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

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides 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. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements, as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

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

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

State/Territory: **District of Columbia**
(Name of State/Territory)

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

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

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

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

Name: **Robert Maruca** Position/Title: **Senior Deputy Director, Medical Assistance Administration, Department of Health**

Name: **Deloris Shepard** Position/Title: **Chief Financial Officer, Department of Health**

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

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

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70):**

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☒ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. ☐ A combination of both of the above.

1.2 ☒ Please 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 ☒ Please 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)**

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date: **Initial plan October 1, 1998; as amended and updated, effective August 24, 2001; as amended and updated, effective February 1, 2007**

Implementation date: **Initial plan October 1, 1998; SPA No. 1 implemented August 24, 2001; SPA No. 2 implemented February 1, 2007**

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

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

Summary of District's Children Population

- Based upon adjusted Current Population Survey (CPS) data, there were an estimated 117,467 children under age 19 living in the District of Columbia. This number includes District residents and undocumented immigrants living in the District.

- According to the most recent Medicaid average monthly report, 70,492 (60.5 percent) of the approximately 117,467 children under age 19 living in the District are covered under Medicaid . The 2006 CPS indicates that 38,268 (32.8 percent) children are covered under an employer-sponsored plan or some other type of coverage, and about 8,543 children (7.3 percent) are uninsured. The CPS estimate for uninsured children excludes those children who are covered under Title XIX (Medicaid) and those who are currently covered under Title XXI (SCHIP). [1]

Summary of Data on Uninsured Children Living in the District

- CPS data shows that, of the 8,543 uninsured children under age 19 living in the District, approximately 38.6 percent are under age 5; 40.8 percent are between the ages of 6 and 14; and 20.6 percent are between the ages of 15 and 18. [1]

- About 56.7 percent of the 8,543 uninsured children under age 19 living in the District are reported as African-Americans and 36.7 percent are reported as white. The remaining 6.6 percent are reported as "other."

- Based upon estimates provided by the Bureau of the Census and the Immigration and Naturalization Service (INS), an estimated 53,144 undocumented immigrants live in the District of Columbia. Of the 53,144 undocumented immigrants living in the District, 4,226 are under age 19. Of the 4,226 undocumented immigrant children living in the District who are under age 19, about 1,465 would be CHIP-eligible "but for" their immigration status. Under federal law, these children are not eligible for either Medicaid or CHIP.

There is no reliable data on the number of legal immigrant children who have arrived in the District since the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (August 22, 1996). These children are statutorily ineligible for Medicaid for their first five years in the country. Thereafter, these children are eligible for Medicaid subject to (a) a state's option and (b) sponsor deeming rules.

Summary of Current Medicaid and SCHIP Enrollment

Under the District's current Medicaid eligibility rules, infants are eligible up to 200 percent of poverty level; children ages 1 through 5 are eligible up to 200 percent of the poverty level;, children ages 6 through 14 are eligible up to 200 percent of poverty level; and children ages 15 through 18 are eligible up to approximately 200 percent of poverty level.

- Of the 117,467 children under age 19 living in District, approximately 91,169 were Medicaid eligible at some point during 2005.[1] This includes all children who qualified for the program under one or more categories of eligibility including:

  - TANF; AFDC recipients; SCHIP; medically needy; disabled children; or the federally mandated expansion in eligibility for poverty-related groups.

- Of the 91,169 children who were Medicaid-eligible at some point during 2005, only 70,492 actually enrolled in the program. This represents an overall program enrollment rate of 77.3 percent.

There were approximately 20,677 children who were eligible for, but not enrolled in, Medicaid. Of these, 5,997 (29.0 percent) were uninsured, 12,103 (58.6 percent) had employer-sponsored coverage, and the remaining 2,557 (12.4 percent) had individually purchased insurance coverage. [1]

Approximate Number of CHIP Eligible Children Among the Total Number of Uninsured

- Of the 8,543 uninsured children living in the District of Columbia, approximately 1,465 are undocumented immigrant children living in families with incomes less than 300 percent of the federal poverty level. Although these approximately 1,465 children meet the income eligibility criteria for CHIP, they are ineligible for CHIP because of their immigration status.

- Of the 8,543 uninsured children living in the District of Columbia, 1,382 are in families with income above 300 percent of the federal poverty level and are therefore ineligible for CHIP.

- Of the 8,543 uninsured children living in the District of Columbia, 4,064 are uninsured, Medicaid-eligible, and not currently enrolled in the Medicaid Program.[1]

- Where one subtracts the following numbers from the total number of 8,543 uninsured children: (a) the number of children who are not eligible for CHIP because of their immigration status (1,465); (b) the number of uninsured children who are in families with incomes above 300 percent of the federal poverty level (1,382); and (c) the number of children who are currently eligible for, but not currently enrolled in, Medicaid (4,064); there remains 1,632 children currently uninsured in the District and eligible for CHIP.

