has had an application pending for at least 180 days;
6. Has been granted withholding of removal under the Convention Against Torture;
7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C.1101(a)(27)(J);
8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).
10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

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.

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)

Separate Child Health Insurance Program	
General Eligibility - Eligibility Processing	CS24
See 4.4 below for details in form	

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)(4)) (42CFR, 457.305(b))

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)

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. **ELE is applied to initial eligibility determinations only.**

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

Express Lane agencies. The Supplemental Nutritional Assistance Program (SNAP) and selected Department of Education National School Lunch Programs (NSLP).

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.

SNAP:

The state will use SNAP income findings and apply this income to the child who is applying for medical. The state will use SNAP findings on verification of SSN and state residency. The state will verify citizenship.

The state allows child support income disregard of \$50 per child, up to \$200 for a family for medical eligibility determinations. Additionally, the state allows the federal earned income disregard of \$33. These disregards do not apply to SNAP. The state considers money from an assistance program withheld to repay an overpayment as available income in determining medical eligibility. SNAP excludes this

income. The state excludes the portion of a payment from the TANF program that is counted as disqualifying income in determining medical eligibility. SNAP does not exclude this income.

The state counts periodic income in the month it is received when determining eligibility for medical programs. SNAP gives clients the choice of either averaging the income over the applicable time period or to have the income counted in the month it is expected to be received.

For medical program determination, the state excludes the first \$30 of lump-sum income received by each family member each quarter. The state counts the amount that exceeds \$30 a quarter as countable income. SNAP excludes lump-sum income. For medical program determination, the state excludes the portion of adoption assistance that is for the special needs of a child. SNAP does not exclude the income.

Cash medical support is excluded by the state for medical program determination. SNAP counts the amount of cash medical support not used to reimburse an actual medical cost.

The state excludes the amount of charitable contributions used to assist with a client's medical expenses for medical eligibility determinations. SNAP counts charitable contributions that exceed \$300 a quarter.

In determining eligibility for medical, the state excludes the earned income of children up to age 19. SNAP counts the earned income of individuals age 18 and over.

Filing groups differ between SNAP and Medicaid/CHIP. For SNAP, filing groups may include anyone living in the same home who purchases and prepares food together. For Medicaid/CHIP, there must be specific relations (blood relationships/marriage).

The National School Lunch Program (NSLP):

The state will use the NSLP income findings and apply this income to the child who is applying for medical. The state will also use the NSLP findings for eligibility group size and residency. The state will then verify SSN and citizenship.

The state allows a child support income disregard of \$50 per child, up to \$200 for a family for medical eligibility determinations. Additionally, the state allows the federal earned income disregard of \$33. These disregards do not apply to the NSLP. Cash medical support is excluded by the state for medical program determination. NSLP counts cash medical support.

The state counts periodic income in the month income in the month it is received when determining eligibility for medical programs. NSLP does not count this income.

For medical program determination, the state excludes the first \$30 of lump-sum income received and counts the rest. NSLP does not count lump-sum income.

The state excludes the amount of charitable contributions used to assist with a client's medical expenses for medical eligibility determinations. NSLP counts charitable contributions.

In determining eligibility for medical, the state excludes the earned income of children up to age 19. NSLP counts this income.

The state excludes adoption assistance, while NSLP counts this income.

The state excludes the income of household members who are not related to children. NSLP counts the income of all household members.

The state excludes income of relatives who are not required to be in the eligibility group. NSLP counts the income of all household members.

The state counts the income of eligibility group members who are in the military and away only because they are deployed. NSLP counts only the income the service people send home.

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. See 4.4 below

4.3.4 MAGI-Based Income Methodologies

Separate Child Health Insurance Program MAGI-Based Income Methodologies	CS15
2102(b)(1)(B)(v) of the SSA and 42 CFR 457.315	

- The CHIP Agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups, as described below, and consistent with 42 CFR 457.315 and 435.603(b) through (i).

In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility, whichever is later.

If the state covers pregnant women, in determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted just as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size.
- Projected annual household income for the remaining months of the current calendar year and family size.

In determining current monthly or projected annual household income the state will use reasonable methods to:

- Include a prorated portion of the reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 457.315 and 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household. Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

- Yes No

The CHIP Agency certifies that it has submitted and received approval for the conversion for all separate CHIP covered group income standards to MAGI-equivalent standards.

- Yes No Attachment submitted.

4.3.5 Eligibility - Deemed Newborns

Separate Child Health Insurance Program Eligibility - Deemed Newborns	CS13
Section 2112(e) of the SSA and 42 CFR 457.360	

- Deemed Newborns** - Children born to targeted low-income pregnant women are deemed to have applied for and be eligible for CHIP or Medicaid until the child turns one.
- The state operates this covered group in accordance with the following provisions:
- The child was born to an eligible targeted low-income pregnant woman under section 2112 of the SSA.
 - The child is deemed to have applied for and been found eligible for CHIP or Medicaid, as appropriate, as of the date of the child's birth, and remains eligible without regard to changes in circumstances until the child's first birthday.

The state elects the following option(s):

- The state elects to cover as a deemed newborn a child born to a mother who is covered as a targeted low-income child under the state's separate CHIP on the date of the newborn's birth.
- The state elects to recognize a child's deemed newborn status from another state and provides benefits in accordance with the requirements of section 2112(e) of the SSA.
- The state elects to cover as a deemed newborn a child born to a mother who is covered under Medicaid or CHIP through the authority of the state's section 1115 demonstration on the date of the newborn's birth.

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.

Separate Child Health Insurance Program General Eligibility - Eligibility Processing	CS24
2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C	
<p><input checked="" type="checkbox"/> The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.</p> <p>Application Processing</p> <p>Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act. <input checked="" type="checkbox"/> An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act <div style="text-align: center; margin-top: 10px;"> <div style="border: 1px solid black; display: inline-block; padding: 5px 20px;">Attachment submitted</div> </div>	

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Separate Child Health Insurance Program		
General Eligibility - Eligibility Processing	CS24	
2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C		
<p><input checked="" type="checkbox"/> An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.</p> <p style="text-align: center;"><table border="1"><tr><td>Attachment submitted</td></tr></table></p> <p><input checked="" type="checkbox"/> The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.</p> <p>The agency accepts applications in the following other electronic means.</p> <p><input type="checkbox"/> Other electronic means:</p> <p>Screen and Enroll Process</p> <p><input checked="" type="checkbox"/> The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.</p> <p>Procedures include:</p> <p><input checked="" type="checkbox"/> Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and</p> <p><input checked="" type="checkbox"/> Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and</p> <p><input checked="" type="checkbox"/> Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.</p> <p>The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA.</p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>		Attachment submitted
Attachment submitted		

Separate Child Health Insurance Program	
General Eligibility - Eligibility Processing	CS24
2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C	
<p>Redetermination Processing</p> <p><input checked="" type="checkbox"/> Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Once every 12 months. <input checked="" type="checkbox"/> Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. <input checked="" type="checkbox"/> If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available. <p>Screening by Other Insurance Affordability Programs</p> <p><input type="checkbox"/> The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.</p> <p><input checked="" type="checkbox"/> The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.</p> <p>Check all types of agencies that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> The Exchange <input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> Other agency administering insurance affordability programs <p><input checked="" type="checkbox"/> The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.</p>	

- 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))
See 4.4.1 above

- 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)).

