OMB #: 0938-0707
Exp. Date:

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.

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: Ohio

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: Tom Hayes Position/Title: Director, Ohio Department of Job and Family Services
Name: Barbara Edwards Position/Title: Deputy Director, Office of Ohio Health Plans
Name: Sukey Barnum Position/Title: Chief, Bureau of Consumer and Program Support

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

1.1.3. ☐ A combination of both of the above.

Effective January 1, 1998, the State expanded its Medicaid Healthy Start program to cover children up to age 19, in families with incomes at or below 150% of the Federal Poverty Level (FPL). The expansion provided coverage for children ages 0 through 6 between 133% and 150% of FPL; for children ages 7 through 14 between 100% and 150% of FPL; and for children ages 15 through 18 between 33% and 150% of FPL.

Effective July 1, 2000, the State expanded its Medicaid Healthy Start program to cover uninsured children up to age 19 in families with incomes above 150% and at or below 200% of FPL.

The State has implemented systems changes that allow for identification of children eligible for Medicaid via SCHIP, so they can be reported separately from children eligible for Medicaid. This allows SCHIP eligible children (optional targeted low-income children) to be reported and claimed at an enhanced rate, and other new eligibles to be reported and claimed at the state's standard FMAP.

Children eligible for coverage as a result of the eligibility expansion receive health care services through the same delivery systems that operate in the current Medicaid program. Each of Ohio's 88 counties has a fee-for-service delivery system in place. Fifteen counties have a managed care delivery system that Ohio offers through an 1115 waiver.

As is true for all eligibles in section 1931 coverage and Healthy Start, once eligibility is determined a card is issued for fee-for-service coverage. In mandatory managed care counties, eligibles receive notice that they must choose an MCP or they will be assigned to one. In preferred option counties, eligibles are enrolled in managed care if they do not opt for fee-for-service coverage. In voluntary managed care counties, eligibles are informed that they may choose to enroll in an MCP or remain in the fee-for-service delivery system; they remain in the fee-for-service delivery system unless they elect to enroll in managed care.

1.2 X 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 X 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: January 1998

Implementation date: January 1998

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))**

The information presented below best represents the information that was available at the time of initial SCHIP state plan submission in December 1997 and serves as a benchmark. Current statistical information on Ohio's children can be found in Ohio's SCHIP evaluation, and thereafter, in Ohio's SCHIP annual report.

Notes on the following table.

Source: U.S. Current Population Survey, March 1997 Supplement, Downloaded from www.bls.census.gov/cps/cpsmain.htm

- Ohio is not able to distinguish the extent to which the coverage reflected below is creditable or non-creditable.
- This chart represents a single month snapshot of the insurance status of the population. The number of uninsured during one month is considerably higher than the number uninsured for the entire year. The estimated number of Medicaid eligibles in March 1997 is an under-representation of exact eligibility counts for that time-period.
- % of Federal Poverty Level is based upon annual income in 1996. For Medicaid eligibles, this might not reflect their financial status during the months that they were Medicaid eligible.
- Health Insurance coverage in March, 1997- Respondents in the CPS were asked the following question: Type(s) of plan(s) was (person's name) covered by last week (up to 5 of the following types are carried including "other").

0 Not in Universe	8 Other Government Care
1 Medicare	9 Employer/Union-Provided (own plan)
2 Medicaid	10 Employer/Union- Provided (as dependent)
3 Champus	11 Privately Purchased (own plan)
4 Champva	12 Privately Purchase (as dependent)
5 VA Health Care	13 Plan of someone outside the household
6 Military Health Care	14 Other
7 Indian Health Service	

Children were assigned to the insurance coverage group based on the following hierarchy:

Coverage Group	Codes:
Medicaid	2
Other Public	1,3,4,5,6,7,8
Employer Sponsored	9,10
Individual	11,12,13,14
Uninsured	0

Demographic and Health Insurance Characteristics of Ohio's Child Population March 1997