Approximate Number of CHIP-Eligible Children Expected to Enroll in CHIP

- The District proposes to increase the Medicaid income eligibility limit for the CHIP program to 300 percent of the federal poverty level (FPL) for all uninsured children living in the District who are under age 19. The benefits provided to these newly eligible children will be the same as those now provided to children currently enrolled in Medicaid.

- There are approximately 1,632 uninsured children who are: (a) District residents; (b) live in families with income between 200 and 300 percent of the federal poverty level; and (c) are under age 19. Approximately 1,469 (90 percent) of these 1,632 uninsured children are expected to enroll in CHIP.

- There are approximately 8,542 children living in the District of Columbia who are in families with access employer-sponsored dependent coverage. Approximately 163 (2 percent) are expected to drop such coverage and enroll in CHIP.

- There are approximately 1,170 children in the District of Columbia who are in families with income up to 200 percent of the federal poverty level and who are either enrolled in CHAMPUS or Medicare. None of these children are expected to drop their coverage with either CHAMPUS or Medicare to enroll in CHIP.[1]

- The total number of children who are expected to enroll in CHIP is derived as follows: (a)approximately 1,469 (90 percent) of the 1,632 uninsured children, plus (b) 163 (2 percent) of the 8,542 children with private insurance coverage who are expected to drop such coverage and enroll in CHIP, plus (c) none of the 1,170 children currently enrolled in CHAMPUS or Medicare, equals a total number of 1,632 children who are expected to enroll in CHIP.

Impact of CHIP Outreach and Education Efforts on Medicaid Enrollment (The Currently Eligible but Not Enrolled Population)

- There are approximately 6,101 children living in the District who are eligible for but not enrolled in the Medicaid program under March 31, 1997 eligibility criteria. All of these children are eligible to enroll in Medicaid even though a portion of them (46.4 percent) already have some sort of private insurance coverage.

- The District's implementation of CHIP will include an outreach effort designed to encourage enrollment among those who are CHIP-eligible.

- Based upon results from prior outreach programs, we assume that about 20 percent of those who are eligible for, but not enrolled in, Medicaid will enroll in response to the intensified outreach efforts. We further assume that the entire 20 percent of persons in this category will come from that portion of the total population of 6,101 who are currently uninsured. Thus, it is estimated that the outreach initiative will increase Medicaid enrollment by about 1,223 children per year.

Impact of CHIP Enrollment and Outreach on Total Program Numbers

- The number of CHIP-eligible children who are likely to enroll in the program is 8,401. The number of currently Medicaid-eligible children who are likely to enroll in the program due to outreach activities is 1,223. Thus overall Medicaid program enrollment will increase from 67,734 to 77,358.

Impact on the Number of Uninsured Children in the District

- There are currently an estimated 8,543 uninsured children living in the District of Columbia. The combined effect of CHIP and its associated outreach program will be to increase the number of children with Medicaid coverage by 1,632. Total Medicaid program enrollment (including regular Medicaid arid CHIP-Medicaid) will increase from 70,492 to 72,124.

- Approximately 5,021 children are expected to remain uninsured despite the CHIP expansion and vigorous outreach activities. About 1,382 (27.5 percent) of the children who remain uninsured are in families with income in excess of 300 percent of the federal poverty level. [1] Another 1,465 (29.1 percent) of these children, who will remain uninsured, meet the income eligibility criteria under either Medicaid or CHIP, but are ineligible because they are undocumented aliens. [1] About 1,865 of the children who will remain uninsured (37.2 percent) will be children who are eligible for Medicaid under the current program who will not enroll despite vigorous outreach efforts. [1] This is equal to the number of eligible but not enrolled persons who are uninsured (5,997) less the number of eligible non-enrollees who would become covered due to outreach (4,131). All of the eligible but not enrolled children who enroll due to intensified outreach efforts are assumed to be persons who would be otherwise uninsured.

- Finally, 309 of those who will remain uninsured are newly eligible CHIP children who, for a variety of possible reasons, will not enroll in the program. Thus, 5,021 children will remain uninsured in the District despite the CHIP expansion and vigorous outreach efforts. (See Appendix A Discussion Paper: *Coverage and Costs under the Children's Health Insurance Program,* revised March 16, 1998, prepared by The Lewin Group, Inc.)

Summary of two Private Initiatives: Capital Community Kids Care and the Kaiser Kids Program

- There are two privately funded initiatives currently underway in the District to provide health insurance coverage to uninsured children.