Presumptive Eligibility for Children-Hospital

Separate Child Health Insurance Program	
General Eligibility - Presumptive Eligibility for Children	CS28
42 CFR 457.355 and 435.1102, 2107(e)(1)(L) and 1920A of the SSA	

The CHIP Agency covers children when determined presumptively eligible by a qualified entity.
 Yes No

- Describe the population of children to whom presumptive eligibility applies:
Targeted Low-income Children (2102(b)(1)(B)(v) of the SSA and 42 CFR 457.310, 315 and 320).

- Describe the duration of the presumptive eligibility period and any limitations:
The presumptive period begins on the date the determination is made. The end date of the presumptive period is the earlier of: The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

- Describe the application process and eligibility determination factors used:
The Hospital is responsible for making immediate eligibility determinations that: Are initiated using the OHA Hospital Presumptive Medical application (OHP 7260) and are based only on information provided by the applicant or his/her representative in Part 1 of the OHP 7260. No additional documentation or verification may be required at the time of the Hospital Presumptive Medical eligibility determination. Information required in order for the hospital to make the determinations are: Applicant's full legal name; Household's gross monthly income and size; citizenship; state residency; and previous period of Hospital Presumptive Medical Assistance.

- Describe the application process and eligibility determination factors used(Cont):

At the time of the presumptive determination, the Hospital gives the applicant immediate written notice of whether s/he is eligible, or ineligible, for Hospital Presumptive Medical coverage.

Within 2 working days of each Hospital Presumptive Medical eligibility determination, the Hospital is responsible for submitting the a copy of the completed Approval or Denial Notice issued to the applicant, and A copy of the applicant’s completed Hospital Presumptive Medical application to OHP Customer Service.

- The CHIP Agency covers children when determined presumptively eligible by a qualified entity.

Separate Child Health Insurance Program General Eligibility - List of Qualified Entities	CS30
42 CFR 457.355 and 435.1102, 2107(e)(1)(L) and 1920A of the SSA	

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual’s household income and other requirements, and that meets at least one of the following requirements. Select the types of entities used to determine presumptive eligibility:

- Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan.
- Is authorized to determine a child’s eligibility to participate in a Head Start program under the Head Start.
- Is authorized to determine a child’s eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990.
- Is authorized to determine a child’s eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants, and Children (WIC) under section 17 of the Child Nutrition Act of 1966.
- Is authorized to determine a child’s eligibility under the Medicaid state plan or for child health assistance under the Children’s Health Insurance Program (CHIP).
- Is authorized to determine a child’s eligibility under the Medicaid state plan or for child health assistance under the Children’s Health Insurance Program (CHIP).
- Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801).
- Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs Is a state or Tribal child support enforcement agency under title IV-D of the Act.

- Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act.
- Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act.
- Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- Any other entity the state so deems, as approved by the Secretary

Name of entity	Description
A qualified hospital	A qualified hospital is a hospital that: Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures. Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

- The CHIP Agency assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

Attachment submitted Yes No

- 4.4.4.** the insurance provided under the State child health plan does not substitute for coverage under group health plans; states should check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR, 457.805) (42CFR 457.810(a)-(c))

OHA has specific measures to prevent the clients from substituting CHIP coverage for group health coverage. The first measure is that persons covered by private health insurance are not eligible for benefits under CHIP.

7.2.2

OHA requires that insurance information on the persons seeking medical assistance coverage be provided on the application for CHIP as a measure to avoid substitution for group health coverage. OHA enrollees' TPR information is maintained in the MMIS system. In addition to self reported insurance information, the OHP Central Processing Center receives TPR insurance information from providers which is verified by Central Processing staff. Eligibility staff also reviews pay stub information that may also indicate whether dependent health insurance is being deducted from the employee paycheck. The State monitors substitution under its Quality Control and Quality Assurance process to analyze the extent to which an applicant drops other health plan coverage. Trends are monitored to ensure that the policy is consistently applied throughout the program.

Targeted, low-income children of employees of the State of Oregon, who are eligible for employer sponsored insurance benefits, are not eligible for CHIP coverage since the State provides coverage of dependents.

The OHP Central Processing Center conducts standardized audits on an ongoing basis to review eligibility determinations to ensure that children who are Medicaid eligible, or who have private coverage are not enrolled in CHIP. The Quality Assurance Unit at OHP Central Processing conducts random audits on an ongoing basis of eligibility determinations to monitor the integrity of determinations. All eligibility elements are reviewed during this process, including assessment of the client's access to TPR and the substitution of coverage.

The Authority will conduct a biennial review of the Oregon Health Insurance Survey (OHIS) which looks at if a person was uninsured at the time of the interview, (there are questions asked about type of previous coverage, why their coverage ended, and how long they have been without coverage). Determine the percent of enrollees who dropped group health insurance without good cause in order to gain eligibility for CHP. If substitution exceeds 10 %, OHA will collaborate with CMS to identify a strategy to reduce substitution.

- 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.**

- 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))

Targeted low-income children who are American Indian or Alaska Native are subject to the same eligibility determination protocol as other targeted low-income children. Due to the unique characteristics of this population, DMAP works with representatives of the tribes in the state through the American Indian/Alaska Native Forum and the N.W. Portland Area Indian Health Board (PAIHB) to develop outreach protocols that specifically target low income children in the state who are American Indians or Alaska Natives. Representatives of the Oregon Health Authority meet quarterly with representatives of the nine federally recognized tribes in the state, the PAIHB and the Portland Indian Health Service. CHIP has been and continues to be a recurring agenda item at these meetings. CHIP policy will mirror OHP Medicaid policy for children in the state who are American Indians or Alaska Natives. Children of recognized Indian heritage will not be required to enroll in managed care and may receive services on a FFS basis, if they choose. Options for tribal participation in CHIP are open. There is a possibility of future Title XXI State Plan amendments if the tribes decide they want to do something different for their children.

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.

