

Section 10. Annual Reports and Evaluations (Section 2108)

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

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

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

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

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

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

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- 10.2.4. ☐ A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5. ☐ An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6. ☐ A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7. ☐ Recommendations for improving the program under this Title.
- 10.2.8. ☐ Any other matters the state and the Secretary consider appropriate.

10.3. ☐ The state assures it will comply with future reporting requirements as they are developed.

10.4. ☐ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

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

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

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

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

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

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

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

The application template includes the following sections:

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

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

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

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

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

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

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

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

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Completed state plans for Title XXI should be submitted to the Health Care Financing Administration at the following address:

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

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

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

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

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

SECTION SPECIFIC INSTRUCTIONS (For attached model application template)

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

Introduction

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

Guidance

- Section 1.1.** Check here if child health assistance shall be provided primarily through the development of an independent insurance program that meets the requirements of Section 2103, which details coverage requirements and the other applicable requirements of Title XXI.
- Section 1.2.** Check here if child health assistance shall be provided primarily through providing expanded eligibility under the state's Medicaid program (Title XIX).
- Section 1.3.** Check here if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the state's Medicaid program).

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

Introduction

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

Guidance

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

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

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

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

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

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

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

Section 3. General Contents of State Child Health Plan

Introduction

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

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

Guidance

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

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

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

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

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

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

Section 4. Eligibility Standards and Methodology

Introduction

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

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

Guidance

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

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

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

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

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

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

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

Section 5. Outreach and Coordination

Introduction

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

Guidance

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

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

This section may also include discussions of the following:

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

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

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

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

Section 6. Coverage Requirements for Children's Health Insurance

Introduction

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

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

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

Guidance

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

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

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

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

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

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

A state approved under this provision, may modify its program from time

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

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

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

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

- 6.2.1. - 6.2.28. Check each box the state elects to provide coverage for in its child health assistance plan.
The following are clarifications of certain types of services:
 - 6.2.14. Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.
 - 6.2.15. Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.
 - 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by state law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of

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

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

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

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

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

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

- 6.3.1.1. If a waiver for cost-effective alternatives is sought, coverage provided to targeted low-income children through such expenditures meet the coverage requirements as stated

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

Section 7. Quality and Appropriateness of Care

Introduction

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

Methods for Evaluating and Monitoring Quality

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

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

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

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

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

Tools for Evaluating and Monitoring Quality

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

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

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

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

Guidance

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

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

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

Section 8. Cost-Sharing and Payment

Introduction

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

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

Guidance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Introduction

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

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

Guidance

Section 9.1. Identify and list the specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children. It is suggested the state identify a minimum of 5, but no more than 10 strategic objectives.

Section 9.2. Specify at least one performance goal and performance measure for each strategic objective. We plan on developing, in conjunction with the states, advocacy groups, and other interested parties, national standards for performance measures. We will be working with states to develop the most useful measures. In the interim, we are proposing examples that may be useful for states in designing their performance measures. In the hope of consistent reporting among states, and for the aggregation of national results, we suggest that each performance goal and performance measure be described as reflected in Section 9.3.

Section 9.3. Briefly describe how the plan's performance will be measured objectively and independently. Check all appropriate measures the state will be utilizing.

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

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

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

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

HEDIS 3.0 Reporting Set Measures Relevant to Children and Adolescents

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

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Adolescent well-care visits States receiving funds would be required to cover, and thus to use, this quality measure, only for children less than 19.	% of members who were age 12 through 21 years¹ during the reporting year who have had at least one comprehensive well-care visit with a primary care provider during the reporting year.
<i>Health Plan Descriptive Information</i>	
Pediatric physician specialists	% of each that has completed residency training or fellowship training in their respective specialties and/or are board certified, reported separately for each payer.
Pediatric mental health services	A narrative description of the health plan's pediatric mental health provider network, including the number and types of MH providers specially trained to treat children and adolescents (including, but not limited to, child psychiatrists, child psychologists and social workers, counselors, marriage and family therapists and nurses with special education and training in child and adolescent mental health). If the plan subcontracts for this service, it is required to describe any special requirements included in the subcontracts.

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

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

For the annual assessment:

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

For the evaluation:

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

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

Section 10. Annual Reports and Evaluations

Introduction and Guidance

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

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

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

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

Section 10.1. These assurances address the annual assessment.

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

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

Section 10.3. Self-explanatory

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

GLOSSARY

Adapted directly from SEC. 2110. DEFINITIONS.

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

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

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

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

(1) **IN GENERAL-** Subject to paragraph (2), the term 'targeted low-income child' means a child--

- (A) who has been determined eligible by the State for child health assistance under the State plan;
- (B)(i) who is a low-income child, or
 - (ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
- (C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

(2) **CHILDREN EXCLUDED-** Such term does not include--

- (A) a child who is a resident of a public institution or a patient in an institution for

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mental diseases; or

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

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

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

ADDITIONAL DEFINITIONS- For purposes of this title:

- (1) **CHILD-** The term 'child' means an individual under 19 years of age.
- (2) **CREDITABLE HEALTH COVERAGE-** The term 'creditable health coverage' has the meaning given the term 'creditable coverage' under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
- (3) **GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC-** The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in section 2191 of the Public Health Service Act.
- (4) **LOW-INCOME CHILD -** The term 'low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
- (5) **POVERTY LINE DEFINED-** The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
- (6) **PREEXISTING CONDITION EXCLUSION-** The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
- (7) **STATE CHILD HEALTH PLAN; PLAN-** Unless the context otherwise requires, the

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terms 'State child health plan' and 'plan' mean a State child health plan approved under section 2106.

- (8) **UNCOVERED CHILD-** The term 'uncovered child' means a child that does not have creditable health coverage.'

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7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

SEP 8 1997

Dear State Official:

The Balanced Budget Act of 1997 (BBA) (Public Law 105-33), as amended by recent technical amendments (Public Law 105-100, signed into law on November 19, 1997), established the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act (the Act). This new Title will enable States to extend health insurance coverage for uninsured children through a new CHIP State program, a CHIP expansion of the Medicaid Program, or a combination of both programs. In a letter dated August 27, 1997, the Health Care Financing Administration (HCFA) provided a summary and highlights of the provisions of this landmark legislation.

This letter and attachments are intended to provide additional and more detailed technical guidance regarding implementation of CHIP and provisions related to payment processes and requirements. We intend to incorporate the information contained in this letter and attachments into a regulation to be published in the Federal Register and appropriate State manuals. Although the attached guidance represents what we believe is required under the CHIP provisions, it is still a DRAFT and the content may change. We are sending this to you in DRAFT form both for your review and preliminary planning.

There are 3 attachments to this letter. The first attachment provides DRAFT guidance and information on the CHIP fiscal year allotment, payment processes, financial reporting forms, and related issues. The areas discussed in this attachment include:

- Allotments and redistribution process;
- Payment and grant award process including State reporting and claiming for Federal financial participation (FFP) at regular and enhanced Federal medical assistance percentages (FMAP) for expenditures under the Medicaid program and the CHIP;
- State report forms.

The second attachment is the September 12, 1997 Federal Register notice (MB-115-N) which contains the charts on the States' CHIP reserved allotments for FY 1998 and the enhanced Federal Medical Assistance Percentages (FMAPs), respectively.

The third attachment is a chart of the States' CHIP reserved allotments, revised to include a \$20 million increase in the FY 1998 Title XXI appropriation, which was one of the provisions of the recent technical amendments.

HCFA staff is available to explain the proposed payment process in greater detail. If you have any questions or require further information, please contact your HCFA Regional Office.

Sincerely,



Sally K. Richardson

Director

Center for Medicaid and State Operations

Attachments

Attachment 1: Child Health Insurance Program (CHIP) and Related Medicaid Program Provisions

Attachment 2: September 12, 1997 Federal Register Notice (MB-115-N)

Attachment 3: CHIP reserved allotments for FY 1998 revised to reflect additional \$20 million appropriation.

cc:

Governors' Offices

All HCFA Regional Offices

All PHS Regional Offices

State Health Officers

**Ms. Lee Partridge
Director Health Policy Unit
American Public Welfare Association**

**Ms. Jennifer Baxendell
Senior Policy Analyst
Human Resources Group
National Governors' Association**

**Ms. Joy Wilson
Director, Health Committee
National Conference of State Legislatures**

FINANCING PROVISIONS OF THE CHILD HEALTH INSURANCE PROGRAM (CHIP) AND RELATED MEDICAID PROGRAM PROVISIONS

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DRAFT 12/5/97

FINANCING PROVISIONS OF THE CHILD HEALTH INSURANCE PROGRAM (CHIP) AND RELATED MEDICAID PROGRAM PROVISIONS

I. OVERVIEW

The purpose of the new State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act (the Act), enacted under the Balanced Budget Act of 1997 (BBA) and technical amendments made by Public Law 105-100 on November 19, 1997, is to provide Federal matching funds to States to enable them to extend coverage to uninsured, low-income children in an effective and efficient manner. States are able to use Title XXI funds for obtaining health benefit coverage through (1) a CHIP State Program, (2) a CHIP Medicaid expansion, or (3) a combination of both.

Because the focus of CHIP is on low-income children, Title XXI funds are only available for "targeted low-income children" as described in law. States therefore must describe the standards used to determine the eligibility of targeted low-income children under this new program.

Under the statute, funding may NOT be used for children who are:

- Eligible for Medicaid or covered through other health insurance coverage;
- Inmates of a public institution;
- Patients in an institution for mental diseases; or
- In families who are eligible for coverage because of a family member's employment with a public agency in the State.

Although children eligible for other health insurance coverage generally are not eligible for Title XXI assistance, children currently covered by a State children's health program that receives no Federal funds and was in operation since before July 1, 1997 can be considered eligible as targeted low-income children as long as the program is "State-operated."

In conjunction with CHIP, the BBA included three new provisions designed to increase children's health care coverage through the Medicaid program: (1) presumptive eligibility for children; (2) coverage of Supplemental Security Income (SSI) Program children; (3) and the option to provide 12 months of continuous coverage.

II. EFFECTIVE DATE

Under section 2101(d) of the Act, no State is eligible for payments under Title XXI for child health assistance for coverage provided for periods beginning before October 1, 1997.

III. ALLOTMENT PROCESS

A. **GENERAL.** The amount of the Federal funds available for Title XXI programs is limited for each fiscal year both nationally and on a State-specific basis. Section 2104(a) of the Act specifies the national total allotment available for each fiscal year and section 2104(b) and (c) of the Act indicates the statutory formula for determining the amount of the allotment for each State, or Commonwealth and Territory, respectively. The following sections describe the process under which the Health Care Financing Administration (HCFA) determines the amount of each States' specific allotment for each fiscal year.

The allotment process involves three determinations. First, prior to the beginning of each fiscal year, HCFA will determine the amount of the "reserved allotment" for each State for that fiscal year, calculated in accordance with the statutory State allotment formula. That amount is calculated as if every State had an approved Title XXI State plan. This amount will be recalculated if some States fail to apply for their Title XXI allotment. However, only with the submission and approval of a State plan by the end of the fiscal year will a State's reserved allotment become its actual allotment.

Second, at the end of each fiscal year, HCFA will determine a "final allotment" for each State for that fiscal year. The final allotment will also be calculated in accordance with the statutory allotment formula, but based only on those States that have approved State plans for that fiscal year. States which do not have approved State plans for that fiscal year will not receive a final allotment for that fiscal year. Thus, in the final allotment process, the amount of the national allotment available for States for that year will be allotted only to those States whose plans have been approved by HCFA by the end of the fiscal year.

Finally, in the third year following the State allotment fiscal year, under a "redistribution process" HCFA will determine the amounts of the unused fiscal year allotments from States that have not expended all of their allotment for that fiscal year and redistribute such amounts to States that have fully expended the amount of their allotments for that fiscal year.

B. **RESERVED ALLOTMENT.** For each fiscal year, beginning with FY 1998, HCFA will develop reserved allotments for the 50 States and the District of Columbia and the Commonwealths and Territories based on the principle that an allotment amount should be reserved for each State so that accurate planning may take place, regardless of whether the State has submitted and the Secretary has approved a State child health plan. However, the reserved allotment does not represent an actual allotment available for a State's use; the State allotment

will only be available to the State once the State has submitted and HCFA has approved a Title XXI plan. This means that in order for a State to receive its FY 1998 allotment, its Title XXI State plan must be submitted and approved by September 30, 1998. As long as this plan remains in effect, a State will continue to be eligible to receive its allotment for succeeding fiscal years.

The reserved allotment for each State will be determined by HCFA using the statutory allotment formula and published in the Federal Register prior to the beginning of each fiscal year. The FY 1998 reserved allotments were published as a notice in the Federal Register on September 12, 1997. That notice, which is attached, provides further details on the reserved allotment process. The reserved allotments have been changed however, with the passage of technical corrections that add \$20 million to the total allotment (see attached chart).

C. FINAL ALLOTMENT. In order to receive a final allotment for a fiscal year, a State must submit, and HCFA must approve, the CHIP State plan for that fiscal year before the end of the fiscal year. Because of this requirement, it is critical that States submit their CHIP State plans as soon as possible during the fiscal year for which an allotment is needed. For FY 1998, this means the plans must be approved by September 30, 1998. The length of time from submission to approval will vary depending upon the quality of the plan and the extent to which the requirements under the law are met. For FY 1998, HCFA cannot guarantee it will be able to approve plans submitted after June 30, 1998 by the end of the fiscal year. Furthermore, for CHIP State plans that are not complete upon submission, HCFA may need to request additional information, thereby stopping the time clock on plan approval. Therefore, States should submit their plans for approval as soon as possible before July 1, 1998.

HCFA will determine the final allotments by the end of the fiscal year or very shortly thereafter, based on the actual number of State plans that have been submitted and approved by the end of such fiscal year. At that time HCFA will publish the final allotments in the Federal Register.

1. Final Allotment Formula. The statutory formula for the final allotment is the same as the one used for determining the reserved allotment. However, the potential difference between the final allotment and the reserved allotment relates to the actual number of States that have approved State plans for the fiscal year by the end of the fiscal year.

The process/formula for determining the final allotment is as follows:

a. Determine the Number of States with Approved State Plans as of the End of the Fiscal Year. In order for a State to receive a final allotment for a fiscal year, HCFA must approve the CHIP State plan for that State by the end of the fiscal year. Only States with approved State plans by the end of the fiscal year will be included in the final allotment calculation.

b. Factors in Determining States' Final Allotments. In general, States' final allotments

will be determined in accordance with the statutory formula that is based on two factors, the "Number of Children" (those potentially eligible for CHIP), and the "State Cost Factor." These factors will be multiplied to yield a "final allotment product" for each State.

Once the final allotment product has been determined for all the States with approved CHIP plans, the products for each State will be added to determine a national total. Then, each State's product will be divided by this national total to determine a State specific percentage of the national total available amount for allotment that each State would be eligible to receive. Finally, the State specific percentage is then multiplied by the national total amount available for allotment, resulting in the final allotment for each State.

The final allotments for each state will be published¹ as a notice in the Federal Register.

D. PERIOD OF AVAILABILITY OF ALLOTMENT/REDISTRIBUTION PROCESS.

Sections 2104(e) and (f) of the Act, contain two provisions relating to the availability of funds under a specific fiscal year allotment, and the redistribution of States' unused funds for a particular fiscal year allotment.

1. 3-Year Period of Availability (POA) of Allotment. Section 2104(e) of the Act provides that the amount of a State's CHIP allotment for a fiscal year shall remain available for expenditures by that State for a 3-year concurrent period; the fiscal year and the two subsequent fiscal years. For example, a State's FY 1998 allotment for a State with an approved plan would be available for that State's expenditures for FY 1998 through FY 2000. Furthermore, unused amounts of States' allotments will be redistributed (see below). Such amounts will be available to the States through the end of the fiscal year of the redistribution. If there is a redistribution, the POA therefore is extended for one additional fiscal year.

2. Redistribution Process. Section 2104(f) of the Act requires the Secretary to determine "an appropriate procedure" for the redistribution of the amounts of States' unused allotments to States that have fully expended their allotments for such fiscal year. HCFA intends to redistribute the unused portions as soon as possible after the end of the 3-year POA for the fiscal year allotment.

a. Process for Redistribution of Fiscal Year Allotments. The following identifies the steps in the redistribution process:

I. Identify the States Which Have Unused Amounts of Allotments for a Particular Fiscal Year. As soon as possible after the end of the 3-year POA, HCFA will identify two categories of States:

- States which have not expended all of their allotments; and,
- States which have expenditures at least equal to their allotments during the 3-year

POA (the Redistribution States).

ii. **Identify the Amounts of Unused State Allotments for a Particular Fiscal Year.**

For the first category of States, HCFA will identify the exact amounts of unused allotments. The total of these unused allotment amounts will become the pool available to the second category of States.

iii. **Redistribute the Unused Amounts of State Allotments for a Fiscal Year.** A formula for redistribution of unused portions of State allotments will be determined by the Secretary. The redistribution amounts will be available for such States through the end of the fiscal year in which the redistribution is done. For example, if the year for which unused allotments are being redistributed is FY 1998, the redistribution period would be both determined and available through the end of FY 2001 (that is, September 30, 2001).

b. **Report/Track Final Expenditures.** States that wish to receive redistribution funds would need to continue to report applicable expenditures even after their allotments are exhausted. States which have exhausted their allotments and do not wish to be considered for the redistribution would not be required to continue to report Title XXI expenditures for that purpose. However, States must continue to report Title XXI related Medicaid expenditures to claim FFP at the regular Medicaid FMAP rate.

IV. ENHANCED FMAP

Under sections 1905(b) and 2105(b) of the Act, as amended by the BBA, all allowable Title XXI and certain Title XIX Medicaid expenditures will be matched at an "enhanced FMAP." The attached September 12, 1997 Federal Register describes the statutory formula for determining States' enhanced FMAPs and contains each States' enhanced FMAP for FY 1998.

V. PAYMENT PROCESS

A. **PAYMENT PROCESS OVERVIEW.** States with an approved State plan may receive a Title XXI grant award and may make claims for Federal matching payments from HCFA for expenditures permissible in Title XIX and Title XXI that are applied against their allotments. The process under which the States will make claims for payment are described below in the following sections:

- Types of programs and State options.
- Grant process .
- Application of State expenditures against the State allotments

- 10 Percent Limit
- Administrative Expenditures
- State Matching Requirements under Title XXI
- Maintenance of Effort Requirements
- Prevention of Duplicate Payments
- Family Planning and Indian Health Services (IHS)
- Application of Certain General Provisions
- Budget and Expenditure Systems Reporting

B. TYPES OF PROGRAMS AND STATE OPTIONS. The Title XXI program provides States with the flexibility for providing medical assistance to uninsured low-income children through the CHIP and/or Medicaid programs. This is explicitly referenced in section 2101(a) of the Act which indicates that States may provide assistance to low-income children in 3 ways:

- Under Title XXI only;
- Under Title XIX only;
- Under a combination of both programs.

States may use a non-Medicaid Title XXI program to expand coverage to eligible low-income children. The BBA also amended the Medicaid statute to offer States three optional categories for providing expanded benefits to children provided as Medical assistance in the Title XIX Medicaid program. The three categories of expanded medical assistance benefits in Title XIX are:

- Medical assistance provided to low-income children under section 1905(u)(2) of the Act (section 4911 of BBA);
- Medical assistance provided to low-income children under section 1905(u)(3) of the Act (section 4911 of BBA) (poverty-related children whose coverage is accelerated under the CHIP); and
- Medical assistance provided during a presumptive eligibility period for children under age 19 under section 1920A of the Act (section 4912 of BBA).

The following principles provide a basis for determining how the choices a State makes determine the requirements for the reporting/tracking of the associated expenditures, application against the Title XXI allotment, and the FFP rates to be applied to the applicable expenditures.

1. FFP in expenditures in accordance with an approved XXI plan, and not under a Medicaid expansion, are funded directly from the Title XXI appropriation.
2. FFP in expenditures for services furnished under a Medicaid expansion are funded from the Title XIX Medicaid appropriation (whether or not referenced in a Title XXI plan). However, for States with an approved Title XXI State plan, the amount of the Title XXI allotment must be reduced by the Title XIX expenditures related to the Medicaid expansions.
3. For purposes of tracking against a fiscal year CHIP Title XXI State allotment, applicable Medicaid Title XIX expenditures need to be properly identified, reported, classified, and tracked.
4. Title XIX expenditures related to medical assistance provided to individuals eligible under sections 1905(u)(2) and (u)(3) of the Act are applied against the Title XXI State allotment. FFP is available for section 1905(u)(2) and section 1905(u)(3) expenditures at the enhanced FMAP rate only until the State's Title XXI allotment is exhausted, after which FFP is available at the regular Title XIX FMAP.

1. **Section 1905(u)(2) and (3) Eligibility.** States have the option of covering certain low-income children in their Medicaid programs. If a State has an approved Title XXI child health plan for such children, it may receive Federal funds at the enhanced FMAP for the Medicaid medical assistance expenditures provided to such children and such expenditures would apply against its allotment. As described in the general principles above, the State can cover children under section 1905(u)(2) and (3) of the Act through a Medicaid State plan without having a Title XXI Child health plan. In such a case, no Title XXI allotment would exist and no such expenditures would be applied against the allotment. The FMAP rates are determined by whether the State has a Title XXI plan and the particular section of 1905(u) of the Act under which it is covering children.

The following table summarizes the treatment of these two optional groups under Title XIX and XXI.

MEDICAID TITLE XIX GROUP	APPROPRIATION USED	HAS TITLE XXI PLAN		HAS NO TITLE XXI PLAN	
		APPLIED AGAINST ALLOTMENT	FMAP USED	APPLIED AGAINST ALLOTMENT	FMAP USED
§§1905(u)(2) and (3)*	Title XIX	Yes, until allotment is used up	Enhanced, until allotment is used up. After, at regular FMAP*	No	Regular FMAP

* Prior to the technical amendments made by Public Law 105-100 on November 19, 1997, the enhanced FMAP continued to be available for expenditures related to §1905(u)(3) of the Act even after a State's allotment was used up. With the enactment of P.L. 105-100, the treatment of expenditures related to section 1905(u)(2) and (3) is the same.

2. **Presumptive Eligibility (PE).** Section 1920A of the Act permits States to provide medical assistance under their Title XIX Medicaid programs for up to two months to children during a PE period. Expenditures classified as Medicaid PE expenditures under section 1920A of the Act may only be claimed as medical assistance and matched at the regular Federal medical assistance percentage (FMAP) under section 1905(b) of the Act. Furthermore, if the State has an approved Title XXI child health plan, such PE payments under section 1920A of the Act must be tracked and applied against the Title XXI allotment.

There are a number of options available to States for classifying and reporting medical assistance expenditures provided to children during the section 1920A PE period. In particular, the actual eligibility category in which PE children are ultimately placed may also determine the treatment of States' expenditures for such children during the PE period. The options a State chooses with respect to reporting expenditures during the PE period and the ultimate eligibility (or ineligibility) category, will determine how the expenditures provided during the PE period would be treated for purposes of application against the allotment and the FMAP rate (regular or enhanced) to be applied.

The following describes the options available to States for classifying and reporting expenditures as PE when it does have a Title XXI Child Health Plan and an associated fiscal year State allotment:

a. **Identify and Claim PE on Ongoing Basis - No Adjustments.** The State can identify and claim FFP for all PE expenditures on an ongoing basis (as such expenditures are incurred and claimed to the State) and claim FFP for them with no subsequent adjustments after the actual eligibility determination. In this case, the amounts of the PE expenditures would be applied against the allotment and would be claimed at the regular Title XIX FMAP. This approach may

be the easiest for States to administer.

b. **Report After Actual Eligibility Determination.** The State can wait and report potential PE expenditures after the actual determination of eligibility; in that case it could classify the expenditures in accordance with the actual eligibility determination:

- Expenditures for children determined to be in a regular Medicaid eligibility category (for example, the Temporary Assistance for Needy Families (TANF) program related eligibility under section 1931 of the Act), are funded at the regular FMAP and are not applied against the allotment.
- Expenditures for children determined to be eligible under section 1905(u)(2) or (u)(3) with an approved Title XXI child health plan are funded at the enhanced FMAP.
- Expenditures for children determined to be eligible under a State's CHIP are funded at the enhanced FMAP.
- Expenditures for children determined not to be eligible for either program are funded at the regular FMAP and, if the State has a Title XXI allotment, are applied against the allotment; that is, such expenditures are treated and reported as PE expenditures.

c. **Identify and Claim PE on Ongoing Basis - Adjust After Actual Eligibility Determination.** The State can identify and claim FFP for all PE expenditures on an ongoing basis, as such expenditures are paid by the State (as would be done in a. above). However, after the actual eligibility determination is made, adjustments would be made to reflect the actual eligibility category determination. In this case, the amounts of the PE expenditures would be reported on an ongoing basis, applied against the allotment, and would be claimed at the regular Title XIX FMAP. After the actual eligibility determination, the State would make an adjustment to the previously reported expenditures as in b. above.