- Both of the initiatives are funded by private foundations and sponsored by two local managed care organizations (Capital Community Health Plan and Kaiser Permanente).

- Each plan has 500 slots into which uninsured children may be enrolled. Both plans have expressed that they intend to expand the number of available slots over time.

- The Capital Community Kids Care Program covers children in families with income up to 275 percent of the federal poverty level.

- The Kaiser Kids Program covers children in families with income up to 200 percent of the federal poverty level.

- As of February 1998, there were 500 children enrolled in the Capital Community Kids Care Program and 500 children enrolled in the Kaiser Kids Program.

- An enrollment criterion for both programs includes: (a) the child may not be eligible for Medicaid; (b) the child must be under age 18; and (c) the child must be a resident of the District of Columbia. (See Appendix B: Description of Capital Community Kids Care Program) (See Appendix C: Description of Kaiser Kids Program)

- Capitol Community Health Plan ("CCHP") will phase out Kids Care and transition eligible children into CHIP. Kids Care is funded by a private donor who has indicated that he no longer intends to fund the program after the CHIP Program is initiated. Kaiser Permanente also plans to transition eligible Kaiser Kids into CHIP. Kaiser has not decided whether it will continue the program with a higher income level, serve a different population, or terminate the program.

  CCFIP and Kaiser are working with the District's Medicaid program to develop a plan for transitioning children into CHIP with the least possible break in coverage. Both CCHP and Kaiser are working with the Medical Assistance Administration ("Medicaid") to develop letters that will be mailed to their enrollees informing them of the upcoming transition to CHIP. The letters will include a brief description of CHIP and a telephone number to call for more information. Children who transition from these privately funded programs into CHIP *will not* be counted in that percentage of children who have substituted health insurance coverage.

Special Needs Children

The District provides care to children who are receiving SSI through a voluntary Section 1115 waiver. Approximately 2,000 children are enrolled in the waiver. The waiver expires at the end of November 1998. The District is in the process of seeking a one year extension on the waiver from the Health Care Financing Administration ("HCFA"). The request for extension will be submitted to HCFA in early August 1998 and will include a road map of activities associated with developing a new waiver application.

The District will not make any substantive changes to the waiver in its request for an extension. That is, the waiver will continue to serve only SSI children. During the one year period during which the waiver continues (should the extension be granted), the District will develop a new waiver application and explore ways to serve additional children with special health care needs, including TANF-related children, foster care children and CHIP children whose family income exceeds the SSI income levels, through the Section 1115 waiver delivery system.

During the interim period, all *targeted* low-income children (including those who have special health care needs) will be enrolled in the Section 1915(b) managed care delivery system. Our networks have the capacity to provide high quality services for these children as they now do for TANF-related children (foster care children are currently *carved out* of our mandatory managed care system). We will continue to monitor network capacity on an ongoing basis by reviewing claim denials, service waiting periods, financial solvency, and other indicators as appropriate.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

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

Summary of District Activities to Identify and Enroll Medicaid Eligible Children

- The Medical Assistance Program: The Medical Assistance Program (Medicaid) is the only public health insurance program currently available to children who are residents of the District of Columbia.

- Income Maintenance Administration: The Income Maintenance Administration (IMA) is the entity within the Department of Human Services responsible for eligibility determinations for the District's Medicaid program as well as cash assistance, food stamps and other benefits. Individuals can walk into any of the eight (8) IMA service centers at any time and be processed for Medicaid eligibility.

- Income Maintenance Administration Community Outreach: Representatives from IMA give talks to community groups upon request. The purpose of these

presentations is to inform the public about: (a) general eligibility requirements for the District's Medicaid program; (b) the requirements for Medicaid eligibility; and (c) the eligibility determination process. Examples of groups addressed include: The Children's Health Coalition, area churches, DSH Hospitals and the Districts two federally qualified health centers, East of the River and Upper Cardoza.

- Disproportionate Share Hospitals: All DSH Hospitals in the District conduct the following outreach and enrollment activities: (a) place signs up in their facilities that alert people about Medicaid; (b) provide assistance with completing the Medicaid application; and (c) collect completed applications and deliver them to IMA offices. DSH hospitals include: Children's Hospital, Hospital for Sick Children, Providence Hospital, Had1ey Hospital, Greater Southeast Hospital, DC General Hospital, Howard University Hospital and Saint Elizabeth's Hospital. Saint Elizabeth's hospital and DC General Hospital have District government employed IMA workers on site who accept applications and make final determinations onsite. All other DSH hospitals have contracts with private firms to gather and collect application information and assist with the preparation of Medicaid applications. This information is then forwarded to the central *IMA* unit on H Street NE within five days of client signing the application.