FPL equals 163% for all children

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):
As part of the outreach effort, the Oregon Health Authority plan to conduct a number of training sessions across the state. These training sessions focus on getting timely and accurate information about Healthy Kids into the hands of local community partners who have extensive contact with clients. Activities will target children eligible as the result of covering higher income levels, but also attempt to reach children at lower income levels who are eligible for but not enrolled in current programs. The Oregon Health Authority, Department of Human Services or Cover Oregon will develop and distribute educational materials for parents that focus on the importance of obtaining health coverage for their children and receiving preventive services

Children from birth to age 6 with family incomes less than 133% of the federal poverty level (FPL) and children 6-18 with family incomes up to 133% of the FPL are eligible for coverage under the Oregon Health Plan Medicaid Demonstration.

OHP Medicaid and CHIP applications and application assistance are available at the 64 DHS Children, Adults and Families Division (CAF) branch offices throughout the state and at 56 Aged and Physically Disabled field offices. A well-publicized 800 number to the OHP Medicaid/CHIP Application Center is also available. The Application Center mails applications on request and helps callers in completing OHP applications and related forms. Applications may also be obtained and submitted on line via the Internet, through outreach locations at FQHCs, Tribal health clinics, DSH hospitals, Healthy Start, local health departments and Certified Application Assistance Organizations. Brochures outlining the services and eligibility requirements and containing the Application Center toll-free number and Web address are widely available in provider offices, libraries and other community distribution points throughout the state. The toll-free number for the Application

Center also appears in the white pages of telephone directories throughout the state. Information about OHP Medicaid/CHIP services, eligibility requirements and processes is also available on the DMAP website.

Express Lane Eligibility:

OHA and DHS utilizes designated agencies (SNAP and NSLP) in order to provide a simplified eligibility determination process and expedited enrollment of eligible children in Medicaid and CHIP.

VISTA Health Links Project

VISTA volunteers work in many counties throughout the state. As a part of their activities to ensure public health systems and programs work well together for the women and children they serve, these volunteers provide clients assistance and information on the Oregon Health Plan, immunizations, prenatal care and other health issues/concerns. The WIC program has the broadest client base of the VISTA Health Links partner programs, and is often the gateway service for women and children. Therefore, a good deal of the VISTA Health Links Project focus is around developing outreach efforts and systems to promote immunizations, OHP registration and early prenatal care access among WIC clients.

Community-Based Application Assistance Project

This program, started in January 1998, allows local health departments, Disproportionate Share Hospitals (DSH), Federally Qualified Health Centers (FQHC) and Tribal Health Clinics to distribute OHP Medicaid/CHIP applications and to give on-site assistance with completion of the OHP application for children, pregnant women and their families. Currently DMAP has 200 outreach sites located throughout the state.

Hospital Hold-CHIP OHP Plus

If an uninsured patient is admitted to a hospital, the hospital may fax a Hospital Hold form for the patient to the OHP Medicaid/CHIP Application Center within 24 hours of the admission, or by the next working day. The intent of this program is to allow people who receive care in a hospital (inpatient only) to secure a date of request for the Medicaid/CHIP program application although they cannot physically reach a phone or a DHS branch. An OHP Medicaid/CHIP application is sent to the patient. For those who complete and return the application and are determined eligible for OHP Medicaid or CHIP, their eligibility is retroactive to the date of request. The original date of request is honored if the application is received within 45 days from the date of request.

SAFENET

SAFENET is a community partnership program that provides a statewide toll free information/referral phone line for Oregonians. It is the state's Maternal and Child

Health (MCH) hotline, designed to link low-income Oregon residents with health care services within their communities, including information on the Oregon Health Plan.

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:

n/a

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))

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) and 2102(c)(2) and 2102(b)(3)(E))(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 described in Section 5.2.

Oregon conducts the following activities to coordinate the Title V Maternal Child Health Program with OHP-CHIP:

The Child Development and Rehabilitation Center (CDRC) administers the Oregon Services to Children with Special Health Needs (OSCSHN) Title V Program at the Oregon Health and Sciences University (OHSU). The OSCSHN Financial Assistance Program provides financial assistance to families who meet the financial eligibility criteria at three times the federal poverty level and whose child has a qualifying medical diagnosis. Financial counselors screen families to determine program eligibility and make referrals to OHP including Medicaid or CHIP when appropriate. OSCSHN staff, conduct follow-up calls to families referred to the OHP to determine the status of applications and to provide

assistance when needed. This effort has resulted in more families qualifying for benefits and cost savings to the OSCSHN budget.

The OHA Public Health Division, Office of Family Health Services (OFHS) serves as the state Title V Agency and continues to work closely with DMAP. The OFHS maintains an agreement with DMAP for a community immunization program and to purchase vaccines for children enrolled in CHIP, for joint management of the Section 1115 Demonstration Family Planning Expansion Project, and for the MCH Hotline, SafeNet, which is contracted to the Multnomah County Health Department. Other coordination efforts include lead screening, preschool and adolescent immunization, vaccines for children, school based health centers, Oregon MothersCare, Babies First and CaCoon.

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.

Express Lane Eligibility agencies include The Department of Human Services, Supplemental Nutritional Assistance Program (SNAP) and the Department of Education, selected districts, through the National School Lunch Program (NSLP).

OHA will use SNAP income findings and apply this income to the child who is applying for medical. The state will use SNAP findings on verification of SSN and state residency. The state will then verify citizenship.

The State Department of Education prepares the application form that all schools use for NSLP Each school district will then send DHS a list of children that are found eligible for free and reduced lunch whose parents did not ‘opt-out’ and who indicated the child does not have any kind of health coverage”. DHS will then send “Express Lane” applications for health coverage to the identified families, requesting additional information. The additional information requested of families includes the names, genders, social security numbers, dates of birth, citizenship status, tribal information, availability of other insurance, disabilities, absent parent information, and managed care information for everyone applying. Applications that are returned will be processed to determine eligibility using regular methodologies including verification of citizenship. The Department will use the NSLP findings for income and household composition for initial eligibility determinations for children. The NSLP will send the Department households’ income and household group size. The Department will send the households shortened applications, and when the applications are returned, the NSLP findings of income and eligibility group size will be used to determine eligibility for children.

The Express Lane option will be applied to initial determinations only.

5.3 Strategies

Guidance: 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) 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.

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.

Outreach for CHIP will be incorporated into existing OHP Medicaid outreach activities, including:

- ◆ VISTA Health Links;
- ◆ DSHs Hospitals, FQHCs and tribal health clinics local health departments.
- ◆ Hospital hold;
- ◆ SAFENET;
- ◆ Outreach through Healthy Start.