		Health Insurance Coverage in March 1997				
Demographic Characteristic	Total Children	Medicaid	Other Public	Employer Sponsored	Individual	Uninsured
% of Federal Poverty level						
< or = 100%	589,054	246,846	12,308	101,875	19,807	208,218
100-133%	182,679	25,571	6,648	34,944	30,581	84,936
133-150%	135,219	19,937		54,146	21,364	39,772
150-185%	224,173	7,110	10,482	106,607	23,583	76,391
185-200%	82,595	2,271		57,563	4,030	18,731
at 200%	1,948,337	51,689	26,402	1,484,028	76,683	309,535
Age Group						
Age 0-1	302,620	66,284	2,978	142,793	20,376	70,188
Age 2-5	695,069	82,856	21,276	369,698	33,078	188,161
Age 6-12	1,217,750	133,199	18,983	742,787	45,882	276,900
Age 13-18	946,618	71,083	12,604	583,885	76,712	202,334
Race and Ethnicity						
White, Non Hispanic	2,611,339	171,835	53,010	1,636,831	168,299	581,364
Black, Non Hispanic	482,098	149,998	2,831	173,850	7,749	147,670
Hispanic	49,667	27,117		16,805		5,746
Amer Indian, Alaskan Native	4,473	4,473				
Asian or Pacific Islander	14,481			11,678		2,803
Location						
MSA	2,669,013	294,598	44,273	1,635,410	139,498	555,234
Non-MSA	493,045	58,825	11,567	203,753	36,550	182,349
Total	3,162,058	353,423	55,841	1,839,163	176,048	737,583

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):

In 1998, Ohio had 576,106 children with health care coverage through the Medicaid program. Eligibility for Medicaid continues to remain available for the following federal categories of children: those who qualify for the Ohio Works First Program (TANF); those who meet Ohio's Section 1931 Family Eligibility; those who qualify for the Healthy Start Program (SOBRA); and those who meet Medicaid disability criteria (keeping in mind that Ohio is a 209b state). Eligibility outreach is described in Section 5.

Ohio has attempted to make it easier to offer health insurance for employers in the small group market by passing insurance reforms in 1992 that encouraged the formation of small group purchasing cooperatives; placed limits on the length of pre-existing condition clauses; and set a rate corridor on premium increases. In addition, Ohio required indemnity plans to offer an annual open enrollment period.

Beginning in 1992, the Ohio Department of Health through its BCMH, Hemophilia and AIDS programs, started paying health insurance premiums for families who could not afford to keep their employer-based insurance. The Ohio Department of Health only pays insurance premiums where it is cost effective to maintain a person's private coverage. The Hemophilia insurance purchasing program currently serves 259 people; the BCMH insurance purchasing program serves 41 children; and the HIV Insurance purchasing program serves 120 people.

These three public health insurance purchasing programs screen potentially eligible candidates to determine that the people for whom health insurance is being purchased are not eligible for Medicaid prior to purchasing insurance. Outreach for these programs is done through public health nurses and the provider networks for the BCMH, HIV and Hemophilia programs. While the Combined Program Application (CPA) is not an application for these health insurance purchasing programs, the information provided on the CPA can be used to initiate the exploration of eligibility for a health insurance purchasing program.

Ohio passed four significant pieces of legislation in 1999 to provide certain patient protections for Ohio's health consumers. They are 1) House Bill 4, which includes the establishment of requirements for conducting internal and external reviews of health care coverage decisions made by health insuring corporations, and sickness and accident insurers; 2) House Bill 361, which includes regulations of aspects of enrollees' access to covered health care services; 3) House Bill 698, which includes revisions of the standards for using electronic signatures in records of health care facilities; and 4) Senate Bill 67, which enacts a new laws to provide for the establishment, operation, and regulation of "health insuring corporations," to provide uniform regulation of providers of managed health care.

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:

The State does not participate in any public/private partnerships for children's health insurance.