The chart on the following page describes the various options related to PE and the interaction between Title XIX and Title XXI.

HOW TO REPORT PRESUMPTIVE ELIGIBLE (PE) EXPENDITURES ON A QUARTERLY BASIS							
PE CASE	State Has Title XXI Plan					State Has No Title XXI Plan	
	Appropriation Used	State Opts to Report During PE Period		State Opts to Reclassify Expenditures		FMAP Rate Used	Counted Against Allotment
		FMAP Rate Used During PE Period	Counted Against Allotment During PE Period	FMAP Rate Used After Final Determination	Counted Against Allotment After Final Determination		
PE 1 - Ultimately Determined to Be a Regular Title XIX Eligible	Title XIX	Regular Title XIX	Yes	Regular Title XIX	No	Regular Title XIX	No
PE 2 - Ultimately Determined to Be §1905(u)(2) or (u)(3) Eligible	Title XIX	Regular Title XIX	Yes	Enhanced Title XXI	Yes	Regular Title XIX	No
PE 3 - Ultimately Determined to be NOT Eligible or Never Submits an Application	Title XIX	Regular Title XIX	Yes	Regular Title XIX	Yes	Regular Title XIX	No

C. GRANT PROCESS. (§2105(e))

1. Obligation/Appropriation Requirement to Issue States' Entire Fiscal Year Allotment as Grant Awards in the Fiscal Year. Because of the Title XXI appropriation language, the Title XXI appropriated funds for each fiscal year (that is, the amounts referred to in section 2104(a)(1)-(10) of the Act, for the FYs 1998-2007, respectively) the entire Title XXI appropriation amount for each fiscal year must be "obligated" by the Federal government by the end of such fiscal year. Any funds not obligated by the Federal government by the end of the fiscal year (that is, prior to the close of the related Federal government's accounting system for that fiscal year) will no longer be available to any State.

The funds are obligated by issuing Title XXI grant awards. To ensure that all of the appropriated funds are available to States, HCFA will issue grant awards to all States with Title XXI State plans approved by the end of the fiscal year which equal, in total, the national amount available for allotment to the 50 States, the District of Columbia, and the Commonwealths and Territories for that fiscal year. Such grant awards must be issued by the time the HCFA/HHS accounting system closes with respect to that fiscal year. The total of the grant awards for the fiscal year will equal the States,' Commonwealths,' and Territories' final allotments, described earlier. Therefore, it is important for Title XXI plans to be submitted as soon as possible before July 1, 1998.

2. State Funding Requests/Amount and Issuance of Grant Awards. As indicated above, in order to ensure that all appropriated funds are available, HCFA will need to issue Title XXI grant awards to all States with approved State plans by the close of the fiscal year in amounts equal to the total available fiscal year appropriation.

a. Budget Submissions/Grant Awards for First Three Quarters of the Fiscal Year. For the first three quarters of the fiscal year, each State with an approved plan will submit a budget request in an appropriate format. HCFA is developing both budget and expenditure reporting mechanisms and forms, for this purpose. For the first three quarters of the fiscal year, HCFA will review, determine the amount of, and issue grant awards, based on the States' Title XXI budget request submissions.

b. Budget Submissions/Grant Awards for Fourth Quarter of the Fiscal Year. For the fourth quarter of the fiscal year, States will also submit their Title XXI budget requests. However, although HCFA will review the States' fourth quarter budget requests, and such budget request amounts will be used to project States' actual outlays for the quarter, the final grant award for the fourth quarter will be based on the amount of the States' final allotments for the fiscal year. This is necessary because, in order to obligate and thereby protect the full amount of the appropriation, the grant awards for the entire fiscal year for all States with approved plans must total the full amount of the available appropriation.

Because the States' final allotments for the fiscal year may differ from their reserved allotments, two grant awards may be needed for the fourth quarter of the fiscal year. Each State's initial fourth quarter grant award will be based on the difference between the State's reserved allotment for the fiscal year, and the total of the grant awards for the first three quarters that have already been issued. The effect of this is that the total of the grant awards to each State for the four quarters of the fiscal year will equal the State's reserved allotment for the fiscal year. However, a second (final) grant award may be issued by the close of that fiscal year, obligating any additional funds a State may be due as a result of the calculation of the State's final allotment. This is necessary because a State's final allotment may be greater than its reserved allotment; and as a result, the total of all grant awards issued to the State for the fiscal year must equal the State's final allotment for that fiscal year.

3. Information Regarding State Administration of the Title XXI Program. In order to issue a Title XXI grant award to the proper State official, each State will need to provide HCFA with the following information regarding the administration of the Title XXI program:

- Name and address of the State agency/organization administering the Title XXI program
- The employer identification number (EIN)
- A State financial official contact name and telephone number.

Note, if this information is the same as that for the Medicaid program, the Payment Management Systems (PMS) account information should already be established and would be used for the Title XXI program. Similarly, the organization administering the Title XXI program may not be the same as the Medicaid agency, in which case the PMS will search its central registry system to determine if an EIN already exists for the organization. If it does, that information would be used for the Title XXI program. If there is no EIN for the Title XXI organization, the PMS will assign the proper payment identification number (PIN) number to establish the Title XXI agency.

D. APPLICATION OF STATE EXPENDITURES AGAINST THE STATE ALLOTMENTS

1. OVERVIEW. Title XXI statute requires that two categories of expenditures be tracked against the Title XXI fiscal year allotments:

- Title XXI expenditures (referred to in 2105(a) of the Act)
- Certain Title XIX Medicaid Expenditures (referred to in §2104(d) of the Act)

These two categories of expenditures must be reported appropriately and applied against the

allotments. The following sections describe how the coordination, reporting, and application of the Title XIX and Title XXI expenditures against the Title XXI fiscal year allotments will take place.

2. **PRINCIPLES FOR TRACKING EXPENDITURES AGAINST ALLOTMENTS.**

Under §2104(d) of the Act, Title XXI fiscal year allotments must be reduced by the following categories of expenditures:

- Payments for certain low-income children under §1905(u)(2) and(u)(3) of the Act (referred to as u₂ and u₃ payments);
- Payments to States for medical assistance during a presumptive eligibility period under §1920A of the Act (referred to as "PE" payments);
- Payments to States for child health assistance under section 2105(a) of the Act.

The following principles, based in statute, will be used by HCFA to:

- Coordinate the application of the Title XIX and Title XXI expenditures against the Title XXI fiscal year allotments
- Determine the order of these expenditures in such application; and
- Determine how such expenditures apply against multiple fiscal year allotments.

1. **Title XIX Before Title XXI Expenditures (§2104(d)).** Under the statute, Title XIX expenditures must be applied against Title XXI fiscal year allotments before Title XXI expenditures are applied. Specifically, u₂, u₃, and PE payments under the Medicaid program are applied before any Title XXI payments are applied.
2. **Expenditures Must Be Applied Against a Fiscal Year Allotment in the Quarter in Which they Are Claimed . (§2104(b), (d), §2105(a)).** Title XIX and Title XXI expenditures must be applied against a fiscal year allotment based on the quarter in which they are claimed. Thus, Principle 1 above applies only on the basis of the quarter the expenditures are claimed. For example, if Title XXI expenditures were claimed in one quarter and Title XIX expenditures were claimed in a second, subsequent quarter, the Title XXI expenditures claimed in the first quarter would be applied against the fiscal year allotment before the Title XIX expenditures claimed in the second quarter.
3. **Expenditures Should be Applied Consistently Over the 3-Year Period of**

Availability (POA) for Fiscal Year Allotments (2101(a), §2104(e), (f)). In order to treat States consistently in the redistribution process, HCFA will attempt to apply the same ordering of expenditures and allotments for all States.

4. **Title XIX Expenditures Should be Applied in the Order Which Provides the Most Benefit for States.** Title XIX expenditures should be applied in the order that maximizes Federal reimbursement for States. We believe the order which most benefits States is as follows: u_2 expenditures first, then u_3 expenditures, and lastly PE expenditures. This is because the u_2 and u_3 are funded at the enhanced FMAP rate which drops to the regular FMAP rate when the allotment is exhausted. PE expenditures are always matched at the regular (lower) FMAP, and also continue to be matched after the allotment is exhausted.
5. **Apply Expenditures and Allotments in the Least Administratively Burdensome, and Most Effective and Efficient Manner (§2101(a)).** To the greatest extent possible, HCFA will use processes which are the least administratively burdensome, and the most effective and efficient. We believe the "first-in-first-out" (FIFO) method should be applied both with respect to the application of expenditures against the allotment and the availability of fiscal year allotments. Thus, expenditures would be applied against a fiscal year allotment in the order they are claimed, and an earlier fiscal year allotment would be used before a subsequent fiscal year allotment. For example, in the case where a State had FY 1998 allotment amounts carried over to FY 1999, expenditures claimed in FY 1999 would first be counted against the FY 1998 carryover allotment amounts before counting them against the FY 1999 allotment (see Principle 7).
6. **Application of Expenditures for One Fiscal Year Against a Subsequent Fiscal Year Allotment (§2104(e), (f)).** Expenditures claimed in one fiscal year would be applied against a subsequent fiscal year's allotment, if the earlier fiscal year's allotment was exhausted. However, this could not be done until the subsequent year's allotment was actually available. For example, expenditures claimed in FY 1998 after the FY 1998 allotment was exhausted would be applied against the FY 1999 allotment, but only after FY 1999 had begun.
7. **Amounts of a State's Prior Year Allotments that Have Not Been Expended and are "Carried Over," are Available for Expenditures Within the 3-Year POA for the Carryover Allotment (§2104(e), (f)).** Under FIFO (see Principle 5), unexpended amounts of an allotment for a fiscal year would be carried over for use in subsequent fiscal years and through the end of the 3-year POA. Furthermore, the carried over allotment would be used before the subsequent fiscal year allotment was used. For example, unspent amounts of the FY 1998 allotment may

be carried over up through FY 2000. The carried over amounts of the FY 1998 allotment would be used before the allotments for FYs 1999 - 2000; that is, expenditures for FYs 1999 and 2000 would be applied against the FY 1998 carryover amount before being applied against the FYs 1999 - 2000 allotments (Principle 5).

Application of Principles 5-7 may mitigate the necessity of having to go through a redistribution process because earlier allotments would be exhausted by expenditures as they were claimed during the POA.

3. EXAMPLES ILLUSTRATING APPLICATION OF TRACKING PRINCIPLES

The following examples illustrate the above principles.

- **Example 1 - Illustration of Principle 1.** The amount remaining of the FY 1998 allotment is \$5 million. Title XIX expenditures claimed in a quarter are \$4 million. Title XXI expenditures claimed in the same quarter are \$3 million. Under Principle 1, the \$4 million in Title XIX expenditures are applied against the remaining \$5 million of the FY 1998 allotment first, leaving \$1 million remaining of the FY 1998 allotment. Therefore, FFP would be available for only \$1 million of the \$3 million in Title XXI expenditures; and at that point, the FY 1998 allotment would be exhausted. The remaining \$2 million in claims for Title XXI expenditures would have to be funded by the State.
- **Example 2 - Illustration of Principle 2.** The FY 1998 allotment is \$5 million. In quarter 1 of FY 1998, \$3 million in Title XXI expenditures are claimed. In quarter 2 of FY 1998, \$4 million in Title XIX expenditures are claimed. Since the \$3 million in Title XXI expenditures were claimed (first) in quarter 1, under Principle 2, they would be applied first against the FY 1998 allotment. This would leave \$2 million remaining under the FY 1998 allotment. In quarter 2 only \$2 million in FFP would be available from the FY 1998 allotment with respect to the \$4 million Title XIX expenditures claimed in that quarter. At that point, the FY 1998 allotment would be exhausted, and FFP for the remaining \$2 million in Title XIX expenditures would be available under Medicaid at the regular Medicaid FMAP.
- **Example 3 - Illustration of Principle 4.** The FY 1998 allotment is \$5 million. In Quarter 4 of FY 1998 the following expenditures are claimed: u₂ \$5 million, u₃ \$4 million, and PE \$1 million. In accordance with Principle 4, in this case the \$5 million u₂ expenditures would be applied against the FY 1998 allotment first. Since the amounts of the u₂ expenditures and the FY 1998 allotment are the same,

the entire amount of **u₂** expenditures would be reimbursed at the enhanced FMAP. Although the \$5 million FY 1998 allotment has been exhausted, the **u₃** and **PE** expenditures would still be reimbursed under the Medicaid program at the regular FMAP rate. Again, this is because the regular Medicaid FMAP rate continues for these groups, even though the FY 1998 allotment was exhausted.

- **Example 4 - Illustration of Principle 6.** The FY 1998 and 1999 allotments are \$5 million for each fiscal year. The State claims \$6 million in Title XXI expenditures for FY 1998, and \$4 million in Title XXI expenditures for FY 1999. In this case the \$6 million FY 1998 expenditures reduce the FY 1998 allotment to \$0 with \$1 million of the FY 1998 expenditures remaining unpaid. When the FY 1999 allotment becomes available, the remaining \$1 million in FY 1998 expenditures would be applied against the FY 1999 allotment, leaving \$4 million remaining of the FY 1999 allotment. The \$4 million in Title XXI FY 1999 expenditures claimed would then be paid from the FY 1999 allotment, thereby exhausting the remaining FY 1999 allotment.
- **Example 5 - Illustration of Principles 5 and 7.** The FY 1998 and 1999 fiscal year allotments are \$5 million for each fiscal year. The State claims \$4 million in Title XXI expenditures for FY 1998 and \$6 million in Title XXI expenditures for FY 1999. Since the FY 1998 was only reduced by the \$4 million amount in FY 1998 Title XXI expenditures, the \$1 million remaining of the FY 1998 allotment would be "carried over" to FY 1999. In applying the FY 1999 expenditures, \$1 million of the \$6 million would first be applied against the carryover of the FY 1998 allotment. The remaining \$5 million for the FY 1999 claims would be applied against the remaining \$5 million allotment for FY 1999, reducing the remaining FY 1999 allotment to \$0.

E. 10 PERCENT LIMIT. Under §2105(c)(2)(A) of the Act, FFP at the enhanced FMAP is available only up to a "10 Percent Limit" for certain categories of State Title XXI expenditures:

- Administrative expenditures;
- Outreach;
- Health services initiatives; and
- Certain other child health assistance

Under the 10 Percent Limit, the "total computable" amount of the above States' Title XXI expenditures (representing the combined total State and Federal share of the expenditures) for

which FFP is available cannot exceed 10 percent of the sum of the following:

- The total computable amount of expenditures under §2105(a) of the Act,
- The total computable amount of expenditures for which the enhanced FMAP was available under §§1905(u)(2) and (u)(3) of the Act.

The 10 Percent Limit is applied on an annual fiscal year basis, and may be waived by the Secretary under section 2105(c)(2)(B) of the Act when coverage is provided through cost-effective community based health delivery systems. Note, prior to the technical amendments enacted under Public Law 105-100 on November 9, 1997, the 10 Percent Limit was calculated on a quarterly basis. Furthermore, prior to the technical amendments, the limit was calculated on the basis of the Federal share of the expenditures while the expenditures applied against the limit were in total computable amounts. The technical amendments made the calculation of the limit and the expenditures applied against the limit be based on total computable amounts.

The following formula for the 10 Percent Limit ($L_{10\%}$) is in accordance with the referenced statutory provisions. Note, as indicated, the 10 Percent Limit ($L_{10\%}$) is a limit on the amounts of total computable expenditures for which FFP is available. Also, the expenditures that are used to calculate the limit are also in total computable amounts.

$$L_{10\%} = (a_1 + u_2 + u_3)/9$$

a_1 = Total computable expenditures for the fiscal year under §2105(a)(1) of the Act

u_2 = Total computable expenditures for the fiscal year under §1905(u)(2) of the Act

u_3 = Total computable expenditures for the fiscal year under §1905(u)(3) of the Act

The applicable expenditures are subject to the 10 Percent Limit on an annual fiscal year basis.

The following example illustrates the calculation of the 10 Percent Limit:

Example. The State's Title XXI enhanced FMAP is 65% (that is, 0.65). The total computable expenditures claimed for the fiscal year for the §2105(a)(1) category (a_1) is \$10 million; the Federal share claimed for those expenditures is \$6.5 million (.65 x \$10 million). The total computable expenditures claimed for the fiscal year for the §2105(a)(2)(A)-(D) category is \$3 million; the Federal share claimed for those expenditures is \$1.95 million (.65 x \$3 million). The total computable expenditures

claimed for the fiscal year for the §1905(u)(2) category (u_2) is \$3 million, and the Federal share claimed for those expenditures is \$1.95 million (.65 x 3 million). The total computable expenditures claimed for the fiscal year for the §1905(u)(3) category (u_3) is \$2 million, and the Federal share claimed for those expenditures is \$1.3 million (.65 x 2 million).

In this example, the 10 Percent Limit is a total computable amount of \$1,666,667, calculated as follows:

$$L_{10\%} = (a_1 + u_2 + u_3)/9$$

a_1 = Total computable expenditures for the fiscal year under §2105(a)(1) of the Act

u_2 = Total computable expenditures for the fiscal year under §1905(u)(2) of the Act

u_3 = Total computable expenditures for the fiscal year under §1905(u)(3) of the Act

$$\begin{aligned} \text{10 Percent Limit} &= ((\$10 \text{ million } (a_1) + \$3 \text{ million } (u_2) + \$2 \text{ million } (u_3))/9 \\ &= \$15 \text{ million}/9 = \$1,666,667 \end{aligned}$$

In this example, FFP would not be available for that portion of the §2105(a)(2) expenditures that are in excess of the 10 Percent Limit of \$1,666,667, a total computable amount. Thus, although the State submitted \$3 million in total computable amounts of §2105(a)(2) expenditures, only \$1,666,667 of the \$3 million total computable amount would be allowable, and the remainder of \$1,333,333 total computable amount would be potentially disallowable.

Under this Example, the allowable amount of Federal funds available under the 10 Percent Limit would be \$1,083,334 (.65 x \$1,666,667); and the unreimbursable amount of Federal funds in excess of the 10 Percent Limit would be \$866,667 (.65 x \$1,333,333).

F. ADMINISTRATIVE COSTS IN TITLE XXI

1. **General.** Title XXI of the Act does not contain a specific definition of administrative expenditures. However, section 2105(a)(2)(D) of the Act indicates that payment under title XXI is available for the "other reasonable costs incurred by the State to administer the plan." Administrative expenditures, and certain other expenditures specified in statute (other child health

assistance, health services initiatives, and outreach activities) in excess of the 10 Percent Limit described above would not be considered to be reasonable. Additionally, in general, section 2101(a) of the Act refers to the provision of child health assistance by States "in an effective and efficient manner." Other sections of title XXI provide additional guidance related to what may be considered "effective and efficient" and/or identified as administrative activities:

- **Data Collection/Records/Reports.** Section 2107(b)(1) of the Act requires State child health plans to assure that data is collected, records maintained, and reports provided to the Secretary, for the purpose of enabling "the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans" under Title XXI.
- **Annual Assessment of Operation of State Plan/Report to Secretary.** Section 2108(a)(1) of the Act, requires States on an annual basis to "assess the operation of the State plan under this title in each fiscal year, including the progress made in reducing the number of uncovered low-income children," and report the results of this assessment to the Secretary.
- **Assessment of Effectiveness.** Section 2108(b)(1)(A) of the Act refers to "an assessment of the effectiveness of the State plan in increasing the number of children with creditable health insurance."
- **Quality Assurance.** Section 2102(a)(7) of the Act refers to "methods (including monitoring)" to assure quality and appropriateness of care under the Title XXI State plan. Section 2108(b)(1)(B)(ii) of the Act refers to State evaluations of the quality of health care coverage in the State's Title XXI State plan.
- **Eligibility Determinations.** Section 2102(b) of the Act refers to activities related to eligibility determinations such as screening and intake.
- **Outreach and Coordination.** Sections 2102(a)(3), (b)(3), and (c), and 2108(b)(1)(D) of the Act refers to coordination and outreach activities (see subsections g. and h. below).
- **Measurement of Performance.** Section 2107 of the Act generally refers to activities related to measurement of performance.
- **Public Involvement.** Section 2107(c) of the Act refers to activities related to the "process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement."

2. **Administrative Costs are Differentiated from Program Costs.** For purposes of

payment under section 2105(a) of the Act, administrative costs are differentiated from the program costs referred to as "child health assistance" in section 2105(a)(1) of the Act (child health assistance is further defined in section 2110(a) of the Act). Child health assistance is generally referred to as "payment for part or all of the cost of health benefits coverage for targeted low-income children." Payment for such program costs are not considered to be payment for administrative costs, and are generally not subject to the 10 Percent Limit.

3. Principles for Determining Administrative Expenditures. The following principles are applicable for determining the allowability, category, and amount of payment for administrative expenditures under Title XXI:

a. Federal Financial Participation (FFP) Rate for Administration. Under section 2105(b)(1) of the Act, all Title XXI expenditures, including those for administrative costs, are matched at a rate equal to the enhanced Federal Medical Assistance Percentage (FMAP).

b. Title XXI Funds for Administrative Expenditures Related to Title XIX Expansions.

In general, the enhanced matching rate under Title XXI is not available for administrative costs for activities related to other non-Title XXI programs. An exception to this is that a State may elect (at its option) to claim FFP at the Title XXI enhanced matching rate for all Title XIX administrative activities directly related to certain Title XIX program expansions that are the result of the CHIP legislation. Specifically, this refers to coverage under Title XIX of targeted low-income children under sections 1905(u)(2) and (3) of the Act, and provision of medical assistance to a child under Title XIX during a presumptive eligibility period under section 1920A of the Act.

If a State elects to claim these Title XIX administrative costs under Title XXI, the State must continue to claim all such expenditures on the Title XXI expenditure forms (discussed below) until the 10 percent limit and/or the Title XXI allotment is reached. Such expenditures will: (1) reduce the State's Title XXI allotment, (2) count against the State's 10 percent limit, (3) be reimbursed at the enhanced Title XXI matching rate, and (4) be paid for out of the Title XXI appropriation.

Once the State reaches its 10 percent limit and/or its Title XXI allotment it may then revert to claiming all such administrative expenditures under the Medicaid program as discussed below. This option of claiming the administrative expenditures under Medicaid is only applicable to expenditures for CHIP-related Medicaid expenditures.

Alternatively, a State may elect (at its option) not to claim FFP at the Title XXI enhanced matching rate for Title XIX administrative activities directly related to the Title XXI related Title XIX program expansions. If a State elects to claim for these administrative expenditures under Medicaid, the State must continue to claim all such expenditures on the Title XIX expenditure forms. Such expenditures will: (1) not reduce the State's Title XXI allotment, (2) not count against the State's 10 percent limit, (3) not be reimbursed at the enhanced Title XXI matching

rate, but will be reimbursed at the applicable Medicaid administrative matching rate, and (4) be paid for out of the Title XIX appropriation.

The following principles summarize the treatment as administrative costs for Title XIX activities:

- **States that do NOT Elect CHIP Related Title XIX Expansions.** States that do not choose to cover the CHIP related Title XIX expansions will only be able to claim for allowable administrative costs under their Title XXI program.
- **States that DO Elect CHIP Related Title XIX Expansions.** States that do choose to cover the CHIP related Title XIX expansions have a choice of programs under which to claim FFP for the related administrative expenditures. If claimed under Title XXI, the FFP rate is the enhanced FMAP; if claimed under Title XIX, the FFP rate is the regular Medicaid FFP.

c. **Administration of Title XXI, NOT Other Programs.** Allowable Title XXI administrative activities should support operation of the Title XXI State plan. FFP for administration under Title XXI would NOT be available for activities related to other programs. For example, FFP would not be available for generalized health education or social service functions (however, see the exception regarding Title XIX expansions discussed above in subsection b., and the exceptions regarding outreach and coordination discussed below in subsections g. and h.).

d. **Administrative Costs Included in Child Health Assistance.** "Child health assistance" means payment for part or all of the cost of health benefits coverage for any of the categories of services listed in section 2110(a) of the Act. State Title XXI administrative expenditures, considered under section 2105(a)(2)(D) of the Act as "other reasonable costs incurred by the State to administer the plan," are applied against the 10 Percent Limit.