- Public Benefits Corporation Clinics: The PBC clinics (13 clinics across the District) have their own employees who (a) collect, gather and assist with the completion of Medicaid applications and, (b) send the client with the completed application packet to the appropriate service center based on census tract information.

- Non-DSH Hospitals: Non DSH Hospitals in the District (George Washington University Hospital. Georgetown University Hospital. Washington Hospital Center. and Sibley Hospital) either have members of their own staffs or hire contracted staff to assist Medicaid applicants This staff activity includes: (a) assisting clients with completing applications (b) assembling completed application packets, and (c) forwarding completed application packets to the central IMA unit on H Street NE. Mary's Center for Maternal and Child Health: Mary's Center is a non-profit community based clinic that provides comprehensive health services to low-income women and children. The clinic primarily provides services to Latino, African and Middle Eastern immigrants. An employee of the District overnmen1 is located at the Center. This individual assists Medicaid applicants with the following: (a) assisting clients with completing applications, (b) assembling completed application packets, and (c) forwarding completed application packets to the central IMA unit on H Street NW. Most of these applications are processed in IMAs Multinational Unit.

- Other Hospital-Related Activities: Many local hospitals hire staff to assist Medicaid eligible individuals during every phase of the enrollment process.

For example, Children's Hospital has contracted with a private organization to (a) assist self-pay customers with filling out the Medicaid application, (b) obtain the necessary supporting documentation, (submit the application to the Income Maintenance Administration, and (c) follow up with eligibility workers until the customer's application is given a final determination.

- Medical Care Advisory Committee: Through its Medical Care Advisory Committee, the District's Medicaid program provides ongoing information to Committee members of key program chances and receives guidance on successful outreach strategies.

- Medical Assistance Program Staff: Staff of the Medical Assistance Program (Medicaid) give frequent presentations and benefits to consumer and provider groups on Medicaid eligibility rules and other aspects of accessing the program. their own staff to assist Medicaid applicants. Their activities include the following: (a) assisting clients with completing applications; (b) assembling completed application packets; and (c) forwarding completed application packets to the central IMA unit on H Street NE.

- The Supplemental Food Program For Women, Infants and Children: The Supplemental Food Program for Women, Infants and Children (WIC) is located within the Department of Health. WIC employees distribute literature on Medicaid and Medicaid eligibility to all WIC applicants. Many WIC sites are located in clinic settings where clients have access to clinic personnel for assistance with applying for Medicaid. (See Appendix D: Medicaid Outreach Information Distributed by WIC Agencies)

- Office of Maternal and Child Health: The District's Office of Maternal and Child Health (OMCH) is located within the Department of Health. Established in 1982, the OMCH is charged with planning, promoting, and coordinating a state-based system of comprehensive health services for all mothers and children, including children with special health care needs, in both the public and private sectors of the District of Columbia. The OMCH integrates Medicaid-related outreach activities into many of their programs. Generally, individuals working in the various programs inform parents and providers about Medicaid eligibility and about Medicaid Managed Care. (See Appendix E: Description of OMCH Outreach Programs Description of HMO Oversight Program)

Other Activities: A number of community clinics, community-based groups, and other nonprofit associations throughout the District conduct the following activities: (a) provide information to consumers about the District's Medicaid program; (b) assist consumers with completing the Medicaid application; (c) assist consumers with locating, assembling and photocopying necessary documentation; (d) provide translation services for non-English speaking or limited-English speaking consumers

who are applying for Medicaid; and (e) interface between eligibility workers and customers when necessary. Examples of some of these groups include:

- The United Planning Organization (UPO)
- The Non-Profit Clinic Consortium
- The 10 Non-Profit Clinics
- The DC Primary Care Association
- DC Action for Children
- Children's Health Coalition of DC
- Chartered Health Plan
- Planned Parenthood
- Whitman Walker Clinic. Inc.

Summary of District Activities to Assist Non-Medicaid Eligible Children in Enrolling in the Private Initiatives

Representatives from the District's Department of Health including the District's Medicaid Program serve on a task force created to identify effective outreach strategies for the District's two privately funded health insurance initiatives. The District is currently exploring ways to incorporate information about these two initiatives into its outreach and education strategy for CHIP. The Medicaid Assistance Program (Medicaid) is the only publicly funded health insurance program in the District of Columbia.