Programs above are described in more detail in Section 5.1.1

Application Assistance:

To help more children, teens, individuals, and families in Oregon to get and maintain health insurance, the Oregon Health Authority (OHA) and Cover Oregon (Oregon’s Insurance Exchange) joined forces to administer a community partner program. Through the program, trained community partners (application assisters) will provide education and outreach and help children, teens, and families enroll in public programs and commercial insurance plans available through Cover Oregon. Grant opportunities will be available to interested organizations.

The types of organizations that can be a grantee are health advocacy groups, cultural specific organizations, Faith based groups, community based organizations, community clinics, libraries, housing authorities, migrant organizations, etc. There will be a competitive bid process as grant opportunities are available to any organizations that qualify to participate.

OHA will also work with community partners that don’t receive grant funding directly from the initiative, including local governments, hospitals, coalitions, etc. Additionally, provider assisters that already provide application assistance through contracts with the Division of Medical Assistance Programs (DMAP). All grantee and volunteer agreements will include conflict of interest, privacy and security, enrollment assistance, and either cultural competency or equitable service standards.

OHA will target potential partnerships with community-based organizations that are diverse and have expertise serving hard-to-reach, non-English speaking, geographically isolated, and underserved populations. Community partner organizations will:

- **Focus on conducting enrollment assistance and outreach to families accessing public and private health insurance coverage in the individual market;**
- **Develop local outreach campaigns tied to the overall marketing effort;**
- **Offer consumer assistance with all aspects of eligibility, enrollment, appeals, and renewals;**
- **Contribute to the overall consumer experience;**
- **Collaborate with other community partners as well as insurance agents, and;**
- **Address misconceptions in local communities about public and private programs and the ACA**

Community partner organizations may have staff and/or volunteers trained as application assisters. Application assisters will lead individuals and families through the entire process of eligibility and enrollment for public and private health coverage. “Application Assister” encompasses what the Affordable Care Act and other states refer to as navigators, in-person assisters, and application counselors. All application assisters must attend training and pass a certification exam. Additionally, application assisters must:

- **Be covered by the organization’s general liability and automobile insurance,**
- **Pass a criminal background check,**
- **Complete an online pre-requisite Cover Oregon overview,**
- **Attend enrollment assistance training annually, and**
- **Pass an annual certification exam.**

Grantees will target geographic areas with high rates of eligible but un-enrolled children, teens, individual, and families including rural areas; racial, ethnic and language minority communities and populations with additional barriers to accessing health insurance, such as those with physical, cognitive, sensory or mental disabilities or chemical dependency and those experiencing homelessness. Grant funds are intended for staff time, local travel, and other expenses necessary to reach and provide assistance to children, teens, individuals, and families. OHA will provide technical assistance and training, publications and other promotional materials.

Outreach and Enrollment Grants:

The Targeted Outreach and Enrollment Grant Program is designed to provide culturally-specific and targeted outreach and direct application assistance to aid families in racial, ethnic and language minority communities, living in geographic isolation or with additional access barriers to enroll their children into the Healthy Kids program. The Outreach and Enrollment Grantee will target geographic areas with high rates of eligible but unenrolled children, including rural areas; racial, ethnic and language minority communities and populations with additional barriers to accessing health care, such as those with physical, cognitive, sensory or mental disabilities or chemical dependency and those experiencing homelessness. Grant funds are intended for staff

time, local travel, and other expenses necessary to reach and provide assistance to targeted families with children. OHA will provide technical assistance and training, publications and other promotional materials

The targeted Outreach and Enrollment Grant program will provide funding opportunities to community organizations that apply and are selected for an award. The funds must be used for activities that will lead to enrollment of children into the Oregon Health Plan for both Medicaid and CHIP. Activities funded may include, but are not limited to, community education, application assistance, and participation in community events. Outreach grants will be awarded to community organizations specifically targeting enrollment of children in racial, ethnic and language minority communities; living in geographic isolation; and/or with additional barriers to accessing health care, such as those with physical, cognitive, sensory or mental disabilities or chemical dependency; and those experiencing homelessness.

The criteria used to award an outreach and enrollment grant are:

- (1) Ability to Target geographic areas with high rates of eligible but unenrolled children, including rural areas; racial, ethnic and language minority communities and populations with additional barriers to accessing health care, such as those with physical, cognitive, sensory or mental disabilities or chemical dependency and those experiencing homelessness;**
- (2) Demonstrate that they have access to, and credibility with, target populations; and**
- (3) Demonstrate that they have the ability to address barriers to enrollment, such as a lack of awareness, stigma concerns and punitive fears or cultural barriers.**
- (4) Are not currently a CAAO participating in the AAP.**

Outreach and Enrollment Grants will begin effective upon CMS approval on or after October 1, 2009. The grant will be for the balance of state fiscal year 2010 and renewable for a second year, based on performance. Grants will range from \$20,000 to \$80,000 a year. We anticipate awarding approximately 20 to 40 grants in the first biennium. Each grantee will have enrollment targets that they have proposed in their application and will have been approved by Office of Healthy Kids. Grantees will be required to provide monthly reports on their progress. Fund disbursement will be contingent upon demonstrating progress toward their goals. The Office of Healthy Kids will be fully staffed with at least one FTE monitoring their progress and providing technical assistance.

Outreach and Enrollment Grant agreement statement of work includes, but is not limited to: Identifying its target population(s);

- Distributing OHA-approved promotional, educational and marketing materials to its targeted population**
- Completing application assistance training, provided by OHA;**
- Participating in meetings and conferences as requested by OHA;**
- Assisting its targeted population in completing the enrollment process into the Healthy Kids program, in accordance with the application assistance training;**

- Collaborating with local community organizations and establishing information-sharing processes as needed.
- Submitting its progress to OHA on monthly and annual basis according to reporting requirements specified by OHA, including the number of families contacted and the number of children enrolled successfully;
- Conducting outreach that is results driven and connected to actual enrollment and retention of children; and
- Developing strategies to overcome barriers that families in the target population may have, and establishing relationships of trust to effectively support enrollment;

Express Lane Eligibility:

The OHA utilizes SNAP and NSLP as indicated in section 1.4 in order to provide a simplified eligibility determination process and expedited enrollment of eligible children in Medicaid and CHIP. For initial determinations the Department will utilize income findings from these designated agencies to automatically enroll children in Healthy Kids if they meet the other eligibility criteria. Families will be contacted by phone and children will be enrolled if their parents give verbal or written approval.

The OHA has ongoing outreach activities as indicated above, to increase enrollment for the health kids programs and have worked with the Department of Education and statewide education organizations to facilitate the express lane eligibility through the NSLP. Agency staff has been trained and will have access to ongoing training.

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.)

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.)

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.)

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.