State child health assistance expenditures includes State payments made directly to providers as well as payments for the purchase of health insurance coverage. The reimbursement rates associated with the direct payments to providers may account for/include certain administrative costs of the providers related to furnishing the services. Similarly, the reimbursement rates associated with payments for health insurance coverage, such as capitation payments, may also account for/include certain administrative costs of the managed care entities contracted to the State to provide child health assistance. However, the administrative costs included in the child health assistance reimbursement rates are NOT considered as State administrative expenditures of the Title XXI in this regard; rather, such costs are considered to be State program (that is, child health assistance) expenditures, similar to the way capitation administrative expenditures are claimed under Medicaid. Therefore, these costs are not applied against the 10 Percent Limit.

Note, there are two categories of child health assistance expenditures; those considered under

section 2105(a)(1), which is the basic child health assistance program described in section 2103 (and within the definition under section 2110(a)), and those under section 2105(a)(2)(A), which are other child health assistance expenditures outside of the basic program. For example, section 2105(a)(2)(A) expenditures might include a program to provide free immunizations for all children in the primary school system in a low-income area. Child health assistance expenditures under 2105(a)(1) are exempt from the 10 Percent Limit, while all "other child health assistance expenditures" under section 2105(a)(2)(A) are applied against the 10 Percent limit. State administrative expenditures related to the provision of child health assistance under both section 2105(a)(1) and (a)(2)(A) are applicable against the 10 Percent Limit.

e. **No Duplicate Payments.** Payments for allowable Title XXI administrative activities should not duplicate payments that are included and paid as part of another payment mechanism, for example:

- rates for outpatient clinic services
- case management services
- part of a capitation rate
- other provider rate
- through some other program (e.g., State/Federal)

Furthermore, in no case should there be reimbursement for more than the actual costs incurred by a State. That is, amounts in excess of actual costs are not considered to be costs incurred by the State. It is the State's responsibility to ensure that there is no duplication in the claims prior to the State submitting any claims for HCFA review.

f. **Payment for Startup Costs.** Under title XXI, FFP is available at the enhanced FMAP for a State's program and administrative expenditures (including related startup costs) during a period for which the State has an approved title XXI plan in effect. Initial State plans can be approved effective as early as October 1, 1997. As indicated above, such administrative expenditures (under section 2105(a)(2) of the Act) are subject to the 10 Percent Limit which is calculated on a fiscal year basis. Therefore, startup costs will be limited by the amount of section 2105(a)(1), 1905(u)(2) and 1905(u)(3) expenditures claimed during the fiscal year in which the startup period occurs. The following example illustrates the availability of FFP for startup costs.

Example. The 10 Percent Limit formula is:

$$L_{10\%} = (a_1 + u_2 + u_3)/9$$

Where a_1 = §2105(a)(1) expenditures, u_2 = §1905(u)(2) expenditures, and u_3 = §1905(u)(3) expenditures

In the first two quarters of the fiscal year, the State's a_1 , u_2 , and u_3 expenditures are \$0 and the State's start up administration expenditures (a_2 expenditures) are \$2.0 million. In the third quarter of the fiscal year, the a_1 , u_2 , and u_3 expenditures total \$.5 million and the startup and other (a_2) administrative expenditures are \$1.5 million. In the fourth quarter of the fiscal year, the a_1 , u_2 , and u_3 expenditures total \$8.5 million and the startup and other (a_2) administrative expenditures are \$1.0 million. The totals for the fiscal year are: \$9.0 million (\$0 + \$.5 million + \$8.5 million) in a_1 , u_2 , and u_3 expenditure, and \$4.5 (\$2.0 + \$1.5 million + \$1.0 million) in startup and other (a_2) administrative expenditures. In this example, the 10 Percent Limit is \$1.0 million, calculated as follows:

$$L_{10\%} = (a_1 + u_2 + u_3)/9 = \$9.0 \text{ million}/9 = \$1.0 \text{ million}$$

In this example, FFP would be available at the enhanced FMAP for \$1.0 million of the \$4.5 million of administrative costs. Thus, the relatively lower benefit expenditures at the beginning of the fiscal year combined with the relatively higher benefits expenditures at the end of the fiscal year serve as the basis for the final 10 Percent Limit calculated on a fiscal year basis.

It is important to note that if a State has no expenditures other than, for example, startup administrative expenditures under section 2105(a)(2)(D) of the Act during a fiscal year, no FFP under Title XXI will be available for such expenditures. This is because the 10 Percent Limit in this example would be \$0 calculated as follows:

$$L_{10\%} = (a_1 + u_2 + u_3)/9 = (\$0 + \$0 + \$0)/9 = \$0$$

g. Outreach. Outreach activities are specifically referenced and defined in sections 2102(c)(1) and 2105(a)(2)(C) of the Act as:

"Outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program."

Therefore, FFP is available for activities related to Title XXI eligibility outreach and intake, in order to enroll children in the Title XXI program. FFP may also be available for such outreach related to public or private health coverage programs. Under section 2105(c)(2)(A) of the Act, outreach activities are subject to the 10 percent limit, unless subject to a variance of the 10 Percent Limit under section 2105(c)(2)(B) of the Act.

As indicated in subsection b. above, States may choose how to claim FFP for expenditures for outreach activities related to CHIP. If claimed under Title XXI, FFP would be available at the enhanced FMAP rate and subject to the 10 Percent Limit; if claimed under Title XIX, FFP for such expenditures would be available at the regular Medicaid FFP rate for administration.

h. Coordination with Other Health Insurance Programs. Section 2102(c)(2) of the Act, specifically allows for administrative activities related to coordinating administration of the States' Child Health Insurance Programs "with other public and private health insurance programs." Therefore, FFP at the enhanced FMAP rate is available under Title XXI specifically for coordination activities related to the administration of Title XXI with other public and private health insurance programs. As indicated in subsection c. above, FFP would not be available for the costs of administering the other public and private health insurance programs. Coordination activities must be distinguished from other administrative activities common among different programs.

As indicated in subsection b. above, States may choose how to claim FFP for expenditures for coordination activities related to CHIP. If claimed under Title XXI, FFP for such expenditures would be available at the enhanced FMAP rate and subject to the 10 Percent Limit; if claimed under Title XIX, FFP would be available at the regular Medicaid FFP rate for administration.

G. STATE MATCHING REQUIREMENTS UNDER TITLE XXI. There are a number of provisions relating to the funds States may use as the State share of Title XXI expenditures:

1. Use of Non-Federal Funds. Section 2105(c)(4) of the Act indicates that "amounts provided by the Federal government, or services assisted or subsidized to any significant extent by the Federal government, may not be included in determining the amount of non-Federal contributions..."

2. Offset of Premiums and Other Cost Sharing Amounts. Section 2105(c)(5) of the Act establishes that a State must offset the amount of expenditures it can claim against its allotment by any premiums or other cost-sharing receipts that it collects. Amounts of States' beneficiary cost sharing receipts would not be considered part of the State match for expenditures under Title XXI as described in section 2105(c)(5) of the Act. Beneficiary cost-sharing revenues must be applied to offset, that is reduce, Federally matchable Title XXI expenditures. Thus, such revenues effectively reduce both the State and Federal shares of allowable Title XXI expenditures.

For example, if the total expenditure for a beneficiary is \$1,000 and the State collects \$100 in beneficiary cost-sharing, the net expenditure claimable for Title XXI against the State's allotment is \$900. If the enhanced Federal matching rate for that State is 65 percent, the Federal government would provide \$585 and the State would provide \$315. As a result, the amount from the beneficiary cost-sharing is distributed proportionately between the State and Federal government.

3. Provider Taxes and Donations. Section 2107(e)(1)(C) of the Act imposes the same limitations on the use of provider taxes and donations as State share as are imposed under Section 1903(w) of Title XIX.

4. **Reporting of Sources of Non-Federal Share.** Section 2107(d) requires the State child health plan to include details on the sources of the non-Federal share of plan expenditures.

5. **Government/Department Wide Draw Down Requirements.** All Government-wide and Departmental requirements for drawing down Federal funds will be applicable to Title XXI. The State matching funds must be available at the time the State draws down the Federal funds.

6. **Public Funds.** The use of IGTs, certified public expenditures (CPE), and public funds (including local/county funds) as the required State share of Title XXI expenditures is not prohibited under Title XXI. In general, the provisions applicable to the Medicaid program related to IGTs and CPEs should apply in title XXI (for example, Federal regulations at 42 CFR 433.51).

7. **In-Kind Contributions.** Federal regulations at 45 CFR Part 74 that deal with uniform administrative requirements for awards and subawards to various entities including grants and agreements with States apply to Title XXI. Therefore, in kind contributions provided by either the public or private sector would qualify for State match if they meet the criteria set forth in 45 CFR 74.23. Furthermore, section 2107(e)(1)(C) of the Act indicates that the provisions of section 1903(w) of the Act relating to limitations on provider taxes and donations apply with respect to Title XXI. Therefore, in kind services may qualify for State match if they are not in violation of section 1903(w).

H. **MAINTENANCE OF EFFORT (MOE).** Beginning with FY 1999, section 2105(d)(2) of the Act requires that the amount of a State's allotment for a fiscal year be reduced by the amount that the "State children's health insurance expenditures" for the previous fiscal year is less than the total of such expenditures for FY 1996. For purposes of this provision, the term "State children's health insurance expenditures" means:

- The State share of Title XXI expenditures
- The State share of expenditures under Title XIX attributable to an enhanced FMAP under section 1905(u) of the Act.
- State expenditures under health benefits coverage under an existing comprehensive State-based program.

With respect to this last condition, under section 2103(d)(1)(C) of the Act, the MOE provision applies only to 3 States: New York, Florida, and Pennsylvania. However, one of the administration's main objectives is to make sure that Federal dollars are used to cover children who have no insurance coverage and are not covered by Medicaid. We are concerned that singling out only three States for the maintenance of effort on current State programs is inconsistent with this intent. We will work with Congress to clarify whether this provision should apply to all States with such programs.

If these States obtain an approved State Child Health Plan under Title XXI, then the State funds that are used to fund their existing programs can be used to draw an enhanced Federal match for expenditures under their new plans. These States must continue to spend --at least-- the same level of State funding for child health insurance as was spent in 1996, but they can draw an enhanced match on this spending under an approved State plan.

The limited maintenance of effort requirements on spending *should not be confused* with the requirements on maintaining Medicaid eligibility levels. In order to receive Title XXI funds, States must continue to maintain their Medicaid eligibility standards and the methodologies that were effective as of June 1, 1997. If a State wants to expand Medicaid and draw down Title XXI funds at the enhanced matching rate, it must maintain the Medicaid eligibility requirements that were effective as of March 31, 1997.

I. PREVENTION OF DUPLICATIVE PAYMENTS. Under section 2105(c)(6) of the Act, certain provisions relating to preventing duplicate payments are applicable:

1. Other Health Plan Obligated to Provide Child Health Assistance. No FFP is available to States for Title XXI Child Health Assistance expenditures to the extent that a private insurer would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan.

2. Payment Under Other Federal Governmental Programs. No FFP is available to States for Title XXI Child Health Assistance expenditures to the extent that payment has been made or can reasonably be expected to be made promptly under any other Federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service.

J. FAMILY PLANNING AND INDIAN HEALTH SERVICES (IHS)

The Medicaid statute provides for a higher Federal matching rate for family planning and Indian Health Services. Because of this, there is special treatment for such services in Medicaid expansions for targeted low-income children. However, if such services are provided on the basis of a presumptive eligibility determination, the treatment may also differ. The sections below describes the treatment for these type expenditures.

1. Family Planning and Indian Health Services (IHS) Provided Under Presumptive Eligibility Provisions. Under section 2104(d)(1) of the Act, Federal matching payments attributable to services provided to children on the basis of a presumptive Medicaid eligibility determination under section 1920A of the Act, must be applied to reduce the State's title XXI allotment. This is regardless of whether the Medicaid presumptive eligibility payments are

reimbursed at the regular FMAP, at the higher family planning, or at the Indian Health Services matching rates. Therefore, the amount of the Federal payments made to a State for Medicaid presumptive eligibility payments under Title XIX, even those made at the higher Federal matching rates associated with these services, must be applied against the CHIP allotment.

2. **Family Planning Services.** Under section 1903(a)(5) of title XIX of the Act, the Federal matching rate under Title XIX for family planning services expenditures is at 90 percent, NOT the regular Medicaid FMAP rate, and NOT the Title XXI enhanced FMAP rate. Therefore, Federal matching payments for States' Medicaid expenditures under Title XIX for Family planning would be Federally matched at the 90 percent rate and such expenditures would not be charged against the States' title XXI allotment.

3. **Indian Health Services.** Section 2104(d)(2) of the Act provides that Medicaid expenditures made under section 1903(a)(1) on the basis of the enhanced FMAP under section 2105(b) of the Act must be applied against the State's allotment. However, IHS expenditures are not Federally matched at the section 2105(b) enhanced FMAP, rather they receive a different higher rate at section 1905(b) of the Act (100 percent). Because of this, expenditures for IHS provided to States' Medicaid expansion groups would be Federally matched at the 100 percent rate and such expenditures would not be charged against the States' title XXI allotments.

K. **APPLICATION OF CERTAIN GENERAL PROVISIONS.** Section 2107(e) of the Act requires the following sections of the Act apply to States under Title XXI in the same manner as they apply to a State under Title XIX:

1. **Administrative and Judicial Review (Including Disallowance Process).**

(Section 1116 of the Act)

2. **Civil Monetary Penalties.** (Section 1128A of the Act)

3. **Criminal Penalties.** (Section 1128B of the Act)

4. **Timely Filing.** (Section 1132 of the Act)

In addition to the above provisions, we believe that in general, the financial/administrative provisions that apply in Medicaid should also apply in title XXI.

VI. BUDGET AND EXPENDITURE SYSTEMS - REPORTING

States will need to report expenditures and budget projections related to the CHIP and Medicaid programs, for purposes including the following: (Attached are copies of the forms States will use for reporting this information.)

- Claiming FFP
- Tracking Against the CHIP Fiscal Year Allotment
- Maintenance of Effort (MOE) Provisions
- 10 Percent Limit Calculation
- Determining Amounts of Grants

Under the current Title XIX Medicaid program, States are already required to submit budget and expenditure information using the Medicaid Budget and Expenditure System (MBES). Using the MBES, States report budget information on the Form HCFA-37 and expenditure information on the Form HCFA-64. HCFA is developing forms under which States will report budget and expenditure information for their Title XXI programs. In order to capture the needed information and to track that information appropriately, the forms for Title XIX and Title XXI will be linked and submissions under each system will be coordinated.

The following highlights these forms:

A. Title XXI Report Forms. The Title XXI budget and expenditure report forms will be similar to the Medicaid report forms and will include:

1. Form HCFA-21 - Summary Sheet. Summary expenditure report form for all Title XXI expenditures. There are only two columns, one for reporting total computable amounts of expenditures and the other for Federal Share amounts of expenditures.

2. Form HCFA-21 Base/HCFA-21/HCFA-21P. These forms are for reporting and isolating States' Title XXI expenditures related to the service categories referenced in section 2110(a) of the Act (which define child health assistance), other child health assistance and initiatives, outreach and administration, for the groups and programs covered by States under their Title XXI programs. The Form HCFA-21 Base represents the total of these expenditures across all Title XXI programs in the State that are being claimed by the State in the quarter. The Form HCFA-21 represent the expenditures that were paid and are being claimed by the State in the current quarter's submission. The Form HCFA-21P representing expenditures paid by the State in prior periods, but also which are being claimed in the current quarter's submission. States must separately identify on these forms the amounts of expenditures which apply against the 10 Percent Limit.

3. Form HCFA-21E - Children's' Health Insurance Program Number of Children Served. This form is for reporting the total number of children served in the Title XXI program. This form provides for reporting under four age breakouts and three family income levels.

4. **Form HCFA-21L - Children's' Health Insurance Program Expenditures for the Title XXI Program Calculation of the 10 Percent Limit.** This form is for tracking and applying the expenditures applicable the 10 Percent Limit. This form is generated from expenditure data reported by the State under Title XIX and XXI.

5. **Form HCFA-21C - Allocation of Title XIX and Title XXI Expenditures to CHIP Fiscal Year Allotment.** This form is equivalent to the Medicaid Title XIX program Form HCFA-64.21C (see below) for tracking the expenditures under States' Title XIX and XXI programs that must be applied against the CHIP fiscal year allotment. This form is generated from the Title XIX and Title XXI expenditures that States have reported and claimed for the current and prior quarters that are applicable to the Title XXI allotment, for purposes of tracking such expenditures against the allotment. The Form HCFA-64.21C contains information which is accumulated by fiscal year in line categories of: fiscal year allotment, amounts previously claimed for the fiscal year, excess amounts reported for previous fiscal years (which may be claimed against a subsequent allotment), amounts being claimed in the current quarter, amounts of the fiscal year allotment that is unused, and amounts of the fiscal year allotment which are in excess of the allotment for that fiscal year. Federal share amounts of expenditures are tracked in four columns for 4 categories of expenditures: u_2 , u_3 , and PE (for the Title XIX program), and the Title XXI. This form will be used for tracking the expenditures applied against the Title XXI fiscal year allotment

6. **Form HCFA-21B - Children's Health Insurance Program Budget Report for the Title XXI Program State Expenditure Plan.** This form is for States to report projected amounts of Title XXI total computable, Federal Share, and the State share of expenditures by quarter and Federal fiscal year. This form is also used for States to certify the availability of funds for the State share of the Title XXI program.

B. **Title XIX Medicaid Forms.** States' Medicaid programs may provide coverage under the three Medicaid options discussed in previous sections, and the Medicaid expenditures related to these options would apply against States' Title XXI allotments. The information reported for these Title XIX groups must be separately identified. Furthermore, specific information on the quarterly claimed expenditures related to the section 1905(u)(2) and (3) options is needed in order to calculate the 10 Percent Limit. In order to be able to compare the information reported on the Medicaid program to the information reported on the Title XXI program, the reported expenditure categories in the two programs will need to be comparable. This requires special reporting.

The following describes the new Title XIX Medicaid forms:

1. **Form HCFA-64.21 and 64.21U/64.21P and 64.21UP - Quarterly Medical Assistance Expenditures by Child Health Insurance Program Expenditure Categories.** Expenditure report form for States to separately report medical assistance expenditures for the 3 Medicaid options (u_2 , u_3 , and PE). There are 24 expenditure categories, including premiums for private

health care coverage. These expenditure categories are the same as contained in the Title XXI report Form HCFA-21. States will report these expenditures in columns for the categories of total computable, and amounts claimed at various FMAPs such as the enhanced FMAP, the IHS rate (100%), and the family planning rate (90%). The Form HCFA-64.21 would be used for reporting States' current quarter PE expenditures. The Form HCFA-64.21U would be used for reporting States' current quarter u_2 and/or u_3 expenditures. The Form HCFA-64.21P would be used for reporting prior period PE expenditures. The Form HCFA-64.21UP would be used for reporting prior period u_2 and/or u_3 expenditures.

2. **Form HCFA-64.21C - Allocation of Title XIX and Title XXI Expenditures to CHIP Fiscal Year Allotment.** This form is exactly the same as the Title XXI program Form HCFA-21C (described above) for tracking expenditures against the fiscal year allotment.

3. **Form HCFA-64EA - Number of Adults Served for the Medical Assistance Program.** This form is for reporting the number of adults served under the entire Medicaid program. This form provides for reporting under two age breakouts and three income levels.

4. **Form HCFA-64EC - Number of Children Served by the Medical Assistance Program.** This form is for reporting the number of children served under the entire Medicaid program. This form provides for reporting under four age breakouts and three family income levels.

5. **Form HCFA-64.21E - Number of Children Related to Children's Health Insurance Program.** Form for reporting the number of children served in the Medicaid program that are specifically related to the three Medicaid options (u_2 , u_3 , and PE). This form provides for reporting under four age breakouts and three family income levels.

6. **Form HCFA-37.3.** This is an existing Medicaid budget reporting form for which an information only line is being added to capture the projected Medicaid expenditures that are included in the total medical assistance payments estimates, for the current and budget fiscal years, for the three Medicaid options (u_2 , u_3 , and PE).

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

**QUARTERLY CHILDREN'S HEALTH INSURANCE PROGRAM
STATEMENT OF EXPENDITURES FOR TITLE XXI
SUMMARY SHEET**

STATE

AGENCY

QUARTER ENDED

EXPENDITURES REPORTED FOR PERIOD	TITLE XXI EXPENDITURES	
	TOTAL COMPUTABLE (a)	FEDERAL SHARE (b)
1. EXPENDITURES IN THIS QUARTER (ATTACH 21 BASE)		
2. ADJUSTMENTS INCREASING CLAIMS FOR PRIOR QUARTERS (ATTACH 21p)		
3. ADJUSTMENTS DECREASING CLAIMS FOR PRIOR QUARTERS: QUARTERS (ATTACH 21p)		
4. NET EXPENDITURES REPORTED IN THIS PERIOD (SUM OF ITEMS 1 AND 2 LESS 3)		

I, EXECUTIVE OFFICER OF THE STATE AGENCY CHARGED WITH THE DUTIES OF ADMINISTERING (OR SUPERVISING THE ADMINISTRATION OF) THE STATE PLAN FOR THE TITLE XXI PROGRAM AS PROVIDED FOR IN THE SOCIAL SECURITY ACT, AS AMENDED, DO CERTIFY THAT THE INFORMATION SHOWN ABOVE AND ON THE HCFA-21 SUMMARY SHEET AND THE SUPPORTING SCHEDULES IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF AND FURTHER ATTEST THAT THE STATE HAS SUBMITTED A VALID STATE PLAN TO THE SECRETARY

DATE , 19	SIGNATURE
--------------	-----------

FORWARD COMPLETED QUARTERLY STATEMENT OF EXPENDITURES (SUMMARY SHEET) WITH SUPPORTING COMPUTATION FORM(S) AND SCHEDULE(S) TO THE HEALTH CARE FINANCING ADMINISTRATION, CENTER FOR MEDICAID AND STATE OPERATION, QPMG, DIVISION OF FINANCIAL MANAGEMENT, MAIL STOP C4-18-27, 7500 SECURITY BLVD., BALTIMORE, MARYLAND 21244-1850

DRAFT

FORM HCFA-21 SUMMARY SHEET

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

**CHILDREN'S HEALTH EXPENDITURES BY TYPE OF SERVICE
FOR THE TITLE XXI PROGRAM
EXPENDITURES IN THIS QUARTER**

STATE

AGENCY

QUARTER ENDED

	TOTAL COMPUTABLE	FEDERAL SHARE	SUBJECT TO 10% LIMIT		TOTAL FEDERAL SHARE
			TOTAL COMPUTABLE	FEDERAL SHARE	
	(a)	(b)	(c)	(d)	(e)
1. PREMIUMS FOR PRIVATE HEALTH CARE INSURANCE COVERAGE UP TO 150% OF POVERTY LEVEL					
A. GROSS PREMIUMS PAID					
B. COST SHARING OFFSETS					
OVER 150% OF POVERTY LEVEL					
C. GROSS PREMIUMS PAID					
D. COST SHARING OFFSETS					
2. INPATIENT HOSPITAL SERVICES					
3. INPATIENT MENTAL HEALTH FACILITY SERVICES					
4. NURSING CARE SERVICES					
5. PHYSICIAN AND SURGICAL SERVICES					
6. OUTPATIENT HOSPITAL SERVICES					
7. OUTPATIENT MENTAL HEALTH FACILITY SERVICES					
8. PRESCRIBED DRUGS					
9. DENTAL SERVICES					
10. VISION SERVICES					
11. OTHER PRACTITIONERS' SERVICES					
12. CLINIC SERVICES					
13. THERAPY AND REHABILITATION SERVICES					
14. LABORATORY AND RADIOLOGICAL SERVICES					

FORM HCFA-21 BASE

PAGE 1 OF 2

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

CHILDREN'S HEALTH EXPENDITURES BY TYPE OF SERVICE FOR THE TITLE XXI PROGRAM EXPENDITURES IN THIS QUARTER				STATE	
				AGENCY	
				QUARTER ENDED	
	TOTAL COMPUTABLE	FEDERAL SHARE	SUBJECT TO 10% LIMIT		TOTAL FEDERAL SHARE
			TOTAL COMPUTABLE	FEDERAL SHARE	
	(a)	(b)	(c)	(d)	(e)
15. DURABLE AND DISPOSABLE MEDICAL EQUIPMENT					
16. FAMILY PLANNING					
17. ABORTIONS NO.					
18. SCREENING SERVICES					
19. HOME HEALTH					
20. HOME AND COMMUNITY-BASED SERVICES					
21. HOSPICE					
22. MEDICAL TRANSPORTATION					
23. CASE MANAGEMENT					
24. OTHER SERVICES					
25. OUTREACH	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX			
26. ADMINISTRATION	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX			
27. BALANCE					
28. LESS: COLLECTIONS					
29. TOTAL (ENTER COLUMNS (a) AND (e) ON SUMMARY SHEET, LINE 1. COLUMNS (a) AND (b) AS APPROPRIATE).					