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

There are no health insurance programs in the District of Columbia that involve a public-private partnership.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and 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. *(Previously 4.4.5.)*
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Triage During the Enrollment Process: Enrollment activities for CHIP will be based on a strategy that is designed to direct families to an appropriate source of health insurance coverage. This means that during the enrollment process eligibility workers will be trained to do CHIP eligibility determinations and income based Medicaid eligibility determinations. As individuals come forward to enroll a child in CHIP, the child will first be screened for Medicaid-eligibility prior to being enrolled in CHIP. Individuals who are eligible for regular Medicaid (based solely on income) will be enrolled in the program as part of the same process as that used for CHIP enrollment.

Appropriate Referrals: Individuals who are eligible for Medicaid based upon other criteria (e.g. spend-down) will be referred to appropriate eligibility workers. These individuals will also be referred to appropriate application assistance programs if such assistance is required. In addition, eligibility workers will be trained to refer individuals to either of the two private initiatives (see above) when the individual

Comprehensive Outreach: Although the primary goals of Title XXI outreach efforts are to identify and enroll CHIP-eligible children (who will be separately tracked once enrolled,) the District is eager to identify and enroll *all* children who are eligible for but not enrolled in the Medicaid program as well as children who are not eligible for Medicaid but may be eligible for one of the two private initiatives. Thus, the District plans to mount a comprehensive outreach strategy designed to reach (a) children who are eligible for but not enrolled in Medicaid and (b) children who are eligible for CHIP. Appropriate referrals will be made for children who are ineligible for Medicaid and CHIP but may be eligible for either of the two private initiatives.

Provider Education: The District's Medicaid Agency will undertake activities to educate providers about CHIP and changes in the enrollment and eligibility determination process. The Agency will work collaboratively with the DC Primary Care Association, the Medical Society of DC, the DC Chapter of the American Academy of Pediatrics and the DC Hospital Association to ensure that a maximum number of providers are reached.

Coordination of Department Health Activities: There will be coordination among all Department of Health Programs (e.g. Maternal and Child Health, Title X Family Planning, Immunizations, etc.). to ensure that each program integrates Medicaid and CHIP outreach strategies and enrollment assistance into their ongoing activities.

Coordination with other City Programs: The Department of Health will work with the City's School Lunch Program, the Head Start Program and other City programs serving large numbers of low-income children to ensure that effective outreach occurs among their respective populations.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

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

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. 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))**

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))**

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

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

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

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

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 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.
- 4.2.3. ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

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

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))**

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box.
(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.5

4.4.4.1. ☐ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

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))**

Section 5. Outreach (Section 2102(c))

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 District's outreach plan has five components: (a) basic principles; (b) public education; (c) materials development; (d) media strategy; (e) in-person application assistance. In addition, the District plans to establish a CHIP telephone *hotline* that will receive calls related to CHIP and regular Medicaid. (See Attachment A)

Basic Outreach Strategy

The District's Comprehensive Outreach Strategy' will be developed based on the following guiding principles:

- Outreach efforts will be Citywide.
- Outreach efforts will be culturally sensitive, language appropriate, and sensitive to the needs of the blind, hearing impaired and the deaf. Special outreach efforts will be developed and targeted to the following: Children with special health care needs, the Hispanic community, and the homeless community.
- Outreach materials (and other strategies) will utilize a variety of media approaches. Printed materials will be written at appropriate literacy levels updated to reflect program changes.
- The comprehensive outreach strategy will inform parents, teachers, school nurses, community-based organizations, and the community at-large about CHIP eligibility, eligibility for regular Medicaid, and enrollment procedures.
- The outreach strategy will incorporate the Department of Health web page at *http//www. dchealth com.* The following will be placed on the web page: (a) general information related to CHIP; (b) a copy of the CHIP application; and (c) step-by-step instructions on how to fill out and submit the application. The Department of Health, through its outreach activities, will encourage school nurses. teachers and others to use the web page to assist potential customers.

Outreach Partners

The District will use existing case management structures in place in the Supplemental Food Program for Women, Infants and Children (WIC), Title V Programs, Healthy Start and Title X Programs to inform potential clients about CHIP eligibility. These programs have

mechanisms in place that will allow for follow-up to see whether the parent of a potentially eligible child successfully completes the application process.

The District plans to hire an outreach coordinator to assist the City in the development and implementation of a comprehensive outreach plan that is based upon the guiding principles (see above). Once the overall outreach approach is identified, the District will integrate the following programs into that strategy:

Public Programs

- DC Public Schools—School Health Program
- DC Head Start and DC Early Head Start
- DC Office of Maternal and Child Health
- DC Office of Early Childhood Development--DC Early Intervention Program (Child Find)
- DC Immunization Program
- The Supplemental Food Program for Women, Infants and Children (WIC)
- The DC Public Housing System
- The DC Public Hospitals (Social Workers. Emergency Rooms, and Other Relevant Departments)
- The Public Benefits Corporation Community Clinics
- Section 330 Clinics