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))

Consumers complete the Combined Programs Application (CPA) to apply for the Healthy Start program. The CPA also serves as an application for three other publicly funded programs: the Women, Infants and Children (WIC) Program, the Child and Family Health Services (CFHS) Program, and the Children with Medical Handicaps (CMH) Program. All three programs are administered by the Ohio Department of Health.

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

X **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))

X **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 access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 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))**

4.4.4.1. ☐ 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)**

Ohio has a solid foundation in place of outreach and coordination efforts with state and local partnerships to assist families in enrolling their children in the Medicaid program. ODJFS participates in several partnerships to enhance Ohio's outreach efforts. They include:

- Surveying community agencies on how they conduct Medicaid eligibility outreach activities (including assisting families to enroll their children in Medicaid) and how they coordinate these activities with other local outreach efforts.
- Working with the Ohio Family and Children First (OFCF) Initiative to improve Medicaid enrollment in Head Start populations.
- Generating outreach ideas and sharing best practices in dialogue sessions with local Family and Children First Councils, Early Intervention Collaboratives, Joint Advisory Councils, Title V agencies, and other groups
- Developing media strategies for statewide education to Medicaid consumers and providers, including linking with OFCF's Help Me Grow program.
- Working with ODH to identify age specific strategies based on different service utilization patterns of different age groups.
- Coordinating SCHIP outreach efforts with ODJFS Welfare Reform Medicaid outreach activities. ODJFS made available to Ohio's 88 counties federal matching funds authorized through the Personal Responsibility and Work Opportunity Act, subject to the availability of allowable non-federal matching funds at the local level, to support Medicaid eligibility/enrollment for persons at risk of losing contact with Medicaid due to the federal delinking from cash assistance. Counties submitted outreach proposals to receive enhanced match for allowable expenditures related to Medicaid eligibility outreach.

ODJFS works with state and local entities to facilitate discussion and direction on proposed outreach endeavors, and to support partnership opportunities. The annual events we have supported include:

January through April - Partner with the IRS' Earned Income Tax Credit (EITC) program by providing Healthy Start information at volunteer tax preparation sites along with IRS-EITC program information

January/February - ODH sponsors regional project directors' meetings for their Children and Family Health Services (CFHS) clinics. We are typically invited to conduct a Healthy Start presentation at each of their four regional meetings.

April - The Ohio Minority Health Commission offers grants to local agencies to sponsor health fairs during "Minority Health Month". We participate in the annual kick-off event as well as many local health fairs by staffing an exhibit booth, conducting presentations, and/or supplying Healthy Start materials such as flyers and brochures.

Spring/Summer - The Head Start Association holds statewide conferences, usually two per year, for their association members. We participate in both full conference presentations, as well as session workshops.

June through August - We provide Healthy Start materials for many community festivals held in Columbus that are directed at specific minority audiences, such as the Asian Fest and the Latino Festival.

August - We staff and display an exhibit booth at the Ohio State Fair. This is our biggest outreach effort because of the exposure to so many people from all parts of the state.

August - We participate in a two-day event called the "Black Family Expo" by staffing an exhibit booth.

September - ODH provides grant funding for local agencies to sponsor health fairs targeting women's health. We participate in several local events by staffing an exhibit booth, conducting presentations, and/or supplying Healthy Start informational materials.

October - We participate in the Ohio Department of Education's Early Childhood Education Annual Conference by conducting session presentations.

Ongoing events, without specific associated time frames are:

Welcome Home Project -This program, sponsored by the ODH, provides a home visit by a nurse to all parents with a newborn child. This "welcome home" gesture is for first-time parents and all teen parents regardless of the number of children. The purpose of the visit is to introduce the parents to the services available to their children, including Healthy Start.

Center for New Directions - This is a monthly outreach opportunity for us to conduct a workshop for women who are entering the work place for the first time, or re-entering after a period away from working. The women in this program gain insight into factors that contribute towards job success (e.g., child care issues/needs, self-sufficiency, health insurance).