FORM HCFA-21 BASE

PAGE 2 OF 2

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

CHILDREN'S HEALTH EXPENDITURES BY TYPE OF SERVICE
FOR THE TITLE XX PROGRAM
EXPENDITURES IN THIS QUARTER

STATE

AGENCY

QUARTER ENDED

NAME OF PROGRAM _____	TOTAL COMPUTABLE	FEDERAL SHARE	SUBJECT TO 10% LIMIT		TOTAL FEDERAL SHARE
			TOTAL COMPUTABLE	FEDERAL SHARE	
	(a)	(b)	(c)	(d)	(e)
1. PREMIUMS FOR PRIVATE HEALTH CARE INSURANCE COVERAGE UP TO 150% OF POVERTY LEVEL					
A. GROSS PREMIUMS PAID					
B. COST SHARING OFFSETS					
OVER 150% OF POVERTY LEVEL					
C. GROSS PREMIUMS PAID					
D. COST SHARING OFFSETS					
2. INPATIENT HOSPITAL SERVICES					
3. INPATIENT MENTAL HEALTH FACILITY SERVICES					
4. NURSING CARE SERVICES					
5. PHYSICIAN AND SURGICAL SERVICES					
6. OUTPATIENT HOSPITAL SERVICES					
7. OUTPATIENT MENTAL HEALTH FACILITY SERVICES					
8. PRESCRIBED DRUGS					
9. DENTAL SERVICES					
10. VISION SERVICES					
11. OTHER PRACTITIONERS' SERVICES					
12. CLINIC SERVICES					
13. THERAPY AND REHABILITATION SERVICES					
14. LABORATORY AND RADIOLOGICAL SERVICES					

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

CHILDREN'S HEALTH EXPENDITURES BY TYPE OF SERVICE
FOR THE TITLE XX PROGRAM
EXPENDITURES IN THIS QUARTER

STATE

AGENCY

QUARTER ENDED

NAME OF PROGRAM _____	TOTAL COMPUTABLE	FEDERAL SHARE	SUBJECT TO 10% LIMIT		TOTAL FEDERAL SHARE
			TOTAL COMPUTABLE	FEDERAL SHARE	
	(a)	(b)	(c)	(d)	(e)
15. DURABLE AND DISPOSABLE MEDICAL EQUIPMENT					
16. FAMILY PLANNING					
17. ABORTIONS NO. _____					
18. SCREENING SERVICES					
19. HOME HEALTH					
20. HOME AND COMMUNITY-BASED SERVICES					
21. HOSPICE					
22. MEDICAL TRANSPORTATION					
23. CASE MANAGEMENT					
24. OTHER SERVICES					
25. OUTREACH	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX			
26. ADMINISTRATION	XXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXX			
27. BALANCE					
28. LESS: COLLECTIONS					
29. TOTAL (ENTER COLUMNS (a) AND (e) ON SUMMARY SHEET, LINE 1. COLUMNS (a) AND (b) AS APPROPRIATE).					

FORM HCFA-21

PAGE 2 OF 2

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

CHILDREN'S HEALTH INSURANCE PROGRAM BUDGET REPORT FOR THE TITLE XXI PROGRAM STATE EXPENDITURE PLAN		STATE	
		AGENCY	
		SUBMISSION DATE	
FISCAL YEAR AND QUARTER	TOTAL COMPUTABLE A	FEDERAL SHARE B	STATE SHARE C
FISCAL YEAR (1)			
1. QUARTER 1			
2. QUARTER 2			
3. QUARTER 3			
4. QUARTER 4			
5. TOTAL			
FISCAL YEAR (2)			
6. QUARTER 1			
7. QUARTER 2			
8. QUARTER 3			
9. QUARTER 4			
10. TOTAL			
I CERTIFY THAT: 1. THE BUDGET ESTIMATES ARE ONLY PROVIDED FOR ALLOWABLE EXPENDITURES FOR THE CHILDREN'S HEALTH INSURANCE PROGRAM UNDER TITLE XXI IN ACCORDANCE WITH APPLICABLE SECTIONS OF THE SOCIAL SECURITY ACT, IMPLEMENTING TITLE XXI REGULATIONS, AND OUR APPROVED TITLE XXI STATE PLAN 2. THE BUDGET ESTIMATES ARE BASED ON THE MOST RELIABLE INFORMATION AVAILABLE TO THE STATE 3. THE AMOUNT OF STATE AND LOCAL FUNDS AVAILABLE FOR THE QUARTER BEGINNING _____ FOR THE TITLE XXI PROGRAM IS. _____ 4. I AM THE EXECUTIVE OFFICER OF THE STATE AGENCY CHARGED WITH THE DUTIES OF ADMINISTERING (OR SUPERVISING THE ADMINISTRATION OF) THE STATE PLAN			
DATE	SIGNATURE	TITLE	
FORWARD COMPLETED FORM TO THE HEALTH CARE FINANCING ADMINISTRATION, CENTER FOR MEDICAID AND STATE OPERATIONS, QPMG, DIVISION OF FINANCIAL MANAGEMENT MAIL STOP C4-18-27 7500 SECURITY BLVD. BALTIMORE, MD 21244-1850			

FORM HCFA-21B

DRAFT

ALLOCATION OF TITLE XIX AND TITLE XXI EXPENDITURES
TO CHIP FISCAL YEAR ALLOTMENT

STATE
AGENCY
QUARTER/FY

	FEDERAL SHARE EXPENDITURES ONLY			TOTAL (d)
	TITLE XIX	TITLE XXI	TOTAL	
	(a)	(b)	(c)	
1. FFY 1998 ALLOTMENT				
2. AMOUNT PREVIOUSLY CLAIMED				
3. EXCESS PREVIOUSLY CLAIMED				
4. EXPENDITURES CLAIMED THIS QUARTER				
5. UNUSED ALLOTMENT				
6. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 1998 ALLOTMENT				
2. FFY 1999 ALLOTMENT				
3. AMOUNT PREVIOUSLY CLAIMED				
4. EXCESS PREVIOUSLY CLAIMED				
5. EXPENDITURES CLAIMED THIS QUARTER				
6. UNUSED ALLOTMENT				
7. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 1998 ALLOTMENT				
2. UNUSED FFY 1999 ALLOTMENT				
3. FFY 2000 ALLOTMENT				
4. AMOUNT PREVIOUSLY CLAIMED				
5. EXCESS PREVIOUSLY CLAIMED				
6. EXPENDITURES CLAIMED THIS QUARTER				
7. UNUSED ALLOTMENT				
8. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 1998 ALLOTMENT				
2. UNUSED FFY 1999 ALLOTMENT				
3. UNUSED FFY 2000 ALLOTMENT				
4. FFY 2001 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				

DRAFT

ALLOCATION OF TITLE XIX AND TITLE XXI EXPENDITURES
TO CHIP FISCAL YEAR ALLOTMENT

STATE

AGENCY

QUARTER/FY

	FEDERAL SHARE EXPENDITURES ONLY			TOTAL (d)
	TITLE XIX	TITLE XXI	TOTAL	
	(a)	(b)	(c)	
1. UNUSED FFY 1999 ALLOTMENT				
2. UNUSED FFY 2000 ALLOTMENT				
3. UNUSED FFY 2001 ALLOTMENT				
4. FFY 2002 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 2000 ALLOTMENT				
2. UNUSED FFY 2001 ALLOTMENT				
3. UNUSED FFY 2002 ALLOTMENT				
4. FFY 2003 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 2001 ALLOTMENT				
2. UNUSED FFY 2002 ALLOTMENT				
3. UNUSED FFY 2003 ALLOTMENT				
4. FFY 2004 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 2002 ALLOTMENT				
2. UNUSED FFY 2003 ALLOTMENT				
3. UNUSED FFY 2004 ALLOTMENT				
4. FFY 2005 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				

DRAFT

ALLOCATION OF TITLE XIX AND TITLE XXI EXPENDITURES
TO CHIP FISCAL YEAR ALLOTMENT

STATE

AGENCY

QUARTER/FY

	FEDERAL SHARE EXPENDITURES ONLY			TOTAL (d)
	TITLE XIX	TITLE XXI	TOTAL	
	(a)	(b)	(c)	
1. UNUSED FFY 2003 ALLOTMENT				
2. UNUSED FFY 2004 ALLOTMENT				
3. UNUSED FFY 2005 ALLOTMENT				
4. FFY 2006 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 2004 ALLOTMENT				
2. UNUSED FFY 2005 ALLOTMENT				
3. UNUSED FFY 2006 ALLOTMENT				
4. FFY 2007 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

CHILDREN'S HEALTH INSURANCE PROGRAM
NUMBER OF CHILDREN SERVED

STATE

AGENCY

QUARTER ENDED

NAME OF PROGRAM _____

AGE

CHILDREN

FEDERAL POVERTY LEVEL

UNDER

1-5

6-12

13-18

<100%

100-150

>150%

1. NUMBER OF UNDUPLICATED CHILDREN EVER ENROLLED IN THE QUARTER

A. FEE-FOR-SERVICE PLANS

B. MANAGED CARE ARRANGEMENTS

2. NUMBER OF UNDUPLICATED NEW ENROLLEES IN THE QUARTER

A. FEE-FOR-SERVICE PLANS

B. MANAGED CARE ARRANGEMENTS

3. NUMBER OF DISENROLLEES IN THE QUARTER

A. FEE-FOR-SERVICE PLANS

B. MANAGED CARE ARRANGEMENTS

4. NUMBER OF MEMBER MONTHS OF ENROLLMENT IN THE QUARTER

A. FEE-FOR-SERVICE PLANS

B. MANAGED CARE ARRANGEMENTS

5. AVERAGE NUMBER OF MONTHS OF ENROLLMENT (LINE 4 DIVIDED BY LINE 1)

A. FEE-FOR-SERVICE PLANS

B. MANAGED CARE ARRANGEMENTS

FORM HCFA-21E

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES		
HEALTH CARE FINANCING ADMINISTRATION		
CHILDREN'S HEALTH INSURANCE PROGRAM EXPENDITURES FOR THE TITLE XXI PROGRAM CALCULATION OF 10% LIMIT	STATE	
	AGENCY	
	QUARTER ENDED	FY
	TOTAL COMPUTABLE (a)	FEDERAL SHARE (b)
1. PREVIOUSLY CLAIMED EXPENDITURES		
A. SECTION 2105(a)(1)		
B. SECTIONS 1905(u)(2) AND 1905(u)(3)		
2. CURRENTLY CLAIMED EXPENDITURES		
A. SECTION 2105(a)(1)		
B. SECTIONS 1905(u)(2) AND 1905(u)(3)		
3. TOTAL OF COLUMN (a) LINES 1 AND 2		
4. 10% LIMIT (DIVIDE LINE 3 COLUMN (a) BY 9)		
5. A. EXPENDITURES PREVIOUSLY CLAIMED UNDER SECTION 2105(a)(2)		
B. EXPENDITURES CURRENTLY CLAIMED UNDER SECTION 2105(a)(2)		
6. AMOUNT OVER/(UNDER) LIMIT (LINE 6 MINUS LINES 5.A. AND 5.B.)		

FORM HCFA-21L

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

CHILDREN'S HEALTH EXPENDITURES BY TYPE OF SERVICE
FOR THE TITLE XXI PROGRAM
PRIOR PERIOD ADJUSTMENTS

STATE

AGENCY

QUARTER ENDED

FY

CHECK ONE:

☐

LINE 2

(increasing)

☐

LINE 3

(decreasing)

NAME OF PROGRAM _____	TOTAL COMPUTABLE	FEDERAL SHARE	SUBJECT TO 10% LIMIT		TOTAL FEDERAL SHARE	DEFERRAL DISALLOWANCE C.I.N. NO.
			TOTAL COMPUTABLE	FEDERAL SHARE		
	(a)	(b)	(c)	(d)	(e)	(f)
1. PREMIUMS FOR PRIVATE HEALTH CARE INSURANCE COVERAGE UP TO 150% OF POVERTY LEVEL						
A. GROSS PREMIUMS PAID						
B. COST SHARING OFFSETS						
OVER 150% OF POVERTY LEVEL						
C. GROSS PREMIUMS PAID						
D. COST SHARING OFFSETS						
2. INPATIENT HOSPITAL SERVICES						
3. INPATIENT MENTAL HEALTH FACILITY SERVICES						
4. NURSING CARE SERVICES						
5. PHYSICIAN AND SURGICAL SERVICES						
6. OUTPATIENT HOSPITAL SERVICES						
7. OUTPATIENT MENTAL HEALTH FACILITY SERVICES						
8. PRESCRIBED DRUGS						
9. DENTAL SERVICES						
10. VISION SERVICES						
11. OTHER PRACTITIONERS' SERVICES						
12. CLINIC SERVICES						
13. THERAPY AND REHABILITATION SERVICES						
14. LABORATORY AND RADIOLOGICAL SERVICES						

FORM HCFA-21P

PAGE 1 OF 2

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

CHILDREN'S HEALTH EXPENDITURES BY TYPE OF SERVICE
FOR THE TITLE XX PROGRAM
PRIOR PERIOD ADJUSTMENTS

STATE

AGENCY

QUARTER ENDED

FY

CHECK ONE:

☐

LINE 2
(increasing)

☐

LINE 3
(decreasing)

NAME OF PROGRAM _____	TOTAL COMPUTABLE	FEDERAL SHARE	SUBJECT TO 10% LIMIT		TOTAL FEDERAL SHARE	DEFERRAL DISALLOWANCE C.I.N. NO.
			TOTAL COMPUTABLE	FEDERAL SHARE		
	(a)	(b)	(c)	(d)	(e)	(f)
15. DURABLE AND DISPOSABLE MEDICAL EQUIPMENT						
16. FAMILY PLANNING						
17. ABORTIONS NO. _____						
18. SCREENING SERVICES						
19. HOME HEALTH						
20. HOME AND COMMUNITY-BASED SERVICES						
21. HOSPICE						
22. MEDICAL TRANSPORTATION						
23. CASE MANAGEMENT						
24. OTHER SERVICES						
25. OUTREACH	XXXXXXXXXX	XXXXXXXXXX				
26. ADMINISTRATION	XXXXXXXXXX	XXXXXXXXXX				
27. BALANCE						
28. LESS: COLLECTIONS						
29. TOTAL (ENTER COLUMNS (a) AND (e) ON SUMMARY SHEET, LINES 2 OR 4 COLUMNS (a) AND (b) AS APPROPRIATE).						

FORM HCFA-21P

PAGE 2 OF 2

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

**QUARTERLY MEDICAL ASSISTANCE EXPENDITURES
BY CHILD HEALTH INSURANCE PROGRAM
EXPENDITURES CATEGORIES**

STATE

AGENCY

QUARTER ENDED

TYPE OF ELIGIBLE _____ (INDICATE PE)	TOTAL COMPUTABLE						TOTAL FEDERAL SHARE
		ENHANCED FMAP	I.H.S. FACILITY SERVICES	FAMILY PLANNING SERVICES		FEDERAL SHARE	
		%	100%	90%	%		
	(a)	(b)	(c)	(d)		(e)	(f)
1. PREMIUMS FOR PRIVATE HEALTH CARE INSURANCE COVERAGE UP TO 150% OF POVERTY LEVEL							
A. GROSS PREMIUMS PAID							
B. COST SHARING OFFSETS							
OVER 150% OF POVERTY LEVEL							
C. GROSS PREMIUMS PAID							
D. COST SHARING OFFSETS							
2. INPATIENT HOSPITAL SERVICES							
3. INPATIENT MENTAL HEALTH FACILITY SERVICES							
4. NURSING CARE SERVICES							
5. PHYSICIAN AND SURGICAL SERVICES							
6. OUTPATIENT HOSPITAL SERVICES							
7. OUTPATIENT MENTAL HEALTH FACILITY SERVICES							
8. PRESCRIBED DRUGS							
9. DENTAL SERVICES							
10. VISION SERVICES							
11. OTHER PRACTITIONERS' SERVICES							
12. CLINIC SERVICES							
13. THERAPY AND REHABILITATION SERVICES							
14. LABORATORY AND RADIOLOGICAL SERVICES							

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

**QUARTERLY MEDICAL ASSISTANCE EXPENDITURES
BY CHILD HEALTH INSURANCE PROGRAM
EXPENDITURES CATEGORIES**

STATE _____

AGENCY _____

QUARTER ENDED _____

TYPE OF ELIGIBLE _____ (INDICATE PE)	TOTAL COMPUTABLE						TOTAL FEDERAL SHARE
		ENHANCED FMAP ____%	I.H.S. FACILITY SERVICES 100%	FAMILY PLANNING SERVICES 90%		FEDERAL SHARE	
		(a)	(b)	(c)	(d)	____% (e)	(f)
15 DURABLE AND DISPOSABLE MEDICAL EQUIPMENT							
16 FAMILY PLANNING							
17 ABORTIONS NO. ____							
18 SCREENING SERVICES							
19 HOME HEALTH							
20 HOME AND COMMUNITY-BASED SERVICES							
21 HOSPICE							
22 MEDICAL TRANSPORTATION							
23 CASE MANAGEMENT							
24 OTHER SERVICES							
25 TOTAL							

FORM HCFA-64.21

PAGE 2 OF 2

DRAFT

ALLOCATION OF TITLE XIX AND TITLE XXI EXPENDITURES
TO CHIP FISCAL YEAR ALLOTMENT

STATE
AGENCY
QUARTER/FY

	FEDERAL SHARE EXPENDITURES ONLY			TOTAL (d)
	TITLE XIX	TITLE XXI	TOTAL	
	(a)	(b)	(c)	
1. FFY 1998 ALLOTMENT				
2. AMOUNT PREVIOUSLY CLAIMED				
3. EXCESS PREVIOUSLY CLAIMED				
4. EXPENDITURES CLAIMED THIS QUARTER				
5. UNUSED ALLOTMENT				
6. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 1998 ALLOTMENT				
2. FFY 1999 ALLOTMENT				
3. AMOUNT PREVIOUSLY CLAIMED				
4. EXCESS PREVIOUSLY CLAIMED				
5. EXPENDITURES CLAIMED THIS QUARTER				
6. UNUSED ALLOTMENT				
7. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 1998 ALLOTMENT				
2. UNUSED FFY 1999 ALLOTMENT				
3. FFY 2000 ALLOTMENT				
4. AMOUNT PREVIOUSLY CLAIMED				
5. EXCESS PREVIOUSLY CLAIMED				
6. EXPENDITURES CLAIMED THIS QUARTER				
7. UNUSED ALLOTMENT				
8. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 1998 ALLOTMENT				
2. UNUSED FFY 1999 ALLOTMENT				
3. UNUSED FFY 2000 ALLOTMENT				
4. FFY 2001 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				

DRAFT

ALLOCATION OF TITLE XIX AND TITLE XXI EXPENDITURES
TO CHIP FISCAL YEAR ALLOTMENT

STATE
AGENCY
QUARTER/FY

	FEDERAL SHARE EXPENDITURES ONLY			TOTAL (d)
	TITLE XIX	TITLE XXI	TOTAL	
	(a)	(b)	(c)	
1. UNUSED FFY 1999 ALLOTMENT				
2. UNUSED FFY 2000 ALLOTMENT				
3. UNUSED FFY 2001 ALLOTMENT				
4. FFY 2002 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 2000 ALLOTMENT				
2. UNUSED FFY 2001 ALLOTMENT				
3. UNUSED FFY 2002 ALLOTMENT				
4. FFY 2003 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 2001 ALLOTMENT				
2. UNUSED FFY 2002 ALLOTMENT				
3. UNUSED FFY 2003 ALLOTMENT				
4. FFY 2004 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL
	(a)	(b)	(c)	(d)
1. UNUSED FFY 2002 ALLOTMENT				
2. UNUSED FFY 2003 ALLOTMENT				
3. UNUSED FFY 2004 ALLOTMENT				
4. FFY 2005 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				

DRAFT

ALLOCATION OF TITLE XIX AND TITLE XXI EXPENDITURES
TO CHIP FISCAL YEAR ALLOTMENT

STATE
AGENCY
QUARTER/FY

	FEDERAL SHARE EXPENDITURES ONLY			TOTAL (d)
	TITLE XIX	TITLE XXI	TOTAL	
	(a)	(b)	(c)	
1. UNUSED FFY 2003 ALLOTMENT				
2. UNUSED FFY 2004 ALLOTMENT				
3. UNUSED FFY 2005 ALLOTMENT				
4. FFY 2006 ALLOTMENT				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				
	TITLE XIX	TITLE XXI	TOTAL	TOTAL (d)
	(a)	(b)	(c)	
	(a)	(b)	(c)	
1. UNUSED FFY 2004 ALLOTMENT				
2. UNUSED FFY 2005 ALLOTMENT				
3. UNUSED FFY 2006 ALLOTMENT				
4. FFY 2007 ALLOTMENT				
2. AMOUNT PREVIOUSLY CLAIMED				
5. AMOUNT PREVIOUSLY CLAIMED				
6. EXCESS PREVIOUSLY CLAIMED				
7. EXPENDITURES CLAIMED THIS QUARTER				
8. UNUSED ALLOTMENT				
9. EXCESS EXPENDITURES				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

NUMBER OF CHILDREN SERVED RELATED TO CHILDREN'S HEALTH INSURANCE PROGRAM

STATE

AGENCY

QUARTER ENDED

TYPE OF ELIGIBLE _____ (INDICATE U2 OR U3 OR BOTH)	AGE				FEDERAL POVERTY LEVEL		
	CHILDREN						
	UNDER 1	1-5	6-12	13-18	<100%	00-150	>150%
1. NUMBER OF UNDUPLICATED CHILDREN EVER ENROLLED IN THE QUARTER							
A. FEE-FOR-SERVICE PLANS							
B. MANAGED CARE ARRANGEMENTS							
2. NUMBER OF UNDUPLICATED NEW ENROLLEES IN THE QUARTER							
A. FEE-FOR-SERVICE PLANS							
B. MANAGED CARE ARRANGEMENTS							
3. NUMBER OF DISENROLLEES IN THE QUARTER							
A. FEE-FOR-SERVICE PLANS							
B. MANAGED CARE ARRANGEMENTS							
4. NUMBER OF MEMBER MONTHS OF ENROLLMENT IN THE QUARTER							
A. FEE-FOR-SERVICE PLANS							
B. MANAGED CARE ARRANGEMENTS							
5. AVERAGE NUMBER OF MONTHS OF ENROLLMENT (LINE 4 DIVIDED BY LINE 1)							
A. FEE-FOR-SERVICE PLANS							
B. MANAGED CARE ARRANGEMENTS							

FORM HCFA-64.21E

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

QUARTERLY MEDICAL ASSISTANCE EXPENDITURES
BY CHILDREN HEALTH INSURANCE PROGRAM
PRIOR PERIOD EXPENDITURES

STATE _____

AGENCY _____

QUARTER ENDED _____

FY _____

CHECK ONE:

LINE 7

LINE 8

LINE 10A

LINE 10B

TYPE OF ELIGIBLE _____ (INDICATE PE) WAIVER TYPE _____ WAIVER NUMBER _____	TOTAL COMPUTABLE	FEDERAL SHARE						DEFERRAL DISALLOWANCE C.I.N. NO.
		ENHANCED FMAP _____ %	I.H.S. FACILITY SERVICES 100%	FAMILY PLANNING SERVICES 90%				
		(a)	(b)	(c)	(d)	(e)	(f)	(g)
1. PREMIUMS FOR PRIVATE HEALTH CARE INSURANCE COVE UP TO 150% OF POVERTY LEVEL								
A. GROSS PREMIUMS PAID								
B. COST SHARING OFFSETS								
OVER 150% OF POVERTY LEVEL								
C. GROSS PREMIUMS PAID								
D. COST SHARING OFFSETS								
2. INPATIENT HOSPITAL SERVICES								
3. INPATIENT MENTAL HEALTH FACILITY SERVICES								
4. NURSING CARE SERVICES								
5. PHYSICIAN AND SURGICAL SERVICES								
6. OUTPATIENT HOSPITAL SERVICES								
7. OUTPATIENT MENTAL HEALTH FACILITY SERVICES								
8. PRESCRIBED DRUGS								
9. DENTAL SERVICES								
10. VISION SERVICES								
11. OTHER PRACTITIONERS' SERVICES								
12. CLINIC SERVICES								
13. THERAPY AND REHABILITATION SERVICES								
14. LABORATORY AND RADIOLOGICAL SERVICES								

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

QUARTERLY MEDICAL ASSISTANCE EXPENDITURES
BY CHILDREN HEALTH INSURANCE PROGRAM
PRIOR PERIOD EXPENDITURES

STATE _____

AGENCY _____

QUARTER ENDED _____

FY _____

CHECK ONE:

LINE 7

LINE 8

LINE 10A

LINE 10B

TYPE OF ELIGIBLE _____ (INDICATE PE) WAIVER TYPE _____ WAIVER NUMBER _____	TOTAL COMPUTABLE	FEDERAL SHARE						DEFERRAL DISALLOWANCE C.I.N. NO.
		ENHANCED FMAP _____ %	I.H.S. FACILITY SERVICES 100%	FAMILY PLANNING SERVICES 90%	_____ %	FEDERAL SHARE	TOTAL FEDERAL SHARE	
		(a)	(b)	(c)	(d)	(e)	(f)	(g)
15. DURABLE AND DISPOSABLE MEDICAL EQUIPMENT								
16. FAMILY PLANNING								
17. ABORTIONS NO. _____								
18. SCREENING SERVICES								
19. HOME HEALTH								
20. HOME AND COMMUNITY-BASED SERVICES								
21. HOSPICE								
22. MEDICAL TRANSPORTATION								
23. CASE MANAGEMENT								
24. OTHER SERVICES								
25. BALANCE								
26. LESS: COLLECTIONS								
27. TOTAL								

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

**QUARTERLY MEDICAL ASSISTANCE EXPENDITURES
BY CHILD HEALTH INSURANCE PROGRAM
EXPENDITURES CATEGORIES**

STATE _____

AGENCY _____

QUARTER ENDED _____

TYPE OF ELIGIBLE _____ (INDICATE U2, U3, OR BOTH) WAIVER NAME _____ WAIVER TYPE _____	TOTAL COMPUTABLE				TOTAL FEDERAL SHARE
		ENHANCED FMAP _____ %		FEDERAL SHARE	
		_____ %	_____ %	_____ %	
	(a)	(b)		(c)	(d)
1. PREMIUMS FOR PRIVATE HEALTH CARE INSURANCE COVERAGE UP TO 150% OF POVERTY LEVEL					
A. GROSS PREMIUMS PAID					
B. COST SHARING OFFSETS					
OVER 150% OF POVERTY LEVEL					
C. GROSS PREMIUMS PAID					
D. COST SHARING OFFSETS					
2. INPATIENT HOSPITAL SERVICES					
3. INPATIENT MENTAL HEALTH FACILITY SERVICES					
4. NURSING CARE SERVICES					
5. PHYSICIAN AND SURGICAL SERVICES					
6. OUTPATIENT HOSPITAL SERVICES					
7. OUTPATIENT MENTAL HEALTH FACILITY SERVICES					
8. PRESCRIBED DRUGS					
9. DENTAL SERVICES					
10. VISION SERVICES					
11 OTHER PRACTITIONERS' SERVICES					
12. CLINIC SERVICES					
13. THERAPY AND REHABILITATION SERVICES					
14. LABORATORY AND RADIOLOGICAL SERVICES					

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

**QUARTERLY MEDICAL ASSISTANCE EXPENDITURES
BY CHILD HEALTH INSURANCE PROGRAM
EXPENDITURES CATEGORIES**

STATE _____

AGENCY _____

QUARTER ENDED _____

TYPE OF ELIGIBLE _____ (INDICATE U2, U3, OR BOTH)	TOTAL COMPUTABLE				TOTAL FEDERAL SHARE
		ENHANCED FMAP ____%	____%	FEDERAL SHARE	
	(a)	(b)		(c)	(d)
15. DURABLE AND DISPOSABLE MEDICAL EQUIPMENT					
16. FAMILY PLANNING					
17. ABORTIONS NO. _____					
18. SCREENING SERVICES					
19. HOME HEALTH					
20. HOME AND COMMUNITY-BASED SERVICES					
21. HOSPICE					
22. MEDICAL TRANSPORTATION					
23. CASE MANAGEMENT					
24. OTHER SERVICES					
25. TOTAL					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

QUARTERLY MEDICAL ASSISTANCE EXPENDITURES
BY CHILDREN HEALTH INSURANCE PROGRAM
PRIOR PERIOD EXPENDITURES

STATE

AGENCY

QUARTER ENDED

FY

CHECK ONE:

LINE 7

LINE 8

LINE 10A

LINE 10B

TYPE OF ELIGIBLE _____ (INDICATE U2, U3, OR BOTH)	TOTAL COMPUTABLE	FEDERAL SHARE				DEFERRAL DISALLOWANCE C.I.N. NO.
		ENHANCED FMAP ____%	%	FEDERAL SHARE	TOTAL FEDERAL SHARE	
	(a)	(b)	(c)		(d)	(e)
1. PREMIUMS FOR PRIVATE HEALTH CARE INSURANCE COVER UP TO 150% OF POVERTY LEVEL						
A. GROSS PREMIUMS PAID						
B. COST SHARING OFFSETS						
OVER 150% OF POVERTY LEVEL						
C. GROSS PREMIUMS PAID						
D. COST SHARING OFFSETS						
2. INPATIENT HOSPITAL SERVICES						
3. INPATIENT MENTAL HEALTH FACILITY SERVICES						
4. NURSING CARE SERVICES						
5. PHYSICIAN AND SURGICAL SERVICES						
6. OUTPATIENT HOSPITAL SERVICES						
7. OUTPATIENT MENTAL HEALTH FACILITY SERVICES						
8. PRESCRIBED DRUGS						
9. DENTAL SERVICES						
10. VISION SERVICES						
11 OTHER PRACTITIONERS' SERVICES						
12. CLINIC SERVICES						
13. THERAPY AND REHABILITATION SERVICES						
14. LABORATORY AND RADIOLOGICAL SERVICES						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

QUARTERLY MEDICAL ASSISTANCE EXPENDITURES
BY CHILDREN HEALTH INSURANCE PROGRAM
PRIOR PERIOD EXPENDITURES

STATE _____

AGENCY _____

QUARTER ENDED _____

FY _____

CHECK ONE:

LINE 7

LINE 8

LINE 10A

LINE 10B

TYPE OF ELIGIBLE _____ (INDICATE U2, U3, OR BOTH)	TOTAL COMPUTABLE	FEDERAL SHARE				DEFERRAL DISALLOWANCE C.I.N. NO.
		ENHANCED FMAP _____%	%	FEDERAL SHARE	TOTAL FEDERAL SHARE	
	(a)	(b)		(c)	(d)	(e)
15. DURABLE AND DISPOSABLE MEDICAL EQUIPMENT						
16. FAMILY PLANNING						
17. ABORTIONS NO.						
18. SCREENING SERVICES						
19. HOME HEALTH						
20. HOME AND COMMUNITY-BASED SERVICES						
21. HOSPICE						
22. MEDICAL TRANSPORTATION						
23. CASE MANAGEMENT						
24. OTHER SERVICES						
25. BALANCE						
26. LESS: COLLECTIONS						
27. TOTAL						

DRAFT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

NUMBER OF ADULTS SERVED FOR THE MEDICAL ASSISTANCE PROGRAM			STATE		
			AGENCY		
			QUARTER ENDED		
	AGE		FEDERAL POVERTY LEVEL		
	19-64	5 AND OVE	<100%	100-150%	>150%
1. NUMBER OF UNDUPLICATED ADULTS EVER ENROLLED IN THE QUARTER					
A. FEE-FOR-SERVICE PLANS					
B. MANAGED CARE ARRANGEMENTS					
2. NUMBER OF UNDUPLICATED NEW ENROLLEES IN THE QUARTER					
A. FEE-FOR-SERVICE PLANS					
B. MANAGED CARE ARRANGEMENTS					
3. NUMBER OF DISENROLLEES IN THE QUARTER					
A. FEE-FOR-SERVICE PLANS					
B. MANAGED CARE ARRANGEMENTS					
4. NUMBER OF MEMBER MONTHS OF ENROLLMENT IN THE QUARTER					
A. FEE-FOR-SERVICE PLANS					
B. MANAGED CARE ARRANGEMENTS					
5. AVERAGE NUMBER OF MONTHS OF ENROLLMENT (LINE 4 DIVIDED BY LINE 1)					
A. FEE-FOR-SERVICE PLANS					
B. MANAGED CARE ARRANGEMENTS					

FORM HCFA-64EA

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

NUMBER OF CHILDREN SERVED FOR THE MEDICAL ASSISTANCE PROGRAM					STATE	AGENCY		QUARTER ENDED
	AGE				FEDERAL POVERTY LEVEL			
	CHILDREN				<100%	00-150	>150%	
	INFANTS	1-5	6-12	13-18				
1. NUMBER OF UNDUPLICATED CHILDREN EVER ENROLLED IN THE QUARTER								
A. FEE-FOR-SERVICE PLANS								
B. MANAGED CARE ARRANGEMENTS								
2. NUMBER OF UNDUPLICATED NEW ENROLLEES IN THE QUARTER								
A. FEE-FOR-SERVICE PLANS								
B. MANAGED CARE ARRANGEMENTS								
3. NUMBER OF DISENROLLEES IN THE QUARTER								
A. FEE-FOR-SERVICE PLANS								
B. MANAGED CARE ARRANGEMENTS								
4. NUMBER OF MEMBER MONTHS OF ENROLLMENT IN THE QUARTER								
A. FEE-FOR-SERVICE PLANS								
B. MANAGED CARE ARRANGEMENTS								
5. AVERAGE NUMBER OF MONTHS OF ENROLLMENT (LINE 4 DIVIDED BY LINE 1)								
A. FEE-FOR-SERVICE PLANS								
B. MANAGED CARE ARRANGEMENTS								

FORM HCFA-64EC

DRAFT

MEDICAID PROGRAM BUDGET REPORT				
ESTIMATED MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE (IN THOUSANDS)				
STATE	AGENCY	SUBMISSION DATE		
Type of Service	TOTAL BUDGETED SERVICES FISCAL YEAR (1)		TOTAL BUDGETED SERVICES FISCAL YEAR (2)	
	TOTAL COMPUTABLE	FEDERAL SHARE	TOTAL COMPUTABLE	FEDERAL SHARE
	A	B	C	D
1 Inpatient Hospital Services				
A. Regular Payments				
B. DSH Adjustment Payments				
2 Mental Health Facility Services				
A. Regular Payments				
B. DSH Adjustment Payments				
3 Nursing Facility Services				
4 Intermediate Care Facility Services				
- Mentally Retarded				
A. Public Providers				
B. Private Providers				
5 Physicians' Services				
6 Outpatient Hospital Service				
7 Prescribed Drugs				
7A. Drug Rebate Offset				
1. National Agreement				
2. State Sidebar Agreement				
8 Dental Services				
9 Other Practitioners' Services				
10 Clinic Services				
11 Laboratory and Radiological Services				
12 Home Health Services				
13 Sterilizations				
14 Abortions				
15 EPSDT Screening Services				
16 Rural Health Clinic Services				

DRAFT

MEDICAID PROGRAM BUDGET REPORT				
ESTIMATED MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE (IN THOUSANDS)				
STATE	AGENCY	SUBMISSION DATE		
Type of Service	TOTAL BUDGETED SERVICES FISCAL YEAR (1)		TOTAL BUDGETED SERVICES FISCAL YEAR (2)	
	TOTAL COMPUTABLE	FEDERAL SHARE	TOTAL COMPUTABLE	FEDERAL SHARE
	A	B	C	D
17 Medicare Health Insurance Payments				
A. Part A Premiums				
B. Part B Premiums				
C. Qualifying Individuals				
1. 120% - 134% of Poverty				
2. 135% - 175% of Poverty				
D. Coinsurance and Deductibles				
18 Medicaid Health Insurance Payments				
A. Managed Care Organizations (MCO)				
B. Prepaid Health Plans (PHP)				
C. Group Health Plan Payments				
D. Coinsurance and Deductibles				
E. Other				
19 Home & Community-Based Services				
20 Home & Community-Based Care for Functionally Disabled Elderly				
21 Community Supported Living Arrangements				
22 Programs of All-Inclusive Care for the Elderly				
23 Personal Care				
24 Targeted Case Management Services				
25 Primary Care Case Management Services				
26 Hospice Benefits				
27 Emergency Services Undocumented Aliens				
28 Federally-Qualified Health Center				
29 Other Care Services				
30 SUBTOTAL				
31 Collections				
32 Prior Period Adjustments				
33 TOTAL				
34. Medicaid Expenditures for Sections 1920A, 1905(u)(2) and 1905(u)(3) Eligibles Included in Line 33 Above				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

MB-115-N

RIN 0938-AI23

**State Children's Health Insurance Program; Reserved
Allotments to States for Fiscal Year 1998; Enhanced Federal
Medical Assistance Percentages**

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: This notice provides advance notification of the reserved fiscal year (FY) 1998 State allotments available to provide Federal funding to individual States, Commonwealths, and Territories for expenditures in the new State Children's Health Insurance Program established under title XXI of the Social Security Act. The notice also describes the methodology and process that HCFA used to determine these reserved allotments in accordance with section 2104 of the Act. These reserved State allotments are estimates of States' FY 1998 title XXI allotments, assuming that each State were to submit, and receive approval for, a State child health plan. Under title XXI the amount of a State's allotment for a fiscal year is available for 3 years for States with approved child health plans.

This notice also specifies the enhanced Federal medical assistance percentages (FMAP) for child health assistance provided under Title XXI for fiscal year 1998.

Established by section 4901 of the Balanced Budget Act of 1997 (Public Law 105-33), the State Children's Health Insurance Program will provide Federal matching funds to States to initiate and expand health insurance coverage to uninsured, low-income children.

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FOR FURTHER INFORMATION CONTACT:

Richard Strauss, (410) 786-2019

SUPPLEMENTARY INFORMATION:

I. General Background on New Legislation

Section 4901 of the Balanced Budget Act of 1997 (BBA, Public Law 105-33, signed into law on August 5, 1997), amended the Social Security Act (the Act) to add a new title XXI. Under title XXI, a new State Children's Health Insurance Program is established to assist State efforts to initiate and expand child health assistance to uninsured, low-income children. Under the program, child health assistance is to be provided primarily for obtaining health benefits coverage through (1) providing coverage that meets requirements specified in the law under section 2103 of the Act; or (2) expanding coverage under the State's Medicaid plan under title XIX of the Act; or (3) a combination of both.

In order to be eligible for Federal matching funds under the State Children's Health Insurance Program, States must submit to the Secretary, and receive approval for, a State child health plan that describes how the State intends

to use the funds provided under title XXI. The plan must meet certain criteria specified in the statute, which include benefit packages, eligibility standards and methodologies, coverage requirements, basic and additional services offered, strategic objectives and performance goals, plan administration, and evaluations.

The law limits the total amount of Federal funds for the State Children's Health Insurance Program and specifies the formula that is to be used to determine an allotment for each State from this total amount, as described under section III of this notice.

II. Purpose of this Notice

We are issuing this notice to provide advance notification to States, Commonwealths, and Territories of the reserved allotments that will be available to them for FY 1998 for child health insurance expenditures if they choose to establish a State Children's Health Insurance Program under an approved State child health plan under title XXI of the Act, or to claim an enhanced FMAP rate for certain Medicaid expenditures under title XIX of the Act as specified in title XXI. States, Commonwealths, and Territories may submit State child health plans to HCFA for approval, to be effective as early as October 1, 1997. We believe that this notification is necessary to enable States, Commonwealths, and Territories to conduct advance planning and budgeting.

Section 2104(b) of the Act indicates that "the Secretary shall allot to each State... with a State child health plan approved under this title." We believe that this language requires States to have an approved State child health plan for the fiscal year in order for the Secretary to provide a final allotment to that State for that fiscal year. We believe that if a State does not have an approved State child health plan for that fiscal year, the amount of that State's reserved allotment would be unavailable to that State and would be included in the final allotments for States with approved child health plans.

The reserved allotment amounts in this notice were determined by application of the formula specified in title XXI of the Act and described in detail in section III of this notice. Final allotments for each State will be determined in accordance with statutory requirements; we plan to issue a notice of proposed rulemaking as soon as possible on the requirements for the allotment and payment process under title XXI. Although final allotments have not been determined, under section 2105(e), we have authority to make ongoing payments based on advance estimates of allowable expenditures. At this time, we intend to make advance payments to States with approved health plans based on these reserved allotments. All issues related to the allotment and payment process, however, will be open for public comment as part of the rulemaking process.

III. Methodology for Determining Reserved Allotments for States, Commonwealths, and Territories

This notice specifies in Table I under section IV the reserved FY 1998 allotments that would be available to individual States, Commonwealths, and Territories for child health assistance expenditures under approved State child health plans, assuming that each State, Commonwealth, or Territory qualifies for such an allotment. We have applied the applicable statutory formula specified in section 2104 of the Act in determining the reserved allotments for FY 1998, as discussed below.

Section 2104(a) of title XXI provides that, for purposes of providing allotments to the 50 States and the District of Columbia, the following amounts are appropriated: \$4.275 billion for each FY 1998 through 2001; \$3.15 billion for each FY 2002 through 2004; \$4.05 billion for each FY 2005 through 2006 and \$5 billion for FY 2007. However, under section 2104(c) of the Act, 0.25 percent of the total amount appropriated each year is available for allotment to the Territories and Commonwealths of Puerto Rico, Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands. This total amount is allotted among the Commonwealths and the Territories according to the following percentages: Puerto Rico, 91.6 percent; Guam, 3.5 percent; the Virgin Islands, 2.6 percent; American Samoa, 1.2 percent; and the Northern Mariana Islands, 1.1 percent.

Further, under sections 4921 and 4922 of the BBA, the total allotment available to the 50 States and the District of Columbia is reduced by an additional total of \$60,000,000; \$30,000,000 each for a special diabetes research program for Type I diabetes and special diabetes programs for Indians. The diabetes programs are funded from FY 1998 through FY 2002 only.

The total amount of the allotment available for the 50 States and the District of Columbia for FY 1998 was determined in accordance with the following formula:

$$A_{TA} = S_{2104(a)} - T_{2104(c)} - D_{4921} - D_{4922}$$

A_{TA} = Total amount available for allotment to the 50 States and the District of Columbia for the fiscal year.

$S_{2104(a)}$ = Total appropriation for the fiscal year indicated in section 2104(a) of the Act. For FY 1998, this is \$4,275,000,000.

$T_{2104(c)}$ = Total amount available for allotment for the Commonwealths and Territories; determined under section 2104(c) of the Act as 0.25 percent of the total appropriation for the 50 States and the District of Columbia. For FY 1998, this is:

$$.0025 \times \$4,275,000,000 = \$10,687,500$$

D_{4921} = Amount of grant for research regarding Type I Diabetes under section 4921 of the BBA. This is \$30,000,000 for FYs 1998 through 2002.

D_{4922} = Amount of grant for diabetes programs for Indians under section 4922 of the BBA. This is \$30,000,000 for FYs 1998 through 2002.

Therefore, for FY 1998 the total amount available for allotment to the 50 States and the District of Columbia is \$4,204,312,500. This was determined as follows:

$$\begin{aligned} A_{TA}(\$4,204,312,500) &= S_{2104(a)}(\$4,275,000,000) - \\ &T_{2104(c)}(\$10,687,500) - D_{4921}(\$30,000,000) - \\ &D_{4922}(\$30,000,000) \end{aligned}$$

The total amount available for allotment to the 50 States and the District of Columbia is allotted to each State with a child health plan approved under title XXI based on the formula indicated at section 2104(b)(1) of the Act. The fiscal year allotment for each State with an approved child health plan is determined on the basis of the product of two factors, the Number of Children and the State

Cost Factor, for each State divided by the sum of these products over all States.

For FYs 1998 through 2000, the first factor, the Number of Children, is based only on the total number of low-income, uninsured children in the State. For FY 2001 only, the Number of Children is calculated as the sum of 75 percent of the low-income, uninsured children in the State, and 25 percent of the number of low-income children in the State. For FY 2002 and succeeding years through FY 2007, the Number of Children is calculated as the sum of 50 percent of the low-income, uninsured children in the State, and 50 percent of the number of low-income in the State.

For FY 1998 the Number of Children for each State (provided in thousands) was determined and provided by the Bureau of the Census based on the arithmetic average of the number of low-income children and low-income children with no health insurance as calculated from the three most recent March supplements to the Current Population Survey (1994, 1995, and 1996) prior to FY 1998. Because of time constraints we are using Bureau of Census data obtained prior to September 1, 1997. These data refer to information for calendar years 1993, 1994, and 1995, respectively, and represent the number of people in each State under 19 years of age whose family income is at or below 200 percent of the poverty threshold appropriate for that family, and who are not reported to be covered by health insurance. The Number

of Children for each State was developed by the Bureau of the Census based on the standard methodology used to determine official poverty status and uninsured status in their annual Current Population Reports on these topics. As part of a continuing formal process between HCFA and the Bureau of the Census, each fiscal year HCFA will obtain such Number of Children data officially from the Bureau of the Census.

The second factor, the State Cost Factor, is based on annual average wages in the health services industry in the State. The State Cost Factor for a State is equal to the sum of: .15 and .85 multiplied by the ratio of the annual average wages in the health industry per employee for the State to the annual wages per employee in the health industry for the 50 States and the District of Columbia. The State Cost Factor for each State was calculated based on such wage data for each State as reported, determined, and provided to HCFA by the Bureau of Labor Statistics (BLS) in the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year. Because of time constraints we are using BLS data obtained prior to September 1, 1997.

The average of wages per employee for the 50 States and the District of Columbia was calculated by HCFA directly from the State specific data for each State provided by the BLS. This was necessary because BLS suppressed certain

State specific data in providing HCFA with the State specific average wages per health services industry employee. BLS is required to suppress such data under the Privacy Act. The State Cost Factor is determined based on the calculation of the ratio of each State's average annual wages in the health industry to the National average annual wages in the health care industry. In order for such National average to appropriately reflect the State specific suppressed data, HCFA calculated the National average wages directly from the State specific data provided by BLS. As part of a continuing formal process between HCFA and the BLS, each fiscal year HCFA will obtain these wage data officially from the BLS.

Under section 2104(b)(4) of the Act each of the 50 States and the District of Columbia will receive a minimum allotment of \$2 million. Under this provision, to the extent any State's allotment is increased to \$2,000,000 from a lower amount that would otherwise have been allotted to the State, the allotments to other States and the District and Columbia must be reduced in a "pro rata manner" (but not below \$2,000,000) so that the total amount available for allotment to all States does not exceed the amount previously available. For FY 1998, no State's reserved allotment is below \$2,000,000; therefore, no pro rata adjustment was necessary.

Following is an explanation of how HCFA applied the two State-related factors specified in the statute to determine the States' child health plan reserved allotments for FY 1998. The formula for determining each State's reserved allotment for FY 1998 of the total available allotment is:

$$SA_i = \frac{(C_i \times SCF_i)}{\sum (C_i \times SCF_i)} \times A_{TA}$$

SA_i = Allotment for State i.

C_i = Number of Children. This is the number of certain low-income children in State i as officially reported, defined, and provided to HCFA by the Bureau of the Census. For FY 1998, this is the number of children under age 19 with no health insurance whose family income is at or below 200 percent of the poverty line for a family of the same size. (section 2104(b)(2)(B))

SCF_i = The State cost factor for State i (section 2104(b)(1)(A)(ii)). This is equal to:

$$.15 + .85 \times (W_i/W_n) \quad (\text{section 2104(b)(3)(A)}).$$

$W_i =$ Certain annual average wages per health industry employee for State i.

$W_n =$ Certain annual wages per health industry employee for the 50 States and the District of Columbia.

The annual wages per employee for a State or for all States for a fiscal year is equal to the average of such wages for employees in the health industry, as reported by the Bureau of Labor Statistics of the Department of Labor.

$\sum (C_i \times SCF_i) =$ The sum of the products of $C_i \times SCF_i$ for each State (section 2104(b)(1)(B)).

$A_{TA} =$ Total amount available for allotment to all States for the fiscal year. For FY 1998, this is \$4,204,312,500.

Section 2104(e) of the Act requires that the amount of a State's allotment for a fiscal year be available to the State for a total of 3 years, the fiscal year in which the State child health plan is approved and 2 years following. Section 2104(f) of the Act requires the Secretary to establish a process for redistribution of the amounts of

States' allotments that are not expended during the 3-year period to States that have fully expended their allotments.

HCFA will soon issue a notice of proposed rulemaking that will address the redistribution process and propose to incorporate the process in Federal regulations.

In accordance with section 2104(b) and (c) of the Act, the total allotment for all States for each fiscal year is available to the 50 States and District of Columbia, the Commonwealths and the Territories. Although the statute precludes the Secretary from making an allotment to a specific State until it has an approved State child health plan, because of the statutory provisions for redistribution of unused amounts of allotments, the availability of allotments for 3 years, and the potential for retroactive effective dates of State child health plans back to October 1, 1997, we believe it is necessary to establish and publish these reserved allotment amounts for FY 1998 so that States can begin to plan operation, if they chose to establish a State children's health insurance program under title XXI, effective October 1, 1997. No payments may be made from these allotments until a State has an approved State child health plan under title XXI.