Private Programs

- Area Houses of Worship and Representative Organizations
- Managed Care Organizations
- Private Not-For-Profit Community Clinics
- DC Action for Children
- Children's Health Coalition of DC
- Private Hospitals

- The District of Columbia Hospital Association
- Local Chapter of the American Academy of Pediatrics
- The DC Primary Care Association
- The Medical Society of the District of Columbia
- Advocacy Organizations
- Immigrant and Ethnic Organizations

New Enrollment Procedures

The District is currently developing an enrollment process for CHIP and income based Medicaid applicants that is: (a) user friendly; (b) timely; (c) accommodates working parent(s); (d) requires less documentation; and (e) is accompanied by appropriate supportive services. To accomplish these goals the District is considering the following:

- Naming the program *Healthy DC Kids.* It is believed that giving the program an appealing name will remove the welfare stigma and encourage enrollment.
- Developing a two-page application form that does not include documentation of resources. The new application form will be distributed at the following sites: WIC Centers, Head Start Centers, Title V OMCH Programs, Title X Family Planning Programs, D.C. Public Schools and other appropriate community-based sites.
- Working with the Income Maintenance Administration to implement an efficient eligibility determination process that is dedicated to processing only CHIP and income-based Medicaid applications. The unit will be adequately staffed and trained to ensure quicker application processing.
- Hiring and training additional eligibility workers to enroll children in CHIP and regular Medicaid (income-based only). This function will also include ongoing training.
- Working to ensure a faster turn-around time in application processing and eligibility determination. The District's goal is to determine eligibility in between seven (7) to ten (10) days. Eligibility workers' caseloads will be continuously monitored and appropriately adjusted to reach this goal.

- Contracting with community-based entities to assist potential customers with all aspects of application assistance, language access, and other required supportive services.

- Distributing printed outreach and education materials as well as program applications among public and private outreach partners

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

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

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

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

- 6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)
- 6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

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

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. **(Section 2103(a)(4)) (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 project
- 6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

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

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 (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

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. ☐ Pre-natal care and pre-pregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10. ☐ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

6.2.11. ☐ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

6.2.12. ☐ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

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

6.2.14. ☐ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

6.2.15. ☐ Nursing care services (See instructions) **(Section 2110(a)(15))**

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

6.2.17. ☐ Dental services **(Section 2110(a)(17))**

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

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

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

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

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

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

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

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

6.2.26. ☐ Medical transportation **(Section 2110(a)(26))**

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

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

6.3 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 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

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))**

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))**

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 relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

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))**

Section 7. Quality and Appropriateness of Care

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

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

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

7.2. Describe the methods used, including monitoring, to assure: (**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))**

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))**

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))**

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))**

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

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

8.1. Is cost sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☐ YES
8.1.2. ☐ NO**, skip to question 8.8.**

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 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:
8.2.2. Deductibles:
8.2.3. Coinsurance or copayments:
8.2.4. 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)(B)) (42CFR 457.505(b))**

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)**

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

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- ☐ 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, copays, 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 (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

Strategic Objectives

Strategic Objective 1: The District will achieve at least 5 percent of its projected enrollment of CHIP eligible children within the first year of implementation of the eligibility expansion.

Strategic Objective 2: Within the first year of the eligibility expansion and its associated outreach strategy, the District will identify and enroll at least 35 percent of those children who are: (a) uninsured, and (b) currently Medicaid-eligible but not enrolled.

Strategic Objective 3: Fifty percent of CHIP-enrolled children will have self-selected an HMO and a primary care provider within the first year of enrollment.

Strategic Objective 4: Those newly enrolled in CHIP and regular Medicaid (income based) will express satisfaction with the new enrollment process.

Strategic Objective 5: The District will develop and implement a process for determining the effectiveness of (a) the enrollment process. and (b) the Citywide outreach strategy.

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

Performance Goals

Performance Goal for Strategic Objective 1: The District will collect data on the number of CHIP-eligible children enrolled in the program on a monthly basis.

Performance Goal for Strategic Objective 2: The District will collect data on the number of new Medicaid-eligible and CHIP eligible enrollees on a monthly basis.

Performance Goal for Strategic Objective 3: The District's Medicaid Agency will monitor data on CHIP enrollees and whether or not they were selected enrollments or default enrollments on a monthly basis.

Performance Goal for Strategic Objective 4: The District will capture information related to consumer satisfaction with the eligibility determination process through its managed care enrollment broker. The District is considering developing a questionnaire for this purpose.