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 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

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

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

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

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

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)

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)

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)

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)

- 6.2.1. Inpatient services (Section 2110(a)(1))
6.2.2. Outpatient services (Section 2110(a)(2))
6.2.3. Physician services (Section 2110(a)(3))
6.2.4. Surgical services (Section 2110(a)(4))
6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
6.2.6. Prescription drugs (Section 2110(a)(6))
6.2.7. Over-the-counter medications (Section 2110(a)(7))
6.2.8. Laboratory and radiological services (Section 2110(a)(8))
6.2.9. Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
6.2.10. Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section

- 2110(a)(10))
- 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))

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 (See instructions) (Section 2110(a)(14))

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))
- 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))
**** state only funded abortion services are available to CHIP OHP Plus .**
- 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)
- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. Hospice care (Section 2110(a)(23))

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. (See instructions) (Section 2110(a)(24))
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))

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 (See instructions) (Section 2110(a)(27))
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

6.2. *Applicable for Unborn population only- When any grouping below is provided only if medically necessary and/or limited to emergency for the Unborn population it is identified with *L/MN. Services for the Unborn population are the same benefits, regardless of county, (subject to section 4.1.8) as identified in items 6.2.1 through 6.2.28.

- 6.2.1. Inpatient services (Section 2110(a)(1))
- 6.2.2. Outpatient services (Section 2110(a)(2))
- 6.2.3. Physician services (Section 2110(a)(3))
- 6.2.4. Surgical service (Section 2110(a)(4)) *L/MN
- 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. Prescription drugs (Section 2110(a)(6))
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12)) *L/MN
- 6.2.13. Disposable medical supplies (Section 2110(a)(13)) *L/MN

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 (See instructions) (Section 2110(a)(14))

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))

6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))

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

6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18)) *L/MN

6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19)) *L/MN

6.2.20. Case management services (Section 2110(a)(20))

6.2.21. Care coordination services (Section 2110(a)(21))

6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22)) *L/MN

6.2.23. Hospice care (Section 2110(a)(23))

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. (See instructions) (Section 2110(a)(24)) *L/MN

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

6.2.26. Medical transportation (Section 2110(a)(26)) *L/MN

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 (See instructions) (Section 2110(a)(27))

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

6.2-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 (CDT¹) 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

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)

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 CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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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)Page - 11 – State Health Official

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)

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 2103(a)(5). 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. Previously 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 (Section 2103(f)). Describe: Previously 8.6

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% 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))

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))

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% 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% 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))

Guidance: Check 6.6.2.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)

- 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.

- 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))

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

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

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).

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.

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

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).

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

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).

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).

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)).

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))

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.

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.

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.

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)).

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

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.)

For CHIP OHP Plus, DMAP contracted coordinated care organizations results of consumer satisfaction surveys, EQRO and site review identify areas that need system improvements in quality of or access to care. DMAP measures well-baby care/child/adolescent care and childhood immunizations through the use of HEDIS performance measures. The results of these measures are reported by FCHP, as well as fee-for-service. In addition, access to primary care provider and measures of early childhood cavities prevention efforts are measured.

Health KidsConnect private option plans are licensed and regulated by the Department of Consumer and Business Services (DCBS), Oregon’s insurance division. The regulations for Health insurers require the carriers to report annually to DCBS on grievance and appeals, utilization review policies, quality assessments activities and health promotion and disease prevention activities, including a summary of screening and prevention health care activities covered by the insurer, as well as the scope of the insurers network and to the accessibility of services. Health insurers measure well-baby care/child/adolescent care and childhood immunizations through the use of HEDIS performance measures.

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
 - 7.1.2 (a) CHIPRA Quality Core Set
 - 7.1.2 (b) Other
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

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))

CHIP OHP Plus: CHIP services will be provided through Oregon’s existing OHP Medicaid Demonstration delivery system. The managed care plans are contracted directly with DMAP (described in Section 3.1). Since 1994, health plans that contract with the state to provide Title XIX services have been required to adhere to established quality assurance methods and protocols. As the state of the art of managed care quality assurance has changed and become more sophisticated, so have Oregon’s requirements for plan participation. Activities of the OHP Medicaid Demonstration quality improvement program extend to CHIP OHP Plus coverage. This assures CHIP OHP Plus members will receive the same quality of care and access to care currently provided to OHP Medicaid members. Specific studies of the quality of care and access to care of CHIP OHP Plus members are conducted within the context of ongoing DMAP quality improvement and evaluation efforts. As described in DMAPs Oregon Health Plan Administrative Rules and the General Rules, Coordinated Care Organizations (CCOs) that contract with DMAP must meet specific mandatory obligations designed to assure quality, medically appropriate care for all OHP enrollees. The data specifications and reporting requirements outlined in the Rules are consistent with CMS’s quality initiatives for Medicaid managed care. All services provided to children enrolled in Oregon’s CHIP OHP Plus program will meet the same standards of quality assurance and medically appropriate care as currently provided by OHP Medicaid. With respect to health care delivery systems, DMAP has many contractual requirements for plan participation. PHPs must meet various quality assurance reporting requirements, including the following:

Reporting Area Quality Assurance Requirement

Plan Infrastructure and Management

Solvency plan and financial reporting

- ◆ **Medical and dental record keeping system**
- ◆ **Utilization control requirements and review procedures**

- ◆ **Credentialing and recredentialing procedures**
- ◆ **Information materials for the orientation of new members and the continuing education of existing members**
- ◆ **Provider compensation and turnover rates**

Access/Availability Utilization of Medically Appropriate Covered Services, including:

- ◆ **Inpatient/Outpatient care;**
- ◆ **Maternity and newborn care;**
- ◆ **Ambulatory care;**
- ◆ **Preventive care; and**
- ◆ **Emergency services**
- ◆ **Sufficient quantity of providers to ensure adequate capacity**
- ◆ **24-hour-a-day, 7-day-a-week emergency and urgent care services**
- ◆ **Language and transportation services**
- ◆ **Medical Case Management services**
- ◆ **ADA compliant physical access to facilities and providers**
- ◆ **Community Standards governing scheduling, rescheduling and waiting time for scheduled appointments**
- ◆ **Client Referral system**

Reporting Area Quality Assurance Requirement

Quality of Care

- ◆ **Documented policies and procedures for member care**
- ◆ **External review of policies and procedures relating to member care and medical record review for quality of care**
- ◆ **Internal Quality Assurance and Quality Improvement programs based on written policies, standards and procedures**
- ◆ **Quality assurance committee structure and membership guidelines**

Member Rights

- ◆ **Due process rights; including a formal complaints and hearings process**
- ◆ **Rights to informed consent**
- ◆ **Rights to treatment with dignity and respect**
- ◆ **Other processes establishing and maintaining rights to adequate medical care**

Clinical Measures and Utilization

The Health Plan Employers Data Information Set (HEDIS) and statewide goals described in Oregon Shines II, the state's 20-year strategic plan, serves as the basis on which CHIP OHP Plus health care is assessed for quality and appropriateness of care. DMAP collects the following health measures specific to the population of OHP clients under 19 years of age:

- ◆ Access to Primary Care Provider
- ◆ Childhood Immunizations
- ◆ Well-Baby, Child and Adolescent Visits
- ◆ Annual dental visit

Over 85 percent of CHIP OHP Plus children are enrolled in managed care. DMAP evaluates and monitors the measures listed above for each health plan. These measures are used as part of our periodic on-site reviews of each health plan to promote access to necessary services. DMAP does not currently sanction plans for not meeting minimum performance levels for these measures. However, DMAP has both a Quality Improvement Coordinator and a coordinated care organization coordinator assigned to each plan to monitor access to services and performance on these critical indicators. If problems are encountered, these staff members work with the health plans to establish and monitor corrective action plans in order to achieve acceptable performance.