In developing the reserved allotment amounts for FY 1998, we applied the following principles, upon which we will be inviting public comment during the rulemaking process.

• For each fiscal year for FY 1998 through FY 2007, an allotment amount will be reserved for all 50 States and the District of Columbia and for the Commonwealths and Territories, regardless of whether every State, Commonwealth, or Territory has submitted and the Secretary has approved a State child health plan. This will provide States with the flexibility and time to develop their programs and submit their State child health plans.

• The formula for "reserving" an allotment amount for each State will be the same as the formula contained at section 2104(b) of the Act. The reserved amount is an estimate of the State's title XXI allotment upon submission and approval of the State's child health plan.

• Under sections 2101(b)(2) and 2105(a) of the Act, no payment of Federal funds from a State's allotment is available for expenditures under a State's title XXI program unless the State has an approved State child health plan. Therefore, States may be at risk for expenditures made under a title XXI child health plan that is submitted, but not yet approved.

IV. Table of Reserved State Children's Health Insurance Program Allotments for FY 1998

Key to Table II

<u>Column</u>	<u>Description</u>
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Column A =	Name of State, Commonwealth, or Territory.
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Column B = Number of Children. The Number of Children for each State (provided in thousands) was determined and provided by the Bureau of the Census based on the arithmetic average of the number of low-income children and low-income children with no health insurance as calculated from the three most recent March supplements to the Current Population Survey. These data represent the number of people in each State under 19 years of age whose family income is at or below 200 percent of the poverty threshold appropriate for that family, and who are reported to be not covered by health insurance. The Number of Children for each State was developed by the Bureau of the Census based on the standard methodology used to determine official poverty status and uninsured status in their annual Current Population Reports on these topics.

For FYS 1998-2000, the Number of Children is equal to the number of low-income children in each State with no health insurance for the fiscal year. For FY 2001, the Number of Children is equal to the sum of 75 percent of

the number of low-income children in the State with no health insurance and 25 percent of the number of low-income children in the State. This is also based on a 3-year average of Census data. For FY 2002 and succeeding years, the Number of Children is equal to the sum of 50 percent of the number of low-income children in the State with no health insurance and 50 percent of the number of low-income children in the State. This is also based on a 3-year average of Census data.

Column C = State Cost Factor. The State Cost Factor for a State is equal to the sum of: .15, and .85 multiplied by the ratio of the annual average wages in the health industry per employee for the State to the annual wages per employee in the health industry for the 50 States and the District of Columbia. The State Cost Factor for each State was calculated based on such wage data for each State as reported, determined, and provided to HCFA by the BLS in the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year.

Column D = Product. The Product for each State was calculated by multiplying the Number of Children in Column B by the State Cost Factor in Column C. The sum of the Products for all 50 States and the District of Columbia is below the Products for each State in Column D. The Product for each State and the sum of the Products for all States provides the basis for allotment to States.

Column E = Percent Share of Total. This is the calculated percentage share for each State of the total allotment available to the 50 States and the District of Columbia. The Percent Share of Total is calculated as the ratio of the Product for each State in Column D to the sum of the products for all 50 States and the District of Columbia below the Products for each State in Column D.

Column F = Allotment. This is the State Child Health Program allotment for each State, Commonwealth, or Territory. For each of the 50 States and the District of Columbia, this is determined as the Percent Share of Total in Column E for the State multiplied by the total amount available for allotment for the

50 States and the District of Columbia for the fiscal year.

For each of the Commonwealths and Territories, the allotment is determined as the Percent Share of Total in Column E multiplied by the total amount available for allotment to the Commonwealths and Territories. For the Commonwealths and Territories, the Percent Share of Total in Column E is specified in section 2104(c) of the Act.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM ALLOTMENTS FOR FISCAL YEAR:					1998
A	B	C	D	E	F
STATE	NUMBER OF LOW-INCOME CHILDREN (000)	STATE COST FACTOR	PRODUCT	PERCENT SHARE OF TOTAL (3)	ALLOTMENT (1)
ALABAMA	154	0.9510	146.46	2.05%	\$85,997,312
ALASKA	9	1.0449	9.40	0.13%	\$8,438,146
ARIZONA	184	1.0473	192.69	2.69%	\$113,138,521
ARKANSAS	90	0.8871	79.84	1.12%	\$46,878,537
CALIFORNIA	1,281	1.1348	1,458.92	20.33%	\$884,864,484
COLORADO	72	0.9088	71.19	0.99%	\$41,801,288
CONNECTICUT	53	1.1237	59.55	0.83%	\$34,948,861
DELAWARE	13	1.0553	13.72	0.19%	\$8,683,513
DISTRICT OF COLUMBIA	16	1.2887	20.57	0.29%	\$12,879,104
FLORIDA	444	1.0348	459.32	6.43%	\$378,284,188
GEORGIA	314	0.9923	312.34	4.37%	\$124,691,179
HAWAII	13	1.1723	15.24	0.21%	\$8,947,683
IDAHO	31	0.8724	27.05	0.38%	\$15,883,789
ILLINOIS	211	0.9092	200.73	2.82%	\$122,560,847
INDIANA	151	0.9169	138.12	1.93%	\$78,538,557
IOWA	67	0.8253	55.30	0.77%	\$32,468,807
KANSAS	60	0.8704	52.22	0.73%	\$30,664,400
KENTUCKY	93	0.9146	85.06	1.19%	\$45,948,341
LOUISIANA	194	0.8934	173.31	2.42%	\$101,762,991
MAINE	24	0.8863	21.27	0.30%	\$12,490,186
MARYLAND	108	1.0498	104.98	1.47%	\$61,643,199
MASSACHUSETTS	69	1.0576	72.97	1.02%	\$42,847,342
MICHIGAN	156	1.0001	156.02	2.18%	\$91,609,050
MINNESOTA	50	0.9675	48.37	0.68%	\$28,483,379
MISSISSIPPI	110	0.8675	95.43	1.33%	\$56,831,802
MISSOURI	97	0.9075	88.03	1.23%	\$51,686,485
MONTANA	20	0.8333	16.67	0.23%	\$9,786,177
NEBRASKA	30	0.8440	25.32	0.35%	\$14,866,766
NEVADA	43	1.2046	51.80	0.72%	\$30,414,882
NEW HAMPSHIRE	28	0.9700	19.32	0.27%	\$11,461,319
NEW JERSEY	134	1.1241	150.63	2.10%	\$88,440,626
NEW MEXICO	107	0.9169	98.11	1.37%	\$57,605,326
NEW YORK	399	1.0914	435.47	6.08%	\$285,692,115
NORTH CAROLINA	138	0.9616	132.48	1.89%	\$79,528,899
NORTH DAKOTA	10	0.8587	8.59	0.12%	\$5,042,837
OHIO	205	0.9617	197.16	2.78%	\$115,764,112
OKLAHOMA	161	0.8588	138.26	1.93%	\$81,182,913
OREGON	67	0.9947	66.65	0.93%	\$39,131,718
PENNSYLVANIA	200	1.0005	200.09	2.79%	\$117,486,712
RHODE ISLAND	19	0.9580	18.20	0.25%	\$10,287,168
SOUTH CAROLINA	110	0.9843	108.27	1.51%	\$63,574,155
SOUTH DAKOTA	15	0.8559	12.84	0.18%	\$7,538,311
TENNESSEE	115	0.9799	112.69	1.57%	\$66,170,086
TEXAS	1,031	0.9275	956.25	13.35%	\$661,475,805
UTAH	46	0.8977	41.38	0.58%	\$24,247,398
VERMONT	7	0.8604	6.02	0.08%	\$3,536,354
VIRGINIA	118	0.9862	116.38	1.64%	\$68,332,474
WASHINGTON	85	0.9352	79.49	1.11%	\$46,673,207
WEST VIRGINIA	45	0.8937	40.21	0.56%	\$23,612,812
WISCONSIN	71	0.9229	65.53	0.92%	\$38,475,831
WYOMING	15	0.8758	13.14	0.18%	\$7,713,620
TOTAL STATES ONLY			7,160.33	100.00%	\$4,204,312,500
ALLOTMENTS FOR COMMONWEALTHS AND TERRITORIES (2)					
PUERTO RICO				91.60%	\$9,789,750
GUAM				3.50%	\$374,063
VIRGIN ISLANDS				2.60%	\$277,875
AMERICAN SAMOA				1.30%	\$128,350
N. MARIANA ISLANDS				1.10%	\$117,563
TOTAL COMMONWEALTHS AND TERRITORIES ONLY				100.00%	\$10,687,500
TOTAL STATES AND COMMONWEALTHS AND TERRITORIES					\$4,215,000,000
FOOTNOTES					
(1) Total amount available for allotment to the 50 States and the District of Columbia is \$4,204,312,500; determined as the FY 1998 appropriation (\$4,275,000,000) reduced by the total amount available for allotment to the Commonwealths and Territories (\$10,687,500) and amounts for Special Diabetes Grants (\$60,000,000) under sections 4921 and 4922 of BBA					
(2) Total amount available allotment to the Commonwealths and Territories is \$10,687,500; determined as .25 percent of the FY 1998 appropriation (\$4,275,000,000)					
(3) Per share of total amount available for allotment to the Commonwealths and Territories is as specified in					

**V. Calculation of Enhanced Federal Medical Assistance
Percentage**

In accordance with formulas in sections 1101(a)(8) and 1905(b) of the Act, the Secretary each year calculates and publishes the "Federal percentages" and "Federal medical assistance percentages" (FMAP) that are used in determining the amount of Federal matching in State welfare and medical assistance expenditures. Section 2105(b) of title XXI provides for an "enhanced FMAP" for child health assistance provided under title XXI that is equal to the current FMAP for fiscal year in the Medicaid Title XIX program, increased by 30 percent of the difference between 100 and the current FMAP for that fiscal year. The enhanced FMAP may not exceed 85 percent.

The FMAPs for each State and Commonwealth and Territory for the title XIX Medicaid program that are applicable for FY 1998 have already been published in the Federal Register (on January 29, 1997, 62 FR 4293). We are republishing the FY 1998 FMAPs in Table II, along with the enhanced FMAP for the State Children's Health Insurance Program, computed in accordance with the formula specified in section 2105(b) of the Act.

Key to Table I

<u>Column</u>	<u>Description</u>
Column A =	State. This contains the name of the State, Commonwealth, or Territory.

Column B = Federal Medical Assistance Percentages FY 1998. This contains the title XIX FMAPs, previously published in the Federal Register (January 29, 1997, 62 FR 4293)

Column C = Amount of FMAP Increase. This contains the amount of the FMAP increase calculated as 30 percent of the difference between 100 percent and the title XIX FMAP rate in Column B.

Column D = Enhanced FMAP FY 1998. This is the title XXI enhanced FMAP rate specified at section 2105(b) of the Act. The enhanced FMAP is limited to no more than 85 percent.

ENHANCED FMAPS UNDER SECTION 2105(b) OF THE SOCIAL SECURITY ACT			
A	B	C	D
STATE	FEDERAL MEDICAL ASSISTANCE PERCENTAGES FY 1998	AMOUNT OF FMAP INCREASE	ENHANCED FMAP FY 1998
ALABAMA	69.32%	9.20%	78.52%
ALASKA(1)	59.80%	12.06%	71.86%
AMERICAN SAMOA	50.00%	15.00%	65.00%
ARIZONA	65.33%	10.40%	75.73%
ARKANSAS	72.84%	8.15%	80.99%
CALIFORNIA	51.23%	14.83%	66.06%
COLORADO	51.87%	14.41%	66.28%
CONNECTICUT	50.00%	15.00%	65.00%
DELAWARE	50.00%	15.00%	65.00%
DISTRICT OF COLUMBIA(1)	70.00%	9.00%	79.00%
FLORIDA	55.65%	13.31%	68.96%
GEORGIA	60.84%	11.75%	72.59%
GUAM	50.00%	15.00%	65.00%
HAWAII	50.00%	15.00%	65.00%
IDAHO	69.59%	9.12%	78.71%
ILLINOIS	50.00%	15.00%	65.00%
INDIANA	61.41%	11.58%	72.99%
IOWA	63.75%	10.88%	74.63%
KANSAS	58.71%	12.09%	71.80%
KENTUCKY	70.37%	8.89%	79.26%
LOUISIANA	70.03%	8.99%	79.02%
MAINE	66.04%	10.19%	76.23%
MARYLAND	50.00%	15.00%	65.00%
MASSACHUSETTS	50.00%	15.00%	65.00%
MICHIGAN	53.58%	13.83%	67.41%
MINNESOTA	52.14%	14.36%	66.50%
MISSISSIPPI	77.09%	6.87%	83.96%
MISSOURI	60.66%	11.80%	72.46%
MONTANA	70.56%	8.83%	79.39%
NEBRASKA	61.17%	11.65%	72.82%
NEVADA	50.00%	15.00%	65.00%
NEW HAMPSHIRE	50.00%	15.00%	65.00%
NEW JERSEY	50.00%	15.00%	65.00%
NEW MEXICO	72.81%	8.22%	80.83%
NEW YORK	50.00%	15.00%	65.00%
NORTH CAROLINA	63.09%	11.07%	74.16%
NORTH DAKOTA	70.43%	8.87%	79.30%
NORTHERN MARIANA IS.	50.00%	15.00%	65.00%
OHIO	58.14%	12.58%	70.70%
OKLAHOMA	70.51%	8.85%	79.36%
OREGON	61.46%	11.56%	73.02%
PENNSYLVANIA	53.39%	13.98%	67.37%
PUERTO RICO	50.00%	15.00%	65.00%
RHODE ISLAND	53.17%	14.05%	67.22%
SOUTH CAROLINA	70.23%	8.93%	79.16%
SOUTH DAKOTA	67.75%	9.68%	77.43%
TENNESSEE	63.36%	10.99%	74.35%
TEXAS	62.28%	11.32%	73.60%
UTAH	72.58%	8.23%	80.81%
VERMONT	62.16%	11.35%	73.51%
VIRGIN ISLANDS	50.00%	15.00%	65.00%
VIRGINIA	51.49%	14.55%	66.04%
WASHINGTON	52.15%	14.36%	66.51%
WEST VIRGINIA	73.67%	7.90%	81.57%
WISCONSIN	58.84%	12.35%	71.19%
WYOMING	63.02%	11.09%	74.11%

Footnote:
(1) FMAP as specified in Section 4725 of the Balanced Budget Act of 1997

VI. Impact Statement

HCFA has examined the impact of this notice as required by Executive Order 12866. Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when rules are necessary, to select regulatory approaches that maximize net benefits (including potential economic environments, public health and safety, other advantages, distributive impacts, and equity). We believe that this notice is consistent with the regulatory philosophy and principles identified in the Executive Order.

This notice merely provides advance notification of the reserved FY 1998 State allotments available to provide Federal funding to individual States, Commonwealths, and Territories for expenditures in the new Children's Health Insurance Program and the assumption and methodology that HCFA used to determine these reserved allotments. The formula for State allotments is specified in the statute. This notice by itself has no economic impact. Final allotments will be calculated using the statutory formula and may vary from these reserved amounts depending upon the number of States that submit approved State plans under title XXI. (As noted above, the allotment process will be set forth in more detail in future rule making.)

We believe this notice will have an overall positive impact by informing States of the extent to which they will

be permitted to expend funds under approved State child health plans in FY 1998. States will be able to conduct advance planning necessary for implementation of the State Child Health Insurance Program if they choose, beginning October 1, 1997.

In accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

MB-115-N

September 8, 1997 (4:10pm)

25²⁶

(Section 1102 of the Social Security Act (42 U.S.C. 1302).

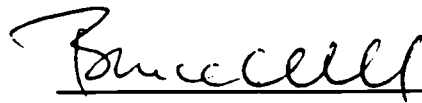
~~(Catalog of Federal Domestic Assistance Program No. 00.000,~~

~~State Children's Health Insurance Program)~~

2
9/8/97

Dated:

9/8/97



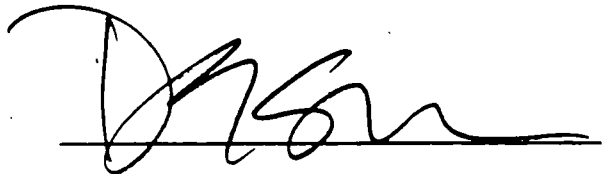
Bruce C. Vladeck,

Administrator, Health Care

Financing Administration.

SEP - 9 1997

Dated:



Donna E. Shalala,

Secretary.

BILLING CODE 4120-01-P

REVISED RESERVED ALLOTMENTS FOR FY 1998 TO REFLECT
ADDITIONAL \$20 MILLION APPROPRIATION

STATE CHILDREN'S HEALTH INSURANCE PROGRAM ALLOTMENTS FOR FISCAL YEAR 1998					
A	B	C	D	E	F
STATE	NUMBER OF CHILDREN (000)	STATE COST FACTOR	PRODUCT	PERCENT SHARE OF TOTAL (3)	ALLOTMENT (1)
ALABAMA	154	0.9510	146.46	2.05%	\$86,405,380
ALASKA	9	1.0669	9.60	0.13%	\$5,664,899
ARIZONA	184	1.0472	192.69	2.69%	\$113,675,378
ARKANSAS	90	0.8871	79.84	1.12%	\$47,100,971
CALIFORNIA	1,281	1.1365	1,455.92	20.33%	\$858,920,926
COLORADO	72	0.9888	71.19	0.99%	\$41,999,641
CONNECTICUT	53	1.1237	59.55	0.83%	\$35,133,989
DELAWARE	13	1.0553	13.72	0.19%	\$8,093,758
DISTRICT OF COLUMBI	16	1.2857	20.57	0.29%	\$12,136,423
FLORIDA	444	1.0368	460.32	6.43%	\$271,566,713
GEORGIA	214	0.9923	212.36	2.97%	\$125,283,859
HAWAII	13	1.1722	15.24	0.21%	\$8,990,060
IDAHO	31	0.8726	27.05	0.38%	\$15,959,159
ILLINOIS	211	0.9892	208.73	2.92%	\$123,141,631
INDIANA	131	0.9169	120.12	1.68%	\$70,865,233
IOWA	67	0.8253	55.30	0.77%	\$32,622,875
KANSAS	60	0.8704	52.22	0.73%	\$30,809,906
KENTUCKY	93	0.9146	85.06	1.19%	\$50,182,358
LOUISIANA	194	0.8934	173.31	2.42%	\$102,245,869
MAINE	24	0.8863	21.27	0.30%	\$12,549,454
MARYLAND	100	1.0498	104.98	1.47%	\$61,935,703
MASSACHUSETTS	69	1.0576	72.97	1.02%	\$43,050,558
MICHIGAN	156	1.0001	156.02	2.18%	\$92,043,746
MINNESOTA	50	0.9675	48.37	0.68%	\$28,538,056
MISSISSIPPI	110	0.8675	95.43	1.33%	\$56,297,379
MISSOURI	97	0.9075	88.03	1.23%	\$51,931,664
MONTANA	20	0.8333	16.67	0.23%	\$9,832,614
NEBRASKA	30	0.8440	25.32	0.35%	\$14,937,291
NEVADA	43	1.2046	51.80	0.72%	\$30,559,205
NEW HAMPSHIRE	20	0.9760	19.52	0.27%	\$11,515,734
NEW JERSEY	134	1.1241	150.62	2.10%	\$88,860,288
NEW MEXICO	107	0.9169	98.11	1.37%	\$57,878,570
NEW YORK	399	1.0914	435.47	6.08%	\$256,905,407
NORTH CAROLINA	138	0.9815	135.45	1.89%	\$79,906,274
NORTH DAKOTA	10	0.8587	8.59	0.12%	\$5,065,962
OHIO	205	0.9617	197.16	2.75%	\$116,313,427
OKLAHOMA	161	0.8588	138.26	1.93%	\$81,568,137
OREGON	67	0.9947	66.65	0.93%	\$39,317,403
PENNSYLVANIA	200	1.0005	200.09	2.79%	\$118,044,201
RHODE ISLAND	19	0.9580	18.20	0.25%	\$10,737,880
SOUTH CAROLINA	110	0.9843	108.27	1.51%	\$63,875,823
SOUTH DAKOTA	15	0.8559	12.84	0.18%	\$7,574,081
TENNESSEE	115	0.9799	112.69	1.57%	\$66,484,072
TEXAS	1,031	0.9275	956.25	13.35%	\$564,140,079
UTAH	46	0.8977	41.30	0.58%	\$24,362,447
VERMONT	7	0.8604	6.02	0.08%	\$3,553,134
VIRGINIA	118	0.9862	116.38	1.63%	\$68,656,720
WASHINGTON	85	0.9352	79.49	1.11%	\$46,894,677
WEST VIRGINIA	45	0.8937	40.21	0.56%	\$23,724,858
WISCONSIN	71	0.9229	65.53	0.92%	\$38,658,404
WYOMING	15	0.8758	13.14	0.18%	\$7,750,222
TOTAL STATES ONLY			7,160.35	100.00%	\$4,224,262,500
ALLOTMENTS FOR COMMONWEALTHS AND TERRITORIES (2)					
PUERTO RICO				91.60%	\$9,835,550
GUAM				3.50%	\$375,813
VIRGIN ISLANDS				2.60%	\$279,175
AMERICAN SAMOA				1.20%	\$128,850
N. MARIANA ISLANDS				1.10%	\$118,113
TOTAL COMMONWEALTHS AND TERRITORIES ONLY				100.00%	\$10,737,500
TOTAL STATES AND COMMONWEALTHS AND TERRITORIES					\$4,235,000,000
FOOTNOTES					
(1) Total amount available for allotment to the 50 States and the District of Columbia is \$4,224,262,500; determined as the FY 1998 appropriation (\$4,295,000,000) reduced by the total amount available for allotment to the Commonwealths and Territories (\$10,737,500) and amounts for Special Diabetes Grants (\$60,000,000) under sections 4921 and 4922 of BBA					
(2) Total amount available for allotment to the Commonwealths and Territories is \$10,737,500; determined as .25 percent of the FY 1998 appropriation (\$4,295,000,000)					
(3) Percent share of total amount available for allotment to the Commonwealths and Territories is as specified in section 2104(c) of the Security Act					

Immigrant Letter



JAN 14 1998

Dear State Health Official:

The Department of Health and Human Services is writing to provide States with information regarding the existing authority under the new Title XXI of the Social Security Act to meet the health care needs of immigrant children. As you know, the Children's Health Insurance Program (CHIP) represents a historic opportunity to meet the health care needs of uninsured, low-income children. The Department wants to ensure that immigrant children benefit from this new program to the maximum extent possible under the law. Current Population Survey data from 1995 showed that 51.7 percent of poor, foreign born persons were uninsured, compared to 26.4% for native born Americans. This letter explains how health care for immigrant children and children born in the U.S. to immigrant parents may be improved through CHIP.

We have determined that Title XXI health insurance coverage meets the definition of a Federal, means-tested public benefit. Therefore, its health insurance coverage cannot be made available to certain immigrant children. States may not segregate their CHIP expenditures to convert a portion of the program into a fully State funded, means-tested program in order to circumvent the restrictions established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which banned certain immigrants from receiving Federal means-tested public benefits for their first 5 years in the country.

Nevertheless, you should be aware that several groups of legal immigrant children are eligible for the full range of benefits provided under CHIP. In addition to providing insurance coverage to eligible immigrant children, States may use a limited amount of CHIP funds for expenditures other than health insurance assistance to conduct targeted outreach and health services initiatives in communities that include substantial numbers of immigrant children. Further guidance on these issues is provided below:

ELIGIBLE "IMMIGRANT" CHILDREN

PRWORA did not change longstanding law providing that any child born in the United States is a citizen. Census data from 1996 found that there are 9.9 million children born in the U.S. to an immigrant parent. These children are U.S. citizens and are subject to the same criteria and procedures to determine eligibility for public programs as any other U.S. citizen.

Additionally, there are certain other categories of immigrant children who may be eligible for both Medicaid and CHIP due to exemptions from the restrictions in PRWORA. They include:

- All legal immigrant children who were in the U.S. before August 22, 1996,
- Refugees, asylees, and certain Cuban, Haitian and Amerasian immigrants,

- Unmarried, dependent children of veterans and active duty service members of the Armed Forces, and
- Legal immigrants arriving on or after August 22, 1996, and in continuous residence for 5 years. (Earliest eligibility for this group is August 22, 2001. Also, their sponsor's income and resources will be taken into account in determining their eligibility for those who have signed legally binding affidavits of support.)