Performance Goal for Strategic Objective 5: The District will: (a) the District will work through its managed care enrollment broker to elicit information from customers related to satisfaction with the eligibility determination process. The City is considering developing a questionnaire for this purpose; and (b) the City will include a question (or series of questions) on its new Medicaid/CHIP application that will elicit from the applicant how he or she found out about the program and whether he/she received community-based assistance with completing the process. The Medicaid Agency will desk audit enrollment forms for customer responses every six months and tabulate the data.

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))

Objective Measurement of Performance Measures

The District's baseline for its performance is those measures as stated in this application and relevant appendixes. The Medical Assistance Administration receives numerical data from the Managed Care Organizations (MCOs) on an ongoing basis. This data is summed and tabulated to determine whether targets have been met and to compare MCO performance. Data used in reports developed by the Medical Assistance Administration is readily verifiable through the contracted Managed Care Organizations and may be independently verified through the MCOs. In addition, the Medical Assistance Administration will employ an External Quality Review Organization (EQRO) to independently verify data received form the MCOs.

The Medical Assistance Administration will work through its independent enrollment broker to capture satisfaction with the eligibility determination process. This information may be independently verified through the enrollment broker.

Performance measures that do not lend themselves to numeric summation will be tabulated and maintained by Medical Assistance Administration personnel. These tabulations, as well as the raw data used to develop them, will be maintained on file by the Medical Assistance Administration, and can be made available for independent verification.

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

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

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

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)**

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)**

District of Columbia Plan for Annual Assessments

The District of Columbia's Medicaid program will collect data consistent with the reporting requirements of Section 10 of this CHIP application. The District will compile the data into an assessment and evaluation report on an annual basis. Specifically, the District will:

- Track all new Medicaid enrollees along the following indicators: (a) monthly number enrolled; (b) income level; (c) age; (d) race and ethnicity; (e) geographic area of residence with the District; and (f) criteria for Medicaid eligibility.

- Collect enrollment information from the two private health insurance initiatives in the District.

- Ensure that enrolled children receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services consistent with standards set forth in the District's contractual agreement with its Managed Care Organizations. (See Appendix F: EPSDT Standards set forth in MCO Contracts)

- Implement an HMO Oversight Program designed to evaluate member satisfaction and quality of care and service delivery. (See Appendix G: Description of HMO Oversight Program and Quality Measures)

- Evaluate effectiveness of outreach and public education activities.

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)**

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)

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))**

Summary of the District's Comprehensive Strategy to Include the Public in its Decision making Process

- The public process for discussing issues related to the development of the District's CHIP plan is an ongoing one that has been city-wide, open and inclusive.

- All meetings that have been held related to CHIP have been open to the community.

- An article, DC Seeks to Expand Health Care for Needy Children, appeared in the Washington Post on December 9. 1997. (See Appendix H: December 9, 1997 Washington Post Article)

- Specific efforts were made to include members and representatives from the District's immigrant communities in the planning process. These include: working with the

Mayor's Office of Diversity, the Mayor's Office of Asian and Pacific Islanders Affairs and the Mayor's Office of Latino Affairs to ensure that members of these communities were aware of CHIP and that they would send representatives to the public forums.

- Translation services and signing for the hearing impaired were made available at several of the public forums. Specifically, Chinese, Vietnamese and Spanish translators were available.

- The Medicaid Managed Care and Eligibility Committee (MMCEC) of the Mayor's Health Policy Council took the lead in the District's public process to involve the community in planning for CHIP. The membership of the MMCEC includes, but is not limited to representatives from the following organizations: The Department of Health, including the DC Medical Assistance Administration (Medicaid). D.C. Dental Association, D.C. Hospital Association, Blue Cross Blue Shield of the National Capitol Area, and the Medical Society of the District of Columbia.

- The Committee process was, and continues to be open to all interested community members. (See Appendix I: Summary of Health Policy Council (including background on members)

- For the purpose of discussing issues related to the District's CHIP plan, the Committee was divided into three Work Groups: (1) The Coverage and Benefits Work Group; (2) The Structure and Administration Work Group; and (3) The Outreach and Education Work Group.

- The Committee and its component Work Groups met several times between September 1997 and December 1998 to evaluate the policy options associated with the development of a CHIP plan. On December 9, 1998, the Committee made final recommendations to the Mayor's Health Policy Council.