Contracted health plans are required to have written policies and procedures and monitoring systems that provide for emergency and urgent services for all DMAP Members on a 24-hour, 7-day-a-week basis.

Contracted health plans are required to have written policies, procedures and monitoring systems that ensure the provision of Case Management Services for all OHP clients, to coordinate and manage services, and to ensure that referrals made are noted in the patient's clinical record. Plans are required to develop and maintain a formal referral system consisting of a network of consultation and referral providers, including applicable Alternative Care Settings, for all services covered by agreements with OHA. Health plans must ensure that access to and quality of care provided in all referral settings is monitored.

Other Efforts to Improve Quality of and Access to OHP Services:

Quality

DMAP coordinates the activities of the OHAs' Oregon Health Plan Quality Improvement Committee (OHPQIC). The OHPQIC is responsible for advising and guiding the quality improvement efforts of all administrative components of the OHP and will serve a similar role in assessing the CHIP OHP Plus. The overall mechanism for quality improvement, administered by DMAP requires PHPs to have an active Quality Improvement Process (QIP) in place and integrated with other management functions. QIP performance is evaluated annually and involves review against standards in the following areas:

- ◆ Member Care is measured against current, relevant, criteria for care.
- ◆ Medical and Dental Records are reviewed for structure and completeness.

- ◆ **Quality Improvement Program Policies and Standards are reviewed and refined to meet changing conditions and needs.**
- ◆ **Comorbidities and Special Needs are reviewed before denial of a service and review of notices of denials.**
- ◆ **Member Access to Service and Utilization of Service is evaluated by site examination of PHP policies and practices and encounter data claim validation.**
- ◆ **Member Educational Plans and Provider Information are evaluated by site examination of PHP policies, practices and materials.**
- ◆ **Preventive care, adequacy of medical or dental record keeping;**
- ◆ **Operation and outcome of referral procedures;**
- ◆ **Medication reviews;**
- ◆ **Appointment systems;**
- ◆ **After-hours call-in system;**
- ◆ **Emergency services;**
- ◆ **Denials of service;**
- ◆ **PHP-initiated disenrollments;**
- ◆ **The access plan and out-of-plan access;**
- ◆ **Encounter data management; and**
- ◆ **Timeliness and appropriateness of referrals.**
- ◆ **DMAP also reviews for compliance with its Administrative Rules which set standards for access, provider credentialing and other structural measures of quality.**

Oregon's PHPs have adopted selected elements of NCQA standards as the basis for their quality improvement programs, credentialing systems, record keeping, and utilization review. DMAP also contracts with an External Quality Review Organization (EQRO) for medical record review of a representative sample of OHP Medicaid clients to determine the quality of care they receive. Recent EQRO studies include prenatal care, diabetes management and depression.

Access and Member Satisfaction

DMAP conducts surveys of members to determine satisfaction with access to medical services in terms of distance and appointment availability. Americans with Disabilities Act (ADA) access is reviewed in the survey of adult populations and children's access to service with the children's form of the Consumer Assessment of Health Plans Study (CAHPS) survey. Oregon has established a biennial member satisfaction survey using the nationally standardized CAHPS instrument to assess members experiences of access, satisfaction, and system performance.

Quality Assurance and Utilization Review

Oregon has built on the successful design, implementation, and improvement of the OHP Quality Improvement Program for CHIP OHP Plus. PHPs monitor the

quality of care using a number of aspects of care, including outcomes of selected procedures. Each PHP is responsible for the maintenance of the organizational and methodological structures (such as Quality Improvement Committees and reviews of adverse events) necessary to ensure the quality and appropriateness of care.

Preventive Care

Oregon's emphasis on primary prevention is best demonstrated through the activities of Project: PREVENTION! a management and quality initiative developed by DMAP in the Spring of 1996 in partnership with the Public Health Division and the OHP managed care plans. The goal of Project: PREVENTION! is to assure the presence and effectiveness of preventive health care services for OHP clients. A task force identified and recommended appropriate preventive health practice measures for individual plans to target and accelerate. In addition, Project: PREVENTION! developed a joint-venture partnership with OHP plans, the Public Health Division, non-OHP plans and county health departments on one unified statewide measure, an electronic pediatric immunization registry, Immunization ALERT. Immunization ALERT is a comprehensive immunization registry designed to give providers access to current and complete childhood immunization records despite changes in family residence, health insurance and choice of health provider if the child remains in Oregon.

Project: PREVENTION! supports a statewide tobacco cessation effort that involves partnership with medical and dental managed care plans, the Public Health Division and the Tobacco Free Coalition of Oregon. Central to the tobacco cessation project is the collective identification, education, and treatment of tobacco users. Medical and dental providers developed programs to help prevent children and adults from starting to use tobacco and have increased their efforts to help them quit. Project: PREVENTION! also adopted HEDIS technical standards for use in the measurement of childhood and adolescent immunization status, diabetes and asthma.

In 2001 Project: PREVENTION! adopted Early Childhood Cavities Prevention as the focus for prevention efforts. These efforts are ongoing with the FCHPs and DCOs.