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

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

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

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

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

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

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

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

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

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

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

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

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

X **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))**

X **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))**

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

Strategic Objectives	Performance Goals For Each Strategic Objective	Performance Measures and Progress
1. Increase the percent of children with coverage below 150% FPL.	The percent of children with coverage for the entire year whose family income for the entire year is below 150% FPL will be increased from 80.6% in CY97 to 87% in CY00.	Data Sources: U.S. Current Population Survey, March Supplement (1998-2001) Numerator: Children who had one or more sources of health care coverage at any time during the year. Denominator: Total Children
2. Increase the percent of children with coverage between 150% and 200% FPL	The percent of children with creditable coverage for the entire year whose family income for the entire year is between 150% and 200% of the FPL will be increased from 89.7% in CY 1998 to 95% in CY 2003	Data Sources: U.S. Current Population Survey, March Supplement (1999-2004) Numerator: Children who had one or more sources of health care coverage at any time during the year. Denominator: Total Children
3. Increase access to health care to children below 200% of FPL	Goal A: Decrease the percent of children who have no usual source of care or use the emergency room from 9.4% in 1998 to 8.7% in 2001 and 8.0% in 2004	Data Sources: Ohio Family Health Survey, 1998. Ohio Family Health Survey, 2001 (planned). Numerator: Children who have either no usual source of care or use emergency room for usual source. Denominator: Total Children
	Goal B: Increase the percent of children on Medicaid and SCHIP who reported having a personal doctor or nurse from 90% in 1999 to 95% in 2004	Data Sources: Medicaid Consumer Satisfaction Survey. Managed Care, Spring 2000 (planned). Numerator: Number of children who reported having a personal doctor or nurse. Denominator: Number of children

3. Increase access to health care to children below 200% of FPL (continued).	Goal C: Decrease the percent of children that report any unmet health care needs from 10.9% in 1998 to 10.4% in 2001 and 9.9% in 2004.	Data Sources: Ohio Family Health Survey Numerator: Children who reported an unmet health care need, including dental care, prescription drug, medical exams, procedures, or physician visits. Denominator: Total children.
4. Increase access to preventive health care services for children below 200% of FPL.	Goal A: Increase the percent of children who had at least one well child/well baby visit from 76.8% in 1998 to 78.4% in 2001 and 80% in 2004	Data Sources: Ohio Family Health Survey, 1998. Ohio Family Health Survey, 2001 (planned). Numerator: Children who reported received at least one well child/well baby visit. Denominator: Total Children
	Goal B: Increase the percent of children enrolled in SCHIP who had the number of comprehensive exams recommended by the American Academy of Pediatrics: Under 15 months: from 22.7% in 1998 to 30% in 2004. Age 3-21: from 22.7% in 1998 to 30% in 2004.	Data Sources: Medicaid claims and encounter data. Numerator: - Number of children under 15 months who had at least 6 comprehensive exams. - Number of children ages 3-21 that had at least 1 comprehensive exam. Denominator: Total number of children at indicated age with 12 months of continuous eligibility with a break of no more than 1 month.
	Goal C: Increase the percent of children who had at least one dental visit from 61.1% in 1998 to 62% in 2001 and 63% in 2004.	Data Sources and Methodology: See Goal A. Numerator: Children who reported at least one dental visit. Denominator Total Children
	Goal D: Increase the percent of children age 3-18 enrolled in Medicaid and SCHIP who had at least one dental visit from 33% in 1998 to 45% in 2004.	Data Sources: Medicaid claims and encounter data. Numerator: Number of children ages 3 thru 18 that had at least 1 dental visit. Denominator: Total number of eligibility years at age 3-18.