Moreover, although Medicaid is classified as a "designated Federal program" under PRWORA, meaning States may deny benefits to qualified aliens other than those listed above, States may not deny benefits to otherwise qualified and eligible aliens under Title XXI. Accordingly, after the expiration of the 5 year period beginning with the date of the alien's entry to the United States, qualified alien children will be eligible for coverage under a Title XXI CHIP program if they meet the other eligibility requirements for that program.

OUTREACH

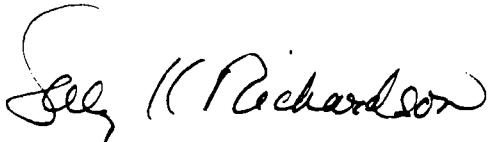
In order to facilitate the enrollment of eligible children, States may choose to target outreach activities toward low-income communities with high concentrations of immigrants. Given the significant numbers of low-income children residing in immigrant communities who are uninsured and qualify for Federal public benefits, targeting outreach to such communities is part of an effective outreach strategy. Funding is authorized in Title XXI for outreach to families of children likely to be eligible for benefits under Title XXI or under other public or private health coverage programs, to inform these families of the availability of the State program, and to assist them in enrolling their children when appropriate. Uninsured, low-income children found to be ineligible for CHIP or Medicaid coverage should be referred to other sources of health benefits coverage such as private, charitable insurance programs and safety net providers in their area, to the extent available.

HEALTH SERVICES INITIATIVES

Additionally, at the State's option, low-income, immigrant communities, including the temporary communities of migrant and seasonal farm workers, can be targeted for health services initiatives. Title XXI, authorizes CHIP funds to be used for "expenditures for health services initiatives... for improving the health of children (including targeted low income children and other low income children)."

The legislation further indicates that these initiatives may benefit the health of all low income children, including but not limited to children eligible to receive services under Title XXI. Therefore, health services initiatives such as health education activities, school health programs and direct services (such as newborn hearing screening and lead testing programs), could be targeted to low-income immigrant communities. Both qualified and non-qualified immigrants may benefit from health services initiatives if such initiatives promote child health in a targeted county, community, or school. (It is important to note that except in States granted waivers, expenditures for health services initiatives, together with outreach, administrative costs, and other child health assistance, are subject to a 10 percent limit as set forth in section 2105(c)(2)(A).)

We hope that this information will help your State achieve the goal of providing access to comprehensive health care for all vulnerable children. Thank you for your continued efforts toward achieving this goal. If you have any further questions, please contact Marty Svolos at (410) 786-4582.



Sally K. Richardson
Director
Center for Medicaid and State Operations
Health Care Financing Administration

Sincerely,



Claude Earl Fox, M.D., M.P.H.
Acting Administrator
Health Resources and Service Administration

cc: Governor's Offices

All HCFA Regional Offices

All PHS Regional Offices

Ms. Lee Partridge
Director Health Policy Unit
American Public Welfare Association

Ms. Jennifer Baxendell
Senior Policy Analyst
Human Resources Group
National Governor's Association

Ms. Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Outreach Letter



JAN 23 1998

Dear State Health Official:

This letter highlights new and existing opportunities for outreach to uninsured children. We share a mutual interest in and commitment to enrolling uninsured children in both Medicaid and the new State Children's Health Insurance Program (CHIP). An estimated 3 million children are eligible for Medicaid, but remain uninsured. Millions more will be eligible for CHIP because of historic, bipartisan legislation passed by the Administration and Congress. Successfully enrolling these eligible but uninsured children is critical to both the success of these programs and the health of these children; as such, outreach is a high priority for the President, First Lady, and Department of Health and Human Services.

In this letter, we describe examples of and options for successful outreach and enrollment and Federal funding available for these activities. Most of these provisions are currently options within Medicaid or reflect preliminary guidance for CHIP. Two of these provisions -- expanding the entities that can determine presumptive eligibility and expanding access to a special fund for outreach -- are proposals in the President's fiscal year 1999 Budget that would provide nearly \$200 million a year in additional Federal dollars to States that choose to take advantage of these initiatives. If passed, they would be effective on October 1, 1998.

I. Funding for Outreach

States have several options for receiving Federal matching funds to find and enroll uninsured children in Medicaid and/or CHIP. Medicaid will match States' expenditures associated with outreach to Medicaid-eligible children. Similarly, CHIP funds may be used to pay for outreach to CHIP-eligible children (up to the 10 percent limit, described below). Because of the importance of outreach, the President's fiscal year 1999 Budget contains proposed legislation that, if enacted, would provide a higher matching rate for outreach activities for all children, regardless of their eligibility. This section describes these options.

◆ Federal Matching of Outreach under Medicaid

There have been questions about what types of outreach activities Medicaid will fund. The Federal government matches State Medicaid expenditures for outreach activities that bring potential eligibles into the Medicaid system to determine if they qualify for Medicaid benefits. These activities include: informing families about Medicaid through brochures or other promotional material; assisting families in completing Medicaid applications; and providing the necessary forms and packaging for Medicaid eligibility determinations. These activities are considered allowable Medicaid administrative activities for the purpose of Federal matching. Since the Medicaid program is an open-ended entitlement program, there is no limit on the amount of allowable Medicaid outreach expenditures States may claim for Federal matching.

◆ **Federal Matching of Outreach under CHIP**

Title XXI places a strong emphasis on outreach. State child health plans cannot be approved without a description of how States will educate families, assist them in enrolling children in the appropriate program, and coordinate health insurance programs across the State. There are several ways that CHIP outreach expenditures may be matched.

Non-Medicaid CHIP Option. Outreach activities related to a non-Medicaid CHIP program only would be matched from the State's CHIP allotment. States may spend up to 10 percent of their total CHIP expenditures (Federal and State) on non-benefit activities, including: outreach conducted to identify and enroll eligible children in CHIP; administration costs; health services initiatives; and other child health assistance. These expenditures are matched at the enhanced CHIP matching rate and count against both the 10 percent limit and the allotment.

Medicaid CHIP Option. Outreach activities related strictly to a Medicaid expansion under CHIP can be matched either from the State's CHIP allotment or under regular Medicaid, at the State's option. If a State elects to claim Federal matching for its outreach expenditures from the CHIP allotment, such Federal payments will count against the State's 10 percent limit and allotment and will be matched at the enhanced CHIP matching rate. Once the State reaches its 10 percent limit and/or its CHIP allotment, it may then claim Federal matching for any additional Medicaid outreach expenditures under the Medicaid program. States may claim Federal matching for outreach expenditures under the Medicaid program only if such expenditures are for CHIP-related Medicaid expansion groups. Alternatively, a State may elect to claim Federal matching for outreach expenditures for CHIP-related Medicaid expansion groups under the Medicaid program at the regular Medicaid administrative matching rate. If claimed in this way, Federal payments for these expenditures would not count against the 10 percent limit or the CHIP allotment.

Joint Medicaid-CHIP Option. Joint outreach efforts for Medicaid and CHIP may similarly be matched by either Medicaid or CHIP. Detailed guidance on these options was provided in a December 8, 1997 letter to State Health Officials on financial issues.

◆ **Enhanced Matching for Children's Outreach Efforts [Proposed Legislation]**

In the welfare reform bill that created the Temporary Assistance for Needy Families (TANF) program, a \$500 million Medicaid fund was established to help States ensure that children and parents losing welfare know about their continued eligibility for Medicaid. These funds, which are allotted to States, provide an enhanced Federal matching rate for outreach and administrative costs related to this narrow group of Medicaid-eligible people. Certain outreach activities are eligible to receive a 90 percent matching rate from the fund. (See the May 14, 1997 *Federal Register* notice for details.) Few States, however, have

taken advantage of this fund so far, in part, due to the difficulty of targeting outreach only to a subset of Medicaid-eligible children.

The President's fiscal year 1999 Budget includes a legislative proposal that, if enacted, would expand the use of this fund. States would be able to receive a 90 percent matching rate for outreach activities for all uninsured children, not just those who would have been eligible for welfare. The Federal funds to cover the extra matching (above Medicaid's regular matching amount) would come from this fund. In addition, the proposal would remove the sunset on the fund in 2000 and add another \$25 million to assist States with increased outreach activities.

II. Expanding Sites for Enrolling Children

In the wake of welfare reform, families often misunderstand their children's continued eligibility for Medicaid. They also may be unsure about differences between Medicaid and CHIP. Thus, it has become more important than ever that States have and pursue options to conduct educational activities and enrollment of children in a wider array of community settings.

◆ Allowing Immediate Medicaid Coverage Through Schools, Head Start, and Child Care Centers [Proposed Legislation]

The Balanced Budget Act (BBA) of 1997 gave States a new option in Medicaid to grant "presumptive eligibility" to children. Certain children may receive immediate health care coverage without having to wait for a full Medicaid eligibility determination. Under this option, a "qualified entity" and/or its employees may presume that a child is temporarily eligible for Medicaid if, using preliminary information, family income does not exceed the State's applicable income eligibility level. The child's parent or guardian has until the end of the following month to submit a full Medicaid application for the child. Until a final eligibility determination on that application is made by the State, the child is covered for Medicaid services. Although the CHIP statute does not expressly provide for presumptive eligibility, States also could use this option in their eligibility for a CHIP separate State program.

The BBA defines "qualified entities" as providers of health care items and services under the Medicaid State plan (including IHS, Tribal and urban Indian health care providers that participate in a Medicaid State plan) and entities that determine eligibility for Head Start, WIC and child care subsidies under the Child Care and Development Block Grant. It also requires that certain costs associated with presumptive eligibility be subtracted from the State's child health allotment (see the December 8, 1997 letter on financial issues).

The President's fiscal year 1999 Budget proposes to make this presumptive eligibility option more flexible and attractive to States. First, it would broaden the definition of "qualified entities" to include sites such as schools, child care resource and referral centers, child support enforcement agencies and CHIP eligibility workers. Second, it would eliminate the requirement that States subtract the costs of presumptive eligibility from their CHIP allotments. Instead, these costs would be matched as a regular Medicaid State plan option. Both of these changes would give States greater incentives and flexibility for using this important authority.

◆ **"Outstationing" Eligibility Workers in Communities**

Outstationing eligibility workers is a promising outreach strategy for enrolling Medicaid and CHIP-eligible children. "Outstationing" means locating eligibility workers in places other than welfare offices to assist with the initial processing of applications. (The final Medicaid eligibility determination must be made by the appropriate State agency.) Current Medicaid law requires States to outstation eligibility workers in Federally qualified health centers and disproportionate share hospitals. States also can receive Federal matching for outstationing eligibility workers in other locations.

We encourage States to consider outstationing eligibility workers at sites that are frequented by families with children such as schools, child care centers, churches, Head Start centers, WIC offices, community centers, Job Corps sites, GED programs, local Tribal organizations and Social Security offices.

◆ **Using Mail-In Applications**

One option that allows States to ease the enrollment process is the use of mail-in applications. Mail-in applications, especially for Medicaid, can significantly reduce the barriers to enrollment that may occur with requiring in-person applications.

Transportation costs are eliminated, the stigma of going to a social services office is removed, parents will not have to miss work, and community groups like PTAs and church organizations can assist in distributing applications and information regarding Medicaid and CHIP. Many, but not all, States use this option in Medicaid today. We encourage all States to adopt this option.

III. Simplifying Enrollment

A key to successfully enrolling children at a wide range of sites is a simple application and enrollment process.

◆ **Simplifying the Medicaid Application and Eligibility Process**

One barrier to enrollment in Medicaid is the complexity of the application. Some States have applications over 20 pages long, posing an often insurmountable challenge for families. We encourage States to develop strategies to simplify these processes by: preparing a simplified Medicaid application for the eligibility groups that include most children; using a “less restrictive” eligibility methodology that drops the Medicaid assets test for children; shortening the Medicaid application form generally; and allowing mail-in applications. Also, there are few verification requirements under Federal law that are mandatory. While it is important to maintain program integrity by verifying income, excessive requirements can deter families from completing the application process.

Medicaid administrative funds can be used to redesign the Medicaid application form. Attached are some examples of shortened and simplified Medicaid applications used in some States (see attachment A).

◆ **Using a Single Application for Medicaid and CHIP**

We encourage States to use one application for both Medicaid and CHIP. The advantages of a single application form include a reduction in paperwork for the State and a simplified process for families potentially eligible for Medicaid or CHIP. Attachment B includes a model joint application form and its instructions. We also encourage States to use single applications for health and non-health programs like TANF.

◆ **Eligibility Screening and Enrollment for Medicaid and CHIP**

CHIP requires States to ensure that only targeted low-income children are furnished child health assistance and that children found eligible for Medicaid through screening are enrolled in Medicaid. At a minimum, State screening processes should assure that all children who are potentially eligible for Medicaid under the poverty-level-related groups are identified. The State may initially use a gross income test that compares total family income to the applicable Medicaid standard. The initial gross income test would immediately identify children whose family income is low enough that Medicaid eligibility would be almost certain. A second test would be needed, however, to detect those children whose gross family income exceeds the Medicaid standard but who are Medicaid-eligible when income disregards are applied. Without this second test, the State would not be meeting its responsibility to ensure that children eligible for Medicaid are identified and enrolled in Medicaid. (Some States have used this technique with simplified Medicaid applications.) Screening is not required for States that elect to expand Medicaid under CHIP, because the child’s eligibility for regular Medicaid will be determined as part of the State’s eligibility determination process.

The statute clearly says that States must include in their State child health plans a description of procedures to ensure that children found to be eligible for Medicaid must be enrolled in Medicaid; a simple referral procedure to Medicaid will not meet this requirement. The Department of Health and Human Services (DHHS) will be providing guidance on options to meet this requirement in the near future. Some examples include:

- **Single State agency for eligibility determination:** States can use the Medicaid State agency to make eligibility determinations for non-Medicaid CHIP expansions as well as Medicaid CHIP expansions.
- **Joint application for both CHIP and Medicaid:** States can use a joint CHIP and Medicaid application. As noted earlier, DHHS has developed a model application form for CHIP and Medicaid (see attachment B). States could use interagency agreements to send applications to the appropriate place for processing.
- **Presumptive eligibility:** If the President's fiscal year 1999 Budget proposal is enacted, States will have the option of allowing their CHIP eligibility workers to make presumptive Medicaid eligibility determinations as well as CHIP eligibility determinations. (The final Medicaid eligibility determination must be made by the appropriate State agency.)

◆ **Granting 12-Month Continuous Eligibility**

Another way to increase the number of children with health insurance is to grant children eligibility for Medicaid for a longer period of time. Many families fall in and out of income eligibility due to job changes or fluctuations in paychecks. The BBA provides States the option to provide individuals under age 19 with up to 12 months of continuous eligibility after they are determined eligible for Medicaid, even if there is a change in the family's income, assets, or size. Under this option, Medicaid eligibility is granted for a period of up to one year regardless of changes in circumstances. States that use their CHIP funds for separate State programs can also provide continuous eligibility, since they have the flexibility to determine how frequently follow-up screening (redetermination) will be conducted.

IV. Other Outreach Strategies

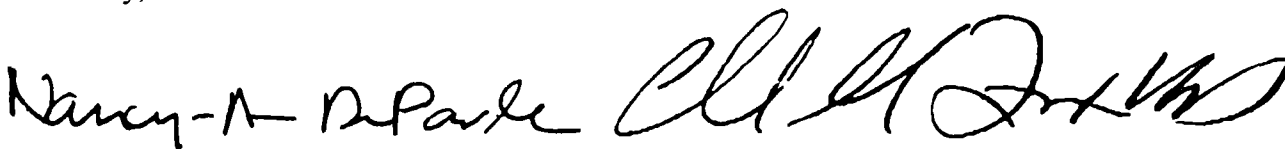
In addition to expanding sites for enrollment and simplifying the process, States have used a number of valuable approaches to help them locate children and facilitate their enrollment in Medicaid and other health programs. This has been especially true for children who are members of special populations, such as children with special health care needs, homeless children and migrant children. State strategies to reduce barriers to enrollment range from advertising on billboards to linking health with other types of public programs like Head Start. Promising examples of State outreach activities are described in attachment C.

Summary

Every successful outreach model requires cooperation among diverse entities. Potential partners for outreach programs include school districts, community-based organizations, local health and human service providers, Head Start programs and child care centers. In addition, collaboration between the Federal and State governments, private businesses, foundations and advocacy groups could also produce creative and effective outreach initiatives.

We believe that the new children's health insurance program provides a unique opportunity to ensure that the millions of eligible children are enrolled in public or private health insurance plans and receive essential health care services. We hope you will join us in meeting this challenge.

Sincerely,



Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Claude Earl Fox, M.D., M.P.H.
Acting Administrator
Health Resources and Service Administration

Enclosures

cc: HHS Regional Directors
HCFA Regional Offices
PHS Regional Offices
TANF State Agencies
Title IV-D Agencies
Child Care Directors
Child Welfare Directors
Ms. Lee Partridge, American Public Welfare Association
Ms. Jennifer Baxendell, National Governors' Association
Ms. Joy Wilson, National Conference of State Legislatures
Ms. Cheryl Beversdorf, Association of State and Territorial Health Officials
Ms. Mary Beth Senkewicz, National Association of Insurance Commissioners

(Attachment A)

EXAMPLES OF SIMPLE MEDICAID APPLICATION FORMS

- List of States that have Simplified the Medicaid Application Process
- Delaware's Application
- Georgia's Application
- South Carolina's Application

States That Have Simplified the Medicaid Application Process

The following States have taken steps to simplify their Medicaid application processes, by allowing mail-in applications, shortening the Medicaid application form, or eliminating the assets test for children or by using a combination of these techniques.

Mail-In Applications (24)

Alabama
Alaska *
Connecticut
Delaware
District of Columbia
Hawaii *
Illinois *
Maine *
Massachusetts
Michigan (local decision)
Minnesota
Mississippi
Missouri
New Mexico *
North Dakota *
Ohio
Oklahoma
Oregon
Pennsylvania
Utah *
Vermont
Virginia
Washington
Wyoming *

Short Application (29) **

Alabama
Alaska
Arkansas
Colorado
Georgia
Hawaii
Illinois
Indiana
Iowa
Kentucky
Michigan
Mississippi
Missouri
New Hampshire
New Mexico
New York
Ohio
Oklahoma
Oregon
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wyoming

No Assets Test (36) ***

Alabama
Alaska
Arizona
Connecticut
Delaware
District of Columbia
Florida
Georgia
Illinois
Indiana
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Mississippi
Missouri
Nebraska
New Hampshire
New Jersey
New Mexico
New York
North Carolina
Ohio
Oklahoma
Pennsylvania
South Carolina
South Dakota
Tennessee
Vermont
Virginia
Washington
West Virginia
Wisconsin

* After the mail-in application is received, the Medicaid agency will conduct a telephone interview.

** Applications are the same length or shorter than the HCFA model application

*** AR, CA, HI & UT count assets in determining Medicaid eligibility for some children.

Source: Center on Budget and Policy Priorities, August 1997



**FAMILY AND COMMUNITY
MEDICAL ASSISTANCE APPLICATION**

This form must be completed before we can see if you are eligible for medical assistance. If you need help completing the form, ask your worker. Return this application within 30 days of the date you asked for Medicaid. If you do not, this may change the date your Medicaid will start.

We must take action on your application for Medicaid within 45 days from the date we receive your application in our office (90 days for disabled children or others who apply on the basis of disability).

We need you to give us proof of the following items for you and your family:

- Birth (birth certificate, driver's license, marriage license)
- Social Security number (copy of card or proof you have applied for one)
- Lawful alien status (registration card, immigration papers)
- Current income (pay stubs, letter from employer, award letter or check)
- Child care costs (receipts or letter from provider)
- Delaware residency and address (enclosed household form, utility bill, lease)
- Medical insurance, such as Medicare (copy of card, benefit letter)
- Pregnancy and due date (statement by medical professional)
- Disability for Disabled Child Program (enclosed medical forms)
- Emergency medical condition for illegal aliens (enclosed medical forms)
- Resources for QMB, SLMB, Disabled Child and SSI related programs (bank statements, life insurance policies, burial fund, savings bonds, trust fund)

You may need to give us more information. If you have already given this information to a Department of Health and Social Services office, let us know. You may not have to give it again. Failure to provide the above information may result in delayed or denied benefits.

HEAD OF HOUSEHOLD:

LAST NAME	FIRST NAME	M.I.
STREET ADDRESS		
DEVELOPMENT OR APARTMENT NAME		APT.NO
CITY	STATE	ZIP CODE
DAYTIME TELEPHONE NUMBER		
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		
PLEASE LIST ANY OTHER NAMES THAT YOU HAVE USED		

HOUSEHOLD MEMBERS

1. Please list everyone in your household (including yourself) and complete each space by their name.

ARE YOU APPLYING FOR THIS PERSON?	LAST NAME	FIRST NAME	M.I.	OFFICE USE ONLY (MCI #)
YES NO				
YES NO				
YES NO				
YES NO				
YES NO				
YES NO				
YES NO				

2. Have you ever been eligible for and received both a Social Security check and a Supplemental Security Income (SSI) check in the same month?

Circle one: Yes No

If yes, list the last month and year you were eligible for and received both benefits: _____

2. Does anyone in your family have unpaid medical bills from the last three months?

Circle one: Yes No

Was your income the same as it is now during those months?

Circle one: Yes No

3. If you pay child care costs, please give names of the children and the monthly amount you pay for each child. Please also include any fees for summer camp or nursery school.

NAME OF CHILD	MONTHLY AMOUNT	NAME OF CHILD	MONTHLY AMOUNT

HOUSEHOLD MEMBERS

SOCIAL SECURITY NUMBER	SEX	RACE/ ETHNIC GROUP	IS THIS PERSON A U.S. CITIZEN OR A LEGAL ALIEN?	ALIEN REGISTRATION NUMBER
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	
			YES NO	

YOUR RIGHTS AND RESPONSIBILITIES

I have read or have had read to me all statements on this form. I understand the questions on this form and the information is true and complete to the best of my knowledge. I understand that the State of Delaware has a law that prohibits giving false information or withholding information to get any type of assistance, including Medicaid, or to get more assistance than I am entitled to get. I understand that if I give any false information or withhold any information, I may be prosecuted to the full extent of the law.

I agree to help establish my eligibility by giving as much information as I can about my circumstances and by giving proof of statements on my application.

I certify, under penalty of perjury, that I am a U.S. Citizen or alien in lawful immigration status. I must provide proof of lawful immigration status. Lawful alien status requires submission of certain information to the Immigration and Naturalization Service for verification. Nonlawful aliens may be eligible for emergency services only.

All information and documentation gathered for determining my Medicaid eligibility is confidential. Medicaid has safeguards and limits disclosure of information about me. Disclosure of information concerning my Medicaid eligibility to anyone not authorized to receive the information is a violation of State and Federal laws and may result in legal sanctions. While Medicaid will keep my eligibility information confidential, these provisions do not affect my right to give specific written consent to release information to other persons or sources.

YOUR RIGHTS AND RESPONSIBILITIES

I understand that I am required by law to assign to the State all rights to medical support and other third party payments (hospital and medical benefits) and to cooperate with the State in establishing paternity and securing medical support. This assignment is a condition of Medicaid eligibility. Medicaid cannot be denied to my children because of their parent's refusal to establish paternity or secure support from absent parents. I understand that pregnant women are not required to cooperate in establishing paternity and securing medical support.

I agree to allow the Department of Health and Social Services, or its representatives, to have access to all medical records that are related to payment and medical services by Medicaid. I agree to allow the Department of Health and Social Services, or its representatives, to act as my agent in recovering money spent by the Medicaid Program when other money from insurance, estates, etc., becomes available to pay my medical bills.

I understand that I may appeal to the Division of Social Services or the U.S. Department of Health and Human Services if I am not satisfied with any decision on my application or if I feel that I have been discriminated against because of race, color, national origin, religion, sex or handicap.

I understand that I may be represented by an attorney at a fair hearing, or any other person I choose. If I am not satisfied with the decision on my fair hearing, I understand that I may request a judicial review in Superior Court in the County where I live. I also understand that I must file for a judicial review within 30 days of the date of my fair hearing decision.

I certify that I have had the services of the Division of Child Support Enforcement explained to me and have been offered an opportunity to participate in their program.

I agree to enroll in a Managed Care Organization if I am required to by the Medicaid Program.

I understand that pregnant or nursing women and children age five and under may apply for WIC benefits by contacting the Division of Public Health at 1-800-222-2189.

I agree to report within ten days changes in my household situation that could affect my eligibility, such as a change in how many people live with me, a change in income, or if I move.

This application must be signed by an adult household member (age 18 or over) or by an emancipated minor (under age 18).