- 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))

CHIP OHP Plus: CCOs that contract with DMAP are required to follow established rules concerning access and availability of covered services outlined in the Oregon Health Plan Administrative Rules under rule OAR 410-141-0220: Oregon Health Plan Prepaid Health Plan Accessibility. Requirements of this rule include:

- ◆ **Written policies and procedures that establish standards for access, capacity, risk assessment, interpreter services, and ADA compliant accommodation to ensure access to health care services to all OHP members**
- ◆ **Geographic proximity of facilities and appointment wait times as determined by the prevailing Community Standard**
- ◆ **Sufficient provider panels and networks to ensure adequate service capacity to provide availability of, and timely access to, medically appropriate services**
- ◆ **Professional expertise among providers to treat or otherwise accommodate the full range of medical, dental or mental health conditions experienced by OHP members**
- ◆ **Monitoring systems to assure access to services according to time standards as indicated by the nature of the appointment including:**
 - ◆ **Emergency care – Immediately for physical. Within 24 hours for dental, mental, or chemical dependency.**
 - ◆ **Urgent care – Within 48 hours for physical, mental or chemical dependency, as indicated. Within one to two weeks for dental.**
 - ◆ **Well Care, Routine, Preventive or Non-urgent – Within four weeks or the Community Standard for physical. Intake assessment for mental or chemical dependency within two weeks of patient request. Within twelve weeks for dental.**
- ◆ **Maintenance of 24-hour telephone coverage with a live operator (not a recording) guided by established standards pertaining to Primary Care Provider (PCP) call-back and back-up in the areas of:**
 - **Emergency, urgent, and routine issues**
 - **Internal Medicine, Family Practice, OB/Gyn, and Pediatrics**
 - **Interpretive services after office hours**

DMAP and the PHPs monitor all access issues from both the planning and implementation perspective. Regular reports, site inspections, internal and external audits, and consumer satisfaction surveys serve to validate the effectiveness and timeliness of access to covered medical services.

- 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))

CHIP OHP Plus: PHPs are required to assure access to the services they provide including: specialists, pharmacy, hospital, vision and ancillary services, as accessible to DMAP Members in terms of timeliness, amount, duration and scope as those services are to non-DMAP persons within the same service area. If the PHP is

unable to provide those services locally, it must so demonstrate to DMAP and provide reasonable alternatives for Members to access care that must be approved by DMAP. PHPs have a monitoring system that demonstrates to OHA, as applicable, that the plan has surveyed and monitored for equal access of DMAP Members to referral providers pharmacy, hospital, vision and ancillary services.

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.

CHIP OHP Plus: DMAP requires PHPs to make a determination on authorization requests within two working days of receipt of an authorization or reauthorization request related to urgent services; alcohol and drug services; and/or care required while in skilled nursing facility. Authorizations for prescription drugs must be completed and the pharmacy notified within 24 hours. If an authorization for a prescription cannot be completed within the 24 hours, the PHP must provide for the dispensing of at least a 72 hour supply if the medical need for the drug is immediate.

For all other pre-authorization requests, PHPs shall notify providers of an approval, a denial or a need for further information within 14 calendar working days of receipt of the request.

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% of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50-.59). For families with incomes of 150% of poverty and above, cost sharing for all children in the family cannot exceed 5% of a family's income per year. 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) &(c), 457.515(a)&(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) &(c), 457.515(a)&(c))

8.2.1. Premiums: None

8.2.2. Deductibles: **None**

8.2.3. Coinsurance or copayments:

8.2.4. Other:

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:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

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))

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))

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)

OHA will provide a PERC code to identify members of a Federally recognized Indian tribe. the carrier systems will be adjusted to ensure that the identified children pay no out of pocket costs or premiums subject to 42 CFR 457.535.

8.7 Non-Payment of Premiums—superseded by ACA form CS21

Separate Child Health Insurance Program	
Non-Financial Eligibility - Non-Payment of Premiums	CS21
42 CFR 457.570	

Non-Payment of Premiums

Does the state impose premiums or enrollment fees? Yes No

Guidance: Section 8.8.1 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. (42CFR 457.570(a))

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

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))

The strategic objective for Oregon’s Children’s Health Insurance Program (CHIP) is to expand coverage of the Oregon Health Plan (OHP) to include eligible low income children. The current OHP delivery system assures quality medical care to the Medicaid and CHIP population by removing financial barriers and providing access to inpatient, outpatient, primary and preventive health care services. Specific strategic objectives include:

Objective 1 Expand OHP eligibility rules to include uninsured children:

- **Birth through age 5. Living in households with gross income between 133% and 200% of the federal poverty level (FPL) .**

Age 6 through 18. Living in households with two months average gross income between 100% and 200% of the FPL.

Objective 2 Identify CHIP eligibles through coordinated and ongoing outreach activities.

Objective 3 Enroll CHIP eligibles in the OHP Plus, health care delivery system to assure a usual source of health care coverage.

Objective 4 Monitor access and utilization patterns among OHA CHIP OHP Plus enrollees.

Objective 5 Improve the health status of CHIP enrollees through provider and client programs specific to the needs of this population.

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))

The following performance goals and measures will be utilized to measure the effectiveness of Oregon’s identified strategic objectives for CHIP:

Performance Goals for Objective 1

Since July 1, 1998, the Division of Medical Assistance Programs (DMAP) has expanded the capacity of the OHP to meet the needs of 48,000 CHIP eligibles. DMAP’s data and operational systems are structured to accommodate CHIP criteria in the areas of eligibility determination, enrollment, client information, and utilization of health care services. OHA staff and field personnel have and continue to receive CHIP-related training.

Performance Goals for Objective 2

Since January 1, 1999, DMAP has developed and implemented outreach efforts among current Medicaid OHP channels to identify, enroll, and meet the health care needs of the CHIP population.

Performance Goals for Objective 3

As of May 2009, 48,000 low income children are enrolled in Oregon’s CHIP. They have access to a usual source of health care coverage in the form of a stable health care plan and a primary care provider (PCP).

Performance Goals for Objective 4

OHA CHIP enrollees are assigned a unique code that will enable DMAP analysts to distinguish CHIP clients from the OHP Medicaid population. DMAP monitors CHIP utilization patterns to help assure access to health care and the delivery of medically appropriate care.

Performance Goals for Objective 5

Health status and health care system measures for Oregon’s OHA CHIP program enrollees are collected and analyzed to demonstrate acceptable utilization in the following areas: access to a primary care provider, childhood immunization status, and well-child and -adolescent visits.

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))

Oregon's performance relative to its stated goals is objectively and independently verified through DMAP analysis of OHA CHIP population and utilization data. The ongoing analysis of data obtained through the Medicaid Management Information System (MMIS) is used to measure the state's progress toward its goals and objectives.

As previously noted, health plan oversight occurs as clinical data review, desktop medical chart audits, and on-site inspection of PHPs. Health plans are notified when areas of deficiency are discovered and of corrective actions needed. PHPs are required to give DMAP medical and dental service utilization reports, provider capacity reports and access to service statistics and various semiannual and annual financial reports. In addition to administering client satisfaction surveys, DMAP produces monthly enrollment reports, quarterly disenrollment reports and reports profiling the demographic characteristics of enrollees.

DMAP staff directly responsible for the implementation and monitoring of CHIP, continuously monitor program administration and take necessary action to ensure the program meets strategic objectives.