4. Increase access to preventive health care services for children below 200% of FPL (continued).	Goal E: Increase the percent of two-year old children on Medicaid and SCHIP who had all of their recommended immunizations by age two from 48% to 65%.	Data Sources: Medical records extraction. Numerator: Children who received all of their immunizations by the age of two. Denominator: Total children age two with at least 6 months of continuous eligibility.
	Goal F: Increase the percent of children on Medicaid and SCHIP age 1 and 2 who had a lead lab test from 26% in 1 year olds and 23% in two year olds in 1998 to 60% in 2003	Data Sources: Medicaid claims and encounter data, lead registry Numerator: Number of children ages 1 and 2 that had a claim or encounter for a lead lab test. Denominator: Total number of eligibility years at age 1 and 2.
5. Increase access and coordination of services to children with special health care needs that prevent health care needs from moving into an acute episode.	Goal A: Increase the percent of children with persistent asthma that use appropriate medications age 5 to 17.	Data Sources: Medicaid claims and encounter data. Numerator: Number of asthmatic children age 5-17 with persistent asthma who used appropriate medications. Denominator: Total number of children with persistent asthma.
	Goal B: Increase the percent of children ages 11 to 18 enrolled in Medicaid and CHIP who were hospitalized for treatment of specific mental health and chemical dependency disorders who were seen on an ambulatory basis within 30 days of hospital discharge.	Data Sources: Medicaid claims and encounter data. Numerator: Children ages 11 to 18 who had inpatient discharge and had a specific mental health or substance abuse CPT code within 30 days of discharge. Denominator Children ages 11 to 18 that had at least one inpatient admission.
	Goal C: Increase the percent of children with special health care needs that were satisfied with the quality of care provided by medical specialists from 59.6% in 2000 to 75% in 2004.	Data Sources: Medicaid Consumer Satisfaction Survey. Numerator: Number of CSHCNs who rated their specialists a 9 or higher on a scale of 0 to 10. Denominator Number of children who reported that they had at least one visit to a specialist.

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:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

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

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

9.3.2. X 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. X Other child appropriate measurement set. List or describe the set used.
Immunizations: Chart review conducted by External Quality Review Organization for people in managed care.
Well Child Care: Encounter and claims data.
Adolescent well visits: Encounter and claims data.
Satisfaction with care: Consumer satisfaction survey.
Mental Health: Encounter data.
Dental Care: Chart review conducted by External Quality Review Organization for people in managed care.
Pediatric Asthma: Chart review conducted by External Quality Review Organization for people in managed care.

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:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. X 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. X 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)**

Using data currently available (Current Population Survey and State Medicaid data bases) and data sources identified over time, the State expects to be able to annually assess progress toward reducing the number of uninsured low-income children. Likewise, using the same data resources, the State expects to be able to describe, analyze, and assess the effectiveness of its plan, and offer recommendations for improving the plan. The assessment will include, to the extent data is available, an evaluation of the effectiveness of other public and private initiatives around children's health coverage, and an analysis of changes and trends in the state which may affect the provision of health care to children.

9.6. X 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. X 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. X Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. X Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. X Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. X 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))**

During the summer of 1996 as part of the biennial budget planning process, the ODJFS, in conjunction with The Lewin Group, held a series of public forums. Forums were held in Athens, Toledo, Cincinnati, Cleveland, and Columbus. Invitations to these forums were sent to a wide variety of public and private sector health, social, and human services agencies and associations throughout the state. These forums were designed to gather public input on priorities for the Medicaid program that should be pursued in the biennial budget, and to identify available dollars to pay for any of these initiatives. Overwhelmingly, one of the highest priorities identified through these forums was to expand Medicaid coverage for children.

ODJFS responded to this request by including a Medicaid eligibility expansion in its budget request. This eligibility expansion was examined through the state budget public process, including a series of public hearings and legislative examination. The Medicaid eligibility expansion was included in the enacted Ohio Biennial Budget for SFYs 1998 and 1999.

Information about the planned Medicaid eligibility expansion, and how it corresponds with Title XXI of the Balanced Budget Act, has been shared extensively at a variety of meetings around the state.