- Upon approval of the Committee's recommendation (as amended) by the Health Policy Council (December 9, 1997) the Committee proceeded with a series of public forums related to CHIP. (See Appendix J: Medicaid Managed Care and Eligibility Committee Consensus Report; Health Policy Council Recommendation; and Comments of Families USA on Recommendations of the Medicaid Managed Care and Eligibility Committee)

- The Medicaid Managed Care and Eligibility Subcommittee of the Mayor's Health Policy Council conducted five public forums between January 12, 1998 and January 28, 1998. The purpose of the meetings were: (a) to inform the public about CHIP and options given to states under federal law; (b) to inform the public that the District is planning to expand Medicaid to implement CHIP; (c) to solicit public input related to effective enrollment processes; and (d) to solicit public input related to effective public education and outreach strategies. (See Appendix K: Summary of Health Policy Council and Flyers and Handouts for Public Hearings Conducted by the

Medicaid Managed Care and Eligibility Committee of the Mayor's Health Policy Council)

- A Public Roundtable sponsored by Council member Sandra Allen (Ward 8), Chair of the Committee on Human Services was held in the City Council Chambers on January 27, 1998. A number of groups and some private individuals offered testimony at the Roundtable. (See Appendix L: Flyer Announcing Public Hearings; Statement of Allan S. Noonan, M.D., M.P.H., Director, Department of Health; Statement of Bailus Walker, Jr., PhD, MPH, Chair, Mayor's Health Policy Council; Statement of Brenda Richardson, Chair, Outreach and Education Work Group; Statement of Jesse Price, Consumer; Statement of Diane Bernstein, President, DC Action for Children; and Statement of Hanita Schreiber, President, Capital Community Health Plan)

- The Department of Health, in partnership with City Council members, conducted a series of public forums between February 12, 1998 and March 16, 1998 in seven of the City's eight wards. The forums were advertised in the Washington Post on February 12, 1998. (See Appendix M: February 12, 1998 Washington Post Article) Representatives from the Department of Health and the City' Council provided information at the meetings. The purpose of these forums was: (a) to ensure city-wide in-put in the CHIP planning process; (b) to inform the public about CHIP and options given to states under federal law; (c) to inform the public that the District is planning to expand Medicaid to implement CHIP; (d) to solicit public input relative to effective enrollment processes; and (e) to solicit public input relative to effective public education and outreach strategies. (See Appendix N: Flyers and News Release Advertising Public Hearings Conducted by the Department of Health and the City Council)

- Representatives from the District's Medicaid Agency have made themselves available to make presentations upon request. Thus far, approximately six presentations have been made to such groups as: The Use Your Power Parent Group, The Welfare Reform Collaborative, The Washington Parent Group Fund, and DC Foster Care Social Workers.

Public Involvement in Program Implementation

- The Director of the Department of Health and members of the Managed Care and Eligibility Committee of the Mayor's Health Policy Council will share ongoing oversight responsibilities for CHIP.

- The Outreach and Education Work Group of the Medicaid Managed Care and Eligibility Committee will have continued involvement in the development, implementation and ongoing oversight of the City's outreach plan as will representatives from key City agencies.

- The District will conduct periodic focus group sessions with consumer groups to evaluate the effectiveness of CHIP and the level of satisfaction with changes in the enrollment process.

- Consumers, providers and other concerned parties will be encouraged to give their input to the Medical Care Advisory Committee, which meets on a monthly basis.

- The Managed Care and Eligibility Committee will continue to review CHIP activities during regular meetings.

- The District will conduct periodic focus group sessions with consumer groups to evaluate the effectiveness of CHIP and the level of satisfaction with changes in the enrollment process.

- Consumers, providers and other concerned parties will be encouraged to give their input to the Medical Care Advisory Committee, which meets on a monthly basis.

- The Managed Care and Eligibility Committee will continue to review' CHIP activities during regular meetings.

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. **(Section 2107(c)) (42CFR 457.120(c))**

N/A

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

N/A

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

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.

- Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

This page intentionally left blank.

SCHIP Budget Plan Template

	Federal Fiscal Year 2007 Costs
Enhanced FMAP rate	**79%**
Benefit Costs	
Insurance payments	
Managed care	**$8,606494**
per member/per month rate @ # of eligibles	**$133.31 x 5,380**
Fee for Service	**$1,600,000**
Total Benefit Costs	**$10,206,494**
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	**$10,206,494**
Administration Costs	
Personnel	**$133,322**
General administration	**$1,125**
Contractors/Brokers (e.g., enrollment contractors)	**$475,000**
Claims Processing	
Outreach/marketing costs	
Other	**$62,000**
Total Administration Costs	**$671,447**
10% Administrative Cost Ceiling	**$1,020,649**
Federal Share (multiplied by enh-FMAP rate)	**$8,593,573**
State Share[1]	**$2,284,368**
TOTAL PROGRAM COSTS	**$10,877,941**

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.
[1]The source of the State Share is General Fund appropriated dollars.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

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

10.2. ☒ 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.

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**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

Health Services Matters

12.2 Please describe the review process for **health services matters** that comply with 42 CFR 457.1120.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please 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.

[1] 2005 CPS Report