Sign, date and return the application as soon as possible. Include copies of all the items listed on page one that apply to your family. If you have questions, call your local Medicaid office.



IMPORTANT REMINDER

Signature of Applicant or Representative

Date

Signature of DSS Worker

Date

Georgia Department of Medical Assistance
Recipient Inquiry Unit
Post Office Box 38420
Atlanta, Georgia 30334

Medicaid Program: Patient Rights and Responsibilities

I agree to give correct information to see if I can receive Medicaid.

I agree to provide the county information to prove any statements given in this application and hereby give permission to the county to get such proof.

I understand that for Medicaid I must report any changes in my circumstance within ten (10) days of becoming aware of the change.

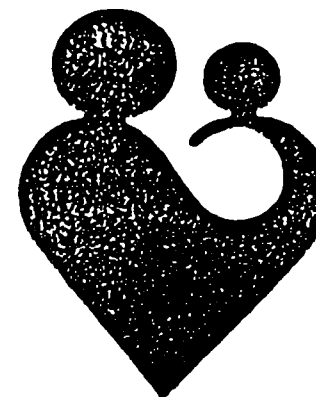
I understand that if I DO NOT like the decision made on my case, I have the right to a fair hearing. I can request a hearing by writing or calling the county where I applied.

If you want AFDC for any family member, you will have to sign a different application form. However, we will use the date on this form to determine your eligibility.

FACTS : RIGHT FROM THE START

-  SEE THE SAME DOCTOR FROM FIRST EXAMINATION TO DELIVERY.
-  APPLYING IS SIMPLE AND EASY.
-  FREE MEDICAL CARE IS AVAILABLE FOR ELIGIBLE CHILDREN BORN AFTER SEPTEMBER 30, 1983.

For more information, contact your county health department or county Department of Family and Children Services.



Right from the Start

FREE

A HEALTHY START IN LIFE FOR YOU AND YOUR BABY.

-  GET FREE PRENATAL CARE RIGHT NOW.
-  YOU CAN QUALIFY IF YOU'RE MARRIED OR SINGLE.
-  YOU DON'T HAVE TO BE PREGNANT TO RECEIVE FREE MEDICAL CARE FOR YOUR CHILD.
-  YOUR LOCAL HEALTH DEPARTMENT CAN GIVE YOU A MEDICAID CARD THE SAME DAY YOU VISIT.

To:

County Department of Family and Children Services

Address

City

State

Zip Code

Place
Stamp
Here

MEDICAID NOW HELPS ALMOST 50,000 GEORGIA WOMEN LIKE YOU.

Married or single. Insured or uninsured. You and your children can receive FREE medical help immediately. Apply today, Medicaid forms are now simple to read. The approval process is now faster. And more doctors than ever before will care for you and your children. Ask at your local health clinic how you can join the Right from the Start program. Get the right care. Get the right start. It's simple. It's easy. And it's smart.

Right from the Start has the right stuff.

When you become pregnant you create life. It's a miracle. Suddenly, a little person lives within you. To help the baby grow inside, you must care for him or her from the outside. See a doctor early and regularly. Get prenatal care. Only you can keep the baby inside happy. Eat right. Quit smoking or cut back. Don't drink alcohol, including beer or wine. Give your baby the right stuff Right from the Start.

So, if you think you're pregnant but can't afford a doctor-- we can help you. If you are pregnant but can't pay your medical bills -- we can help you. And if you have young children who have not seen a doctor regularly -- we can help you.

GET HELP NOW -- Right from the Start.

Apply for medical care inside and out.

If you are pregnant or have a child under a year old, you will qualify for Right from the Start Medicaid if your yearly income is about \$14,000 or less. If you already have two children, you can earn almost \$21,000 a year and still qualify.

Your baby can stay in the Medicaid program until his first birthday. After that, the income requirements become a little stiffer, but most children will still be covered until age 5.

Getting medical care for you and your children is easier than ever before. If you think you might qualify, just fill out this application and send it in or contact your county health department or county Department of Family and Children Services.

Application Date: _____

NAME _____
First Initial Last Maiden Name Telephone #
ADDRESS _____
Street Apt. City County State Zip Code

1. Is anyone in your house pregnant? ☐ Yes ☐ No If yes who? _____

Is she on Medicaid? ☐ Yes ☐ No

2. Whom do you want to receive Medicaid?

List all people in your home (write your name first):								
First	M.I.	Last	Social Security No.	Date of Birth	Race	Sex	Relationship	U.S. Citizen yes/no
MYSELF							Self	

3. INCOME: Do you or does anyone in your home get money from:

	Amount Before Any Deductions	How Often Received	Name of Person(s) Receiving
Current Job Yes ☐ No ☐ Employer's Name:			
Social Security Income/SSI Yes ☐ No ☐			
AFDC Yes ☐ No ☐			
Pensions or Retirement Benefits Yes ☐ No ☐			
Child Support or Contributions Yes ☐ No ☐			
Unemployment Benefits Yes ☐ No ☐			
Student Loan/Grant Yes ☐ No ☐			
Other Income Yes ☐ No ☐			

4. Do you have health insurance on anyone for whom you are qualifying? ☐ Yes ☐ No

(Provider: Complete Form 285) Health insurance company _____

Policy number _____

5. Do you have any unpaid medical bills from the past three months? Yes ☐ No ☐

Medicaid Program • I agree to give correct information to see if I can receive Medicaid. • I agree to provide the county information to prove any statements given in this application and hereby give permission to the county to get such proof. • I understand that I am breaking the law if I give wrong information. • I understand that for Medicaid, I must report any changes in my circumstance within ten (10) days of becoming aware of the change. • I understand that if I DO NOT like the decision made on my case, I have the right to a fair hearing. I can request a hearing by writing or calling the county where I applied.

I certify that the information I have provided is correct.

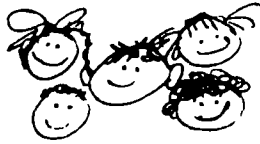
I have read (or had read to me) and understand the information on this form.

I agree to apply for a social security number if I do not have one.

Applicant's Signature _____ Date _____

Representative's Signature _____ Date _____

Title _____



South Carolina
Partners for Healthy Children

Dear Parent,

Welcome to **Partners for Healthy Children**, our new program of health coverage for children. **Partners for Healthy Children** provides free health care to children in families with low income. Health care can be expensive. I am pleased that South Carolina can offer this help to your family as you struggle to meet your child's needs.

So I want to join in a partnership with you. We will provide **Partners for Healthy Children** and, if your family qualifies, your child's health care will be free. But you need to join us as a partner, too. You are in charge of the health care your child receives. You need to fill out and mail an application for **Partners for Healthy Children**. After you get your **Partners for Healthy Children** card in the mail, you will need to make appointments with a doctor and make sure your child gets the health care he needs.

Look at the chart on the back of this letter. If your family income is no more than the amount shown for your family size, your children should qualify for **Partners for Healthy Children**. To apply, simply fill out the attached application form and mail it in.

If your income is greater than the amount on the chart, *your children may still qualify*. In that case, go to one of the locations listed on the back of this letter and ask for assistance in applying for **Partners for Healthy Children**.

I hope this will be a great year for your family and I hope **Partners for Healthy Children** will help you provide the health care for your children that you decide they need.

Sincerely,


David M. Beasley



Office of the Governor
Post Office Box 11369
Columbia, South Carolina 29211

Do Your Children Qualify for Free Health Care from Partners for Healthy Children?

Number of people in family (Count parent(s) and children)	Income levels to qualify for Partners for Healthy Children (Income slightly above may still qualify. See NOTE below.)			
	Hourly wage	Weekly income	Monthly income	Annual income
2	\$7.65	\$306	\$1,327	\$15,915
3	\$9.63	\$385	\$1,667	\$19,995
4	\$11.58	\$463	\$2,007	\$24,075
5	\$13.53	\$541	\$2,347	\$28,155
6	\$15.50	\$620	\$2,687	\$32,235
7	\$17.45	\$698	\$3,027	\$36,315
8	\$19.43	\$777	\$3,367	\$40,395

The number of people in the family includes the parents and the children. Add together all the income received by all family members and see if your income is not more than the amounts above. If so, your children should qualify. If more than 8 people live in your family, please call 1-888-549-0820 for assistance.

NOTE: If your family income is slightly more than the amounts on the chart above, you may still qualify but you will need to apply in person, at one of the following offices. Call the phone number in your county to find out where and when to go to apply. Many county DSS offices have Medicaid eligibility workers located at hospitals, health departments, or federally qualified health centers where applications can be filed also.

Abbeville County DSS 459-5481	Charleston County DSS 792-0444	Edgefield County DSS 637-4040	Lancaster County DSS 286-6914	Orangeburg County DSS 531-3101
Aiken County DSS 642-3650	Cherokee County DSS 487-2704	Fairfield County DSS 635-5502	Laurens County DSS 833-0100	Pickens County DSS 898-5810
Allendale County DSS 584-7063	Chester County DSS 377-8131	Florence County DSS 669-3354	Lee County DSS 484-5376	Richland County DSS 735-7048
Anderson County DSS 260-4100	Chesterfield County DSS 623-2150	Georgetown County DSS 546-5134	Lexington County DSS 957-7333	Saluda County DSS 445-2139
Bamberg County DSS 245-4363	Clarendon County DSS 435-4305	Greenville County DSS 467-7700	McCormick County DSS 465-2627	Spartanburg County DSS 596-3099
Barnwell County DSS 541-1210	Colleton County DSS 549-6090	Greenwood County DSS 229-5258	Marion County DSS 423-4623	Sumter County DSS 773-5531
Beaufort County DSS 525-7861	Darlington County DSS 398-4420	Hampton County DSS 943-3641	Marlboro County DSS 479-4520	Union County DSS 429-1660
Berkeley County DSS 761-8044	Dillon County DSS 774-8284	Horry County DSS 365-5565	Newberry County DSS 321-2155	Williamsburg County DSS 354-5411
Calhoun County DSS 874-3384	Dorchester County DSS 563-4337	Jasper County DSS 726-7747	Oconee County DSS 638-4400	York County DSS 684-8108
		Kershaw County DSS 432-7676		



1. Tell us who you are and where you live.

If you have Medicaid, you do not need to fill out this form.

Last name (Parent's)	First Name (Parent's)	Middle Initial	Phone	
Street Address	City	State	Zip Code	County
Mailing Address, if different	City	State	Zip Code	

2. Tell us who in your family lives with you. List the parent shown in item 1, on the first line below.

Last name <i>List parent(s) and children</i>	First Name <i>List parent(s) and children</i>	Middle Initial	Sex	Race	Date of Birth	Social Security Number	How is this person related to you?

3. Tell us how much income your family has.

Fill in the amount of money you make. If you are married and your spouse works, fill in the amount of money your spouse makes, too. Check one box to show if the amount is hourly, weekly, monthly or yearly. **Enter GROSS pay, not net home pay.** Enter zero ("0") if you or your spouse have no earned income.

Your Income	Spouse's Income
Amount you earn: \$ _____	Amount your spouse earns: \$ _____
☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly	☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly
Hours worked each week _____	Hours worked each week _____
Employer Name and Phone Number	Employer Name and Phone Number

4. Tell us if you have any other income.

List any additional income you or family members living with you may have from the sources listed below and tell us how often you get this income (for example, once each week, every three months, once a year, etc.)

Source	Amount	How Often	Who Gets this Money?
Interest from bank account	\$		
Child support	\$		
Alimony	\$		
Social Security payment	\$		
Other (Please explain)	\$		

5. Attach proof of income.

We need proof of your income. For earnings, provide copies of pay stubs for the last four weeks. If you do not have pay stubs, you may provide a letter from your employer or a copy of your most recent state or federal income tax form. Other documents can be used to provide proof of income. If you are not sure what to send, call our toll-free number 1-888-549-0820 and we will help you.

6. Tell us about any health insurance you already have.

Tell us the name of your insurance company, the policy number and the insured persons name on the policy. Even if you already have health insurance, you can still qualify for Partners for Healthy Children.

Insurance Company or Employer	Phone Number of Insurance Company or Employer	Policy Number or Group Plan Number	Insured (Name on policy)

7. Tell us whether any child received medical services in the last three months.

Did any of your children living with you receive medical services in the past 3 months:

☐ Yes ☐ No

8. Please sign this statement.

I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of South Carolina to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities that is printed below. I know that I could be penalized if I knowingly give false information. I certify that the children listed on this application are S. citizens or lawful immigrants.

Signature of applicant: _____ Date: _____

9. Mail this completed, signed form, together with proof of income, to:

South Carolina Partners for Healthy Children
Post Office Box 100101
Columbia, South Carolina 29202-3101

If you need more information, please call this toll-free number: 1-888-549-0820.

Rights and Responsibilities

Partners for Healthy Children is a program funded through a partnership with regional hospitals, state government and the federal government.

1. I know that my children under age 19 who are eligible for Partners for Healthy Children can have free health checkups under a special Partners for Healthy Children prevention program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs.

2. I know that the information I have given is confidential. I agree that medical information about my children can be released only if needed to administer this program.

3. I know that any information I have given may be reviewed and verified by State of South Carolina staff. Also I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permission is needed to get verification or other information.

4. I know that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief.

5. I know that I may ask for a hearing if I am not satisfied with any action taken by the State of South Carolina in connection with the Partners for Healthy Children program. I may also ask for a hearing if I feel that I have been discriminated against.

6. I know that the State of South Carolina will request and use information from a computer system called the State Income and Eligibility Verification System (IEVS). This computer system compares the Partners for Healthy Children information about me and other members of my family with information from other agencies. Other agencies may include the Internal Revenue Service, Social Security Administration and Employment Security Commission.

7. I know that Partners for Healthy Children does not pay medical expenses that a third party, such as a private health insurance company, is supposed to pay. If my children get Partners for Healthy Children, I give my rights to any third party payments to the Department of Health and Human Services. These payments may include payments from hospital and health insurance policies. I know that if I refuse to give my rights to third party payments to the Department of Health and Human Services, my children will not be eligible to receive a Partners for Healthy Children card.

(Attachment B)

MODEL JOINT APPLICATION FOR CHIP/MEDICAID FOR CHILDREN

Purpose: The attached model joint application can be used for both the Children's Health Insurance Program (CHIP) and children's Medicaid eligibility (under the children's poverty level related groups). States could allow individuals to use this form to apply for both programs and the information on this form would be sufficient for determining which program a child is eligible for. It includes only that information which is required in all circumstances and is provided as a base form which a State can adapt to meet its own needs. As presented, the form is suitable for completion by an intake worker. Modifications would be required to make the form suitable for direct completion by the applicant.

Screening: This application will meet the statutory requirement in Title XXI that States identify children who are eligible for Medicaid.

NOTE: In situations where the State has contracted out the CHIP program eligibility (i.e., determinations will be made by non-State employees), this form can be modified to be used as a pure screening form (or a combination of an application for CHIP and screening form) by removing all references to Medicaid. The statement about the use of the Social Security number [33] would be required. Inclusion of the rights and responsibilities section (without reference to Medicaid), however, would be at State option. Non-State employees cannot make a determination of Medicaid eligibility. If the form is so modified, in order to permit the information on the form to be submitted for use in making a Medicaid determination, the non-State employees could have a separate page for those whom the screen indicates are Medicaid-eligible. On that page, the individual should consent to submission of the information as part of a Medicaid application, and accept the rights and responsibilities outlined on this draft (including a statement under penalty of perjury that the information provided on the "attached screening form" or "attached CHIP application" is correct). After this page is completed, the form could be forwarded to the State for a Medicaid eligibility determination.

Mandatory Information About Medicaid: If a State uses a joint CHIP/Medicaid application and denies the Medicaid application, then the State must thoroughly inform the individual about the availability of Medicaid and his or her right to apply for Medicaid on a basis other than as a poverty-level child. This includes an explanation of the Medicaid program and the various eligibility groups, the advantages of Medicaid over CHIP and information about how and where to apply for Medicaid.

Federal Verification Requirements: Under Federal law, there are no verification requirements pertaining to eligibility for the children's poverty-level-related groups under Medicaid other than those related to alien status of non-citizens, and the posteligibility requirements of §1137 pertaining to use of the individual's social security number and an income and eligibility verification system. Eligibility of a citizen child may be established on the basis of a declaration under penalty of perjury. States are permitted to require further verification as a condition of eligibility.

Additional Simplification of Medicaid Eligibility Determination: If the total gross income of the family is at or below the applicable Medicaid income standard, the questions in the shaded areas need not be answered. The individual is obviously income eligible for Medicaid without further information.

Explanation of Certain Fields: There are some questions on the application that may not elicit all the information needed to make a determination. Under certain circumstances, additional information will be required. For example:

- If the answer to the question about citizenship [18] is no, actual status will need to be determined, official documents submitted, etc.
- If the child has insurance [22] and is Medicaid-eligible, information about the insurance company and policy number will be needed; and
- If the child had medical bills in the last 3 months [32] and is Medicaid-eligible, eligibility information for the last three months will be needed to establish retroactive eligibility, in addition to information about the bills.

In addition, the question concerning employment by a public agency in the State [25] is only needed for CHIP eligibility and is not needed for Medicaid. This field does not ask directly about the availability and nature of health insurance on the assumption that the eligibility worker would have access to a list of public agencies which offer State health insurance of the type which precludes CHIP eligibility. If this is not the case in your State, this field would need to be expanded.

Examples of State Modifications:

- A State may wish to include voter registration; or
- A State may want to use this as an application for Medicaid for the adults which would require additional information about the adults and stock affidavits concerning assignment of rights and pursuit of support.
- A State will need to add a question concerning each individual's resources (assets) if:
 - the State applies a resource test for the poverty level children; or
 - the State has not chosen to cover children born before 10/1/83 under the poverty level group AND the State applies a resource test for the optional group of categorically needy children ("Ribicoff children").

CHILDREN'S HEALTH INSURANCE PROGRAM / MEDICAID JOINT APPLICATION FORM

I. Person Applying for the Child or Children					
Name [1] FIRST MIDDLE LAST			Home Phone [2]		Work Phone [3]
Home Address [4] Street		Apt. # [5]	City [6]	State [7]	Zip [8] County [9]
Mailing Address (if different from above) [10] Street		Apt. # [11]	City [12]	State [13]	Zip [14] County [15]

II. Family Members Living in the Home (Attach extra sheet if needed)						
Children (under 19) living in the home NAMES [16]	Date of Birth [17]	Citizen (Yes or No) [18]	Social Security Number [19]	Mother's Name [20]	Father's Name [21]	Covered by Health Insurance other than Medicaid [22]
Adults living in the home NAMES [23]	Social Security Number [24]		If employed by a public agency in the State, what agency? [25]			

III. Income and Child Care Payments**List all the Income Received by Family Members Listed Above** (Attach Extra Sheet if Needed)

Name of person(s) working or receiving money* [26]	Who provides the money? [27] Employer, program or person	How Often? [28] Weekly, twice a month, monthly	What amount? [29] Before taxes or any deductions
1.			
2.			
3.			

*Be sure to include all sources of gross income (before taxes) such as wages, dividends & interest, TANF, SSI annuities, pension, disability, child support, alimony, cash gifts, & other unearned income.

List the payments made for child care (or care for an adult who cannot care for himself) so that someone in your household can work. [30]

Name of person(s) who works	Name of Person Care For	Under Age 2? Yes ☐ No ☐	How Often?	What amount?

IV. Medicaid Questions**Is any child:** [31] Pregnant: Yes ☐ No ☐In an Institution: Yes ☐ No ☐**Do any of the children have unpaid medical bills from the last 3 months?**
[32] Yes ☐ No ☐**Social Security Number (SSN)** [33]

You must give us your SSN in order to receive Medicaid. This is required by section 1137(a)(1) of the Social Security Act and the Medicaid regulations of 42 CFR 435.910. The Medicaid agency will use the SSN to verify your income, eligibility, and the amount of medical assistance payments we will make on your behalf. It is possible that we will also use the SSN to determine another person's right to Medicaid or to comply with Federal law requiring that we release information from Medicaid records. The information may be matched with the records in other agencies, such as the Social Security Administration or the Internal Revenue Service. These matches may be done by computer or on an individual basis.

Rights and Responsibilities [34]

I agree to the release of personal and financial information from this application form and supporting documents to the agencies that run these programs so that they can evaluate it and verify eligibility. I understand that the agencies that run the programs will determine confidentiality of this information according to the federal laws, 42CFR 431.300-431.307.1, and any applicable federal and state laws and regulations.

Officials from the programs that I, or members of my household, have applied for may verify all information on this form.

I understand that I must immediately tell the Medicaid agency about any changes in information on this form.

I understand that I may be asked to provide additional information.

I understand my eligibility will not be affected by my race, color, national origin, age, disability, or sex, except where this is restricted by law.

I understand that this application is an application for one kind of children's health benefits under Medicaid and is not a full Medicaid application. I understand that if I am not found eligible for this kind of children's health benefits under Medicaid, I may be eligible for Medicaid benefits on some other basis and have a right to complete a full Medicaid application.

I have the right to appeal any decisions made by a local Medicaid program. Information on the appeals process can be obtained from the local Medicaid agency.

I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth is committing a crime which can be punished under federal law, state law, or both. I understand that I may also be liable for repaying in cash the value of the benefits received and may be subject to civil penalties.

I certify under penalty of perjury that everything on this application form is the truth as best I know.

Signature [35]**Date****Date Received by Agency** [36]

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(Attachment C)

DISCUSSION OF PROMISING OUTREACH STRATEGIES

Significant barriers exist to providing health care coverage for uninsured children and enrolling them in Medicaid. States and local communities are implementing a variety of approaches to reducing these barriers. Many States are simplifying the complicated application forms and enrollment processes, as well as allocating more resources to developing innovative outreach activities. The Department of Health and Human Services (DHHS) is prepared to assist States and local communities by facilitating the exchange of information regarding successful outreach endeavors and information related to enrollment simplification. The following are examples of promising outreach strategies currently practiced or being considered in various places.

- Implement an 800 hotline number for enrollment information in each State, to provide information (in appropriate languages) on child health insurance programs, referrals, and telephone assistance in completing application forms. To the extent possible, publicize a single number; several 800 numbers may lead to confusion. Most States already have an effective toll-free hotline through their Title V Maternal and Child Health offices that could be serve as a base for disseminating information relating to Medicaid and CHIP.
- Streamline the eligibility process, have simplified application forms in appropriate languages, and allow application by mail. Ask only for necessary information. Allow for enrollment on certain evenings and Saturdays at convenient sites. Allow appropriate entities, especially in remote areas, to determine eligibility presumptively.
- Use billboards in bus and subway stations and radio stations to publicize the programs, including information that uninsured children of low-income working parents may also qualify for Medicaid or CHIP. Place posters (that have been field-tested in that community) at locations frequented by target families -- e.g., thrift shops, discount stores, fast-food restaurants, laundromats, and ethnic festivals.
- Encourage prenatal care and child health through unified State-wide public service outreach campaigns which are advertised with an identifiable logo and reader-friendly materials that appeal to lower-income families.
- Distribute information about child health insurance programs through child care centers, Head Start programs, schools, child support enforcement agencies, community action programs, refugee resettlement programs, TANF offices, family preservation and support programs, Special Education and Social Security offices -- with materials in simple, appropriate languages. Also, verbally ask the children in the above settings (as they take the literature home) to tell their families that they may be eligible for health care.
- Provide enrollment opportunities at local sites where children receive health care; school-based health centers are a particularly good vehicle for identifying and enrolling children in insurance programs.

- Station eligibility workers in hospitals to assure prompt enrollment of newborns, in health centers, and at locations where immunizations are provided.
- Coordinate with other programs, such as TANF, child support enforcement agencies, family support councils, local Tribes, WIC, food stamps, Title V, free or reduced-price lunch programs, Head Start, Special Education and Social Security offices.
- Establish a State-wide computer program, wherein applications for any one public assistance program will (with the client's permission) be automatically "cross-referred".
- Develop outreach strategies with local community-based organizations, and have them assist in outreach efforts, including at events such as community fairs. Word-of-mouth can be the best outreach tool in communities where there is mistrust of the system. Provide speakers and program information to community, school and religious programs.
- Use trained, trusted persons within the local community to do eligibility outreach and to provide assistance to their neighbors in completing application forms.
- De-stigmatize Medicaid to the extent possible. Some States have addressed this issue by renaming the program with names such as "Dr. Dynasaur", or "KIDMED" or "Child Health Plus." Encourage eligibility workers to treat clients with courtesy and respect. Ensure that the card issued to the family is free of any perceived "welfare stigma." Have posters reflect a positive image of Medicaid and those who use Medicaid.
- Enlist the support of businesses and foundations to provide incentives (e.g., gift certificates, coupons for free meals or merchandise, movie passes) for families who apply for and/or use services.