ALABAMA TITLE XXI STATE PLAN AMENDMENT

Background

- Alabama submitted a State Plan Amendment (SPA) on May 20, 1998, for Phase II of its Children's Health Insurance Program (CHIP), which will be implemented on September 1, 1998. Alabama's original Title XXI plan was approved on January 30, 1998.

- Implementation of Phase I CHIP began on February 1, 1998, with a Medicaid expansion of coverage for targeted low-income children under age 19, whose family income is below 100 percent of the Federal Poverty Level (FPL). The State is currently averaging approximately 400 to 500 new enrollees per week, and anticipates enrolling up to 17,000 children in Phase I by the end of fiscal year 1999.

- This amendment would implement Phase II of Alabama's CHIP plan, which creates a separate State health insurance program for children under age 19 in families with incomes up to 200 percent of the FPL and who are not eligible for Medicaid. This program will be known as AL-Kids and is projecting an enrollment of 19,000 children in the first year.

Administration

- The Alabama Department of Public Health will have overall administrative responsibility for the AL-Kids Program.

- The Department of Public Health will contract with the State Employees Insurance Board (SEIB) and other independent contractors to perform all eligibility determinations, enrollment functions, and premium collections.

Health Care Delivery System

- Services will be provided through indemnity and/or managed care plans. The State will be awarding up to two contracts per region.

- An enrollee will be "locked in" to the plan in which they enroll for a year, unless the child's parent or guardian moves from one provider region to another.

Benefit Package

- The benefit package offered is that of the HMO with the largest insured commercial, non-Medicaid enrollment in the State.

- Coverage of enrollees will be continuous for one year, unless the child moves out of state, becomes covered by other health insurance, becomes eligible for Medicaid or State employees' insurance, becomes institutionalized, or reaches 19 years of age.

Cost Sharing

- There is no cost sharing for families with incomes at or below 150 percent of the FPL.

- Families with incomes above 150 percent of the FPL will have an annual premium of $50 per child or $60 per child if paid in 10 monthly installments of $6. A family's total premium payment will not exceed three times the selected payment method per year, i.e., $150 if premiums are paid annually or $180 if premiums are paid through the installment plan.

- Families with incomes above 150 percent of the FPL will not have copayments for preventative services, well baby care or immunizations, but will have the following copayments: $5 for inpatient hospital confinement, physician office visits, emergency room visits where the patient is not admitted, urgent care services, each confinement for inpatient chemical dependency, and dental services; $3 for brand name prescription drugs; and $1 for generic prescription drugs.

- There will be a $500 annual limit on copayments, which is well below the statutory limit of 5 percent of a family's annual income.

State Action to Avoid Crowd-Out and Outreach Activities

- A common application form will be used for both the Title XIX and the Title XXI program. If a child is found eligible for Medicaid, that child will be enrolled in the State's Medicaid program.

- Alabama has a 3-month waiting period for enrollment in Al-Kids for families that currently have or have voluntarily dropped their health insurance coverage. Declaration of the lack of coverage within the past three months on the application form will be verified, if possible, with data from the Alabama Health Care Information Network.

- The Alabama Health Care Information Network will operate a master patient index of current private health care coverage of Alabama citizens starting in the fall of 1998. Blue Cross/Blue Shield, which covers 85 percent of the State's insured population, will be included in this data base. Additional insurance vendors throughout the State will be included in the network by April 1999.

- Outreach will be conducted through Statewide efforts and local partnerships. These efforts will consist of a Statewide media campaign, outreach conducted by trained workers, and outreach conducted through existing programs and agencies.

Financial Information

1998 CHIP Allotment -- $85,997,312

Enhanced Federal Matching Rate -- 78.52%

ALABAMA TITLE XIX STATE PLAN AMENDMENT AND TITLE XXI STATE PLAN

Background

- On November 3, 1997, Alabama submitted a Title XIX State Plan Amendment and Title XXI State Plan for providing expanded benefits under the Alabama Medicaid Agency's Title XIX Plan. The Alabama Medicaid Agency is proposing amending its State Plan for Medicaid Assistance by adding page 23b to attachment 2.2-A. The agency proposes expanding Medicaid eligibility to children under age 19, who were born on or before September 30, 1983, with family income levels at or below 100 percent of the Federal Poverty Level (FPL). Eligible children will receive the full Medicaid benefit package. All Medicaid program policies will apply.

- Alabama expects to initiate expanded eligibility on February 1, 1998, which is the day the 90 day clock expires.

Administration and Phases

- This expanded coverage for children will be administered by the Alabama Medicaid Agency, Family Certification Division.

- This State Plan Amendment represents the first of a two-phase approach to expanding Medicaid eligibility. Phase I is defined as expanding Medicaid Program eligibility to uninsured children who are less than 19 years of age, born on or before September 30, 1983, with family incomes equal to or less than 100 percent of the FPL. Phase I is projected for implementation as of February 1, 1998. As of February 1, the capacity of the Alabama Medicaid Agency's data systems, personnel, staff training, and publications/documents will be expanded to meet the target of enrolling approximately 20,000 children in the first year.

- By February 2, 1998, a plan to implement the second phase by expanding health care coverage to children between 100 and 200 percent of the FPL will be submitted to HCFA. Implementation in at least one-third of the counties in the State by August 1, 1998 is anticipated.

Health Care Delivery System

- In 26 counties of the State, Medicaid operates a primary care case management program through a 1915(b) waiver. This program, called Patient 1st, is expected to cover every county in the State within the next year, with the exception of Mobile. Patient 1st links each Medicaid beneficiary with a primary care physician who manages the patient's care.

- In Mobile County, the State has an 1115 Waiver which provides health care coverage through a managed care program, known as BAY Health Plan.

- Title XXI eligible children will be primarily included in these managed care networks. The Alabama Medicaid Agency will be providing documentation to HCFA within the near future assuring the adequacy of the networks through each waiver and the methodology for their inclusion.

Benefit Package

- The Medicaid benefit package will be provided.

Cost Sharing

- Medicaid rules will apply.

State Action to Avoid Crowd-Out and Outreach Activities

- There will be no separate enrollment in the Children's Health Insurance Program (CHIP) apart from enrollment in the Medicaid Program. The eligibility process is designed to incorporate investigation of creditable health coverage using data matches and client interviews to insure that only eligible, targeted low-income children are covered.

- An additional 23 Medicaid eligibility workers will be hired, supplementing the State's current 100 positions, in order to enroll the additional children under the State's expanded eligibility. These workers will be located organizationally within the State Medicaid Bureau. All 123 workers will enroll children who are eligible for Medicaid under current eligibility rules as well as those eligible for Medicaid under Phase I of CHIP. Workers will be stationed in health departments, hospitals, primary care centers, and various locations throughout the state to facilitate enrollment in the Medicaid Program.

- In addition to current outreach avenues used by the Medicaid Program, information regarding the expanded eligibility will be advertised through newspaper and newsletter articles, a news conference, public service announcements, and publicity through the public school system.

Potential Issues

- The adequacy of the managed care networks in absorbing the additional children eligible through the expanded eligibility as well as the length of time it may take the State in providing Patient 1st Statewide, since this will affect the accessibility and availability of services.

ARKANSAS TITLE XXI PROGRAM
FACT SHEET

Date Plan Submitted: May 6, 1998

Date Plan Approved: August 6, 1998

Effective Date: July 1, 1998

Background

- On May 6, 1998, Arkansas submitted a Title XXI plan to expand Medicaid eligibility to children born after September 30, 1982, and prior to October 1, 1983, whose family income is at or below 100 percent of the Federal Poverty Level (FPL). This is the first phase of the State's CHIP initiative.

- All program policies of the State's traditional Medicaid program, which operates under a Section 1915(b) waiver, will apply.

- Arkansas also has a separate Section 1115 demonstration entitled ARKids First. This program covers uninsured children through age 18 in families with incomes up to 200 percent of the FPL, who do not qualify for the Section 1915(b) program. ARKids First has a slightly modified benefits package and includes copayments.

Children Covered Under Program

- The State expects to cover an additional 3,572 children under its Title XXI program when it is fully phased in, which is projected to occur one year following implementation.

Administration

- This program will be administered as a Medicaid expansion.

- Arkansas is currently considering how to structure the second phase of its Title XXI initiative, to cover the remainder of the population eligible under Title XXI.

Health Care Delivery System

- The delivery system will be the primary care case management system (ConnectCare) that operates on a fee-for-service basis in both the Medicaid and ARKids First programs.

Benefit Package

- Children eligible for this phase of the Title XXI program will receive the full Medicaid benefit package.

Cost Sharing

- There is no cost sharing in this CHIP program.

Outreach Activities

- The State has a contract with Arkansas Advocates for Children and Families, the State's leading child advocacy agency, to provide a targeted outreach campaign to reach working families with children. Arkansas Advocates for Children and Families will not work directly with applicants, but will focus on providing information, training, and State-prepared materials to grassroots organizations that are in daily contact with the targeted population.

- The State also has a contract with the Arkansas Department of Health to provide information to applicants and recipients through a media campaign and a 24-hour toll-free telephone Help Line Service. The Help Line Service responds to questions received from Medicaid applicants, recipients, and providers by telephone concerning eligibility, access, enrollment, rights and responsibilities and other issues. The media campaign will publicize the existence of the telephone Help Line and will promote appropriate use of the medical care system. The media campaign may include television and radio advertising, direct mail, print media, telemarketing, and other viable methods.

Financial Information

Total Title XXI Reserved Allotment (FFY 1998) -- $46,878,527
Enhanced Federal Matching Rate -- 80.99%
First Year Costs (FFY 1998):
State Share -- $51,534
Federal Share -- $219,553
Total -- $271,087

ARIZONA TITLE XXI PROGRAM
FACT SHEET

Name of Plan:	KidsCare
Date Plan Submitted:	June 23, 1998
Date Plan Approved:	September 18, 1998
Effective Date:	October 1, 1997

Background

- On June 23, 1998, Arizona