The Office for Oregon Health Policy and Research will analyze and evaluate CHIP OHP Plus expansion. The office will report on information using a variety of data sources including a statewide health insurance survey, program administrative data and other quantitative and qualitative data sources. Unless otherwise noted, the program will be evaluated annually.

- **Biennial estimates of the number of children who are eligible for but not enrolled in the program;**
- **The number of children enrolled in the program;**
- **The number of children disenrolled from the program;**
- **A description of any identified barriers to enrolling or maintaining enrollment of children in the program;**
- **The quality of care received using nationally accepted HEDIS measures for children;**
- **Biennial estimates of the number children voluntarily not enrolling in employer-sponsored health coverage and enroll in the program.**

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

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. Immunizations
 - 9.3.7.2. Well 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:
- 9.3.8. Performance measures for special targeted populations.

- 9.4. The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (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)

9.6. The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (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 insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Policy guidance for the development of Oregon's response to Title XXI includes substantial public comment and participation. The Oregon Legislature established the Oregon Health Council as the body responsible for providing a forum for public debate on the policy framework for the state's CHIP program. The Health Council is the policy-recommending body for health planning in the state. It consists of nine public members appointed by the Governor. The Health Council held a public hearing on Oregon's response to CHIP on October 18, 1997 in Salem, Oregon. At this meeting, approximately 30 interested parties, including consumers and consumer advocates, providers, managed care plans, insurance carriers, and educators, delivered testimony. Besides this focused, three-hour public hearing, the Health Council also solicited public comment at its regular meetings. At each of the

six Council meetings held September 1997 through January 1998, written and oral public comment about CHIP was provided and discussed. On January 15, 1998, there were four additional public hearings around the state; Portland and Eugene in the Willamette Valley, Medford in Southern Oregon, and Bend in Central Oregon. Approximately 70 additional parties presented testimony at these hearings. There were comments on general program policy issues.. Program staff then summarized this public input and presented to a joint meeting of the Health Council. Additional opportunities to receive public input around CHIP design and implementation have occurred and continue. A draft of the initial Title XXI State Plan document was circulated for comment internally to state agencies and externally to providers, consumer advocates, and to a broad array of other interested parties. When the original Title XXI State Plan was submitted to CMS, DMAP submitted a notice for publication in Oregon's major newspapers. All interested Oregonians were notified on how to obtain a copy of this document and had timely opportunity to comment on CHIP

Oregon Health Decisions conducted a series of approximately 200 meetings around the state. "Health Decisions '98" continued ongoing efforts by Oregon Health Decisions to engage Oregonians at the grass-roots level in a democratic approach to developing health policy. A similar series of "town hall meetings" in 1990 informed the setting of health service priorities by the Health Services Commission, information upon which they developed the Prioritized List of Health Services. A subsequent set of focus groups in 1995 addressed questions designed to identify the most sensible "next steps" for the Oregon Health Plan following implementation of the Medicaid expansion with benefits based on those priorities. "Health Decisions '98" focused on issues of how we finance health care, who ultimately pays for it, and how we can build more equity into the financing of health care while improving access and quality. As in the past with the Oregon Health Plan, public input on CHIP and more general health care policy questions is being used to inform debate, set policy, and develop concepts for program development and proposed legislation. Public comment is a continuing part of Oregon's design, implementation, and refinement of its CHIP program and other expansions of the Oregon Health Plan

- 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))
The Division engages Tribal consultation prior to submission of state plan amendments, waiver requests, proposed demonstration waivers, and rule-making likely to have a cost or direct impact on Oregon Native Americans, Indian Health Programs, or Urban Indian Organizations. To the extent practical and permitted by law, the state consults with Tribal governments as early as possible in the consultation process. This policy applies to the Children's Health Insurance Program in the same manner in which it applies to Medicaid.

A representative from the Division of Medical Assistance Programs attends quarterly “770” meetings to discuss proposed State Plan Amendments, waiver proposals or amendments, demonstration project proposals or amendments, and rule-making that may have a direct impact on American Indians and Tribal entities. Face-to-face consultation is the preferred method of communication and consultation prior to submission of documents to the Centers for Medicare and Medicaid Services. In the event a deadline is out of the control of the Division, the communication and consultation will be handled by mail distributed through the OHA Tribal Liaison to Tribal designees. A monthly written Division of Medical Assistance Program Update is also provided to the OHA Tribal Liaison, who forwards it to Tribal designees. This update includes the status of State Plan Amendments, waiver or demonstration project proposals or amendments, and rule filings.

- 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 CFR457.65(b) through (d).

Prior to an amendment being submitted, OHA coordinates with the Oregon Health Policy Committee and Tribal organizations, Medicaid Advisory Committee or Legislative Committees as appropriate. Oregon Administrative Rules are filed and at a minimum DMAP gives a public notice 45 days prior to any changes or closure of the program.

- 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.

The Division has a Tribal consultation policy. For SPA’s with no direct effect on tribes the Division notifies them of any upcoming SPA submission on items with no direct effect or for federal law changes with limited flexibility for implementation. Items with a direct effect on Tribes are discussed at the quarterly meeting with the Tribal organizations, HIS etc at a committee meeting call the “770 meeting”. The policy has been developed with the Tribal leaders in this committee and outlines how direct effect is determined what the procedures are for communication and timelines for notifications. For this specific SPA discussion were held at the tribal “770” committee meeting held in Bend, Oregon May 6, 2010 as well as an electronic summary distributed to the tribal contacts on July 21, 2010.

- 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)

See attached

- 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

CHIP Budget

STATE:	FFY Budget
Federal Fiscal Year	
State's enhanced FMAP rate	
Benefit Costs	
Insurance payments	
Managed care	
<i>per member/per month rate</i>	
Fee for Service	
Health Services Initiatives	
Cost of Proposed SPA changes	
Total Benefit Costs	
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	

Administration Costs	
Personnel	
General administration	
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Other	
Total Administration Costs	
10% Administrative Cap	
Federal Share	
State Share	
Total Costs of Approved CHIP Plan	

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds:

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 Specify that 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 items 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.
OHA CHIP applicants and members have the same rights as OHP Medicaid members with respect to eligibility and enrollment matters. Clients and applicants have a right to a timely, written, impartial external review through the administrative hearing process that complies with 42 CFR 457.1120.

Under Express Lane Eligibility when a child is found eligible for HKC which require premiums, the OHA sends a notice informing the client that the child may be eligible for

lower or no premiums using our regular eligibility methods. If a child were found to be ineligible using an ELE finding the OHA would do a full eligibility determination.

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 comply with 42 CFR 457.1120.

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.

Not applicable.

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.mcgregal@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 4 th 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
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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.