Additionally, the State conducted another set of forums as a means to further share the State's planned health insurance expansion and to get statewide input from interested parties regarding the SCHIP option of covering children up to 200% of poverty. Forums were held in Athens, Akron, Dayton, Columbus, and Cleveland.

In January of 1998, then Governor Voinovich requested Bill Ryan, Director of the Ohio Department of Health, establish an Advisory Task Force to propose recommendations on how Ohio could use Title XXI to expand coverage to Ohio's uninsured children living in families with income between 151 and 200% of FPL.

The Task Force consisted of 17 members, representing health care providers, consumer advocates, business, State, public health agencies, and health care plans. The Task Force met ten times between February and June 1998.

Three critical factors helped shape the Task Force's final recommendations: the Medicaid Healthy Start benefit package provides the best model for children's health insurance of the benchmark coverage options specified by Title XXI; the anticipated number of potentially eligible children and how many of those could be expected to apply; and effective outreach, which is critical to the success of a Title XXI, SCHIP program.

The July 1, 2000 eligibility expansion was included in the enacted Ohio Biennial Budget for SFYs 2000 and 2001, and was examined through the state budget public process, including a series of public hearings and legislative examination, and was approved with little debate.

Methods for Ensuring Ongoing Public Involvement

Ohio has several methods for ensuring ongoing public involvement in its Medicaid program expansion.

In each of the counties with mandatory managed care for certain Medicaid consumers, there is a Joint Advisory Council (JAC). JACs and their subcommittees are attended by staff from CDJFS agencies, consumer advocacy organizations, social, health and human service organizations, health maintenance organizations, and state associations. These meetings provide feedback to ODJFS on program design, implementation, and consumer needs.

The State also has a statewide Medical Care Advisory Committee (MCAC) that provides input and feedback to ODJFS on the design, development, implementation and evaluation of the Medicaid program. The MCAC has two subcommittees: Program Design and Development, and Program Outcome and Evaluation.

ODJFS staff also sits on Ohio's RWJ Covering Kids Coalition, which is coordinated by The Ohio Commission on Minority Health.

Lastly, as the State pursues its Value Purchasing Strategy, a main focus has been to develop and maintain community relationships that allow for two way information sharing. Many relationships have been forged through the community work that has been done as part of the Medicaid managed care program and this work will continue to encompass other counties' delivery systems and populations. ODJFS has staff dedicated to developing these relationships, sharing information, and bringing feedback from our local partners into the planning, implementation, and evaluation work of the Office of Ohio Health Plans.

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))**

Ohio has a very small Native American population; the 2001 Ohio Medicaid Report indicates that the Native American population makes up only 0.2% of the total population in Ohio. There are no formal AI/AN groups or organizations in the state that ODJFS interacts with on development and implementation of procedures.

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 §57.65(b) through (d).

Not applicable.

9.10. Provide a one 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.

SCHIP Budget Plan Template

	Federal Fiscal Year 2002 Costs
Enhanced FMAP rate	**0.7115**
Benefit Costs	
Insurance payments	37,420,652
Managed care	37,420,652
Per member/per month rate @ # of eligibles	89.83
Fee for Service	128,578,799
Total Benefit Costs	**165,999,451**
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	**165,999,451**
Administration Costs	
Personnel	
General administration	5,209,589
Contractors/Brokers (e.g., enrollment contractors)	
Claims Processing	
Outreach/marketing costs	
Other	
Total Administration Costs	5,209,589
10% Administrative Cost Ceiling	18,444,383
Federal Share (multiplied by enh-FMAP rate)	121,815,232
State Share	49,393,808
TOTAL PROGRAM COSTS	171,209,040

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

Administrative costs are estimated based on a percentage of current Medicaid administrative costs. No specific cost breakdowns are available because administrative costs are allocated to SCHIP based on cost allocation plans at the state and local level.

Non-Federal plan expenditures are provided through the State's General Revenue Fund (GRF).

The assumptions on which the budget is based are being sent in a separate document.

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. X 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. X The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. X 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))**

X **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))

X **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 complies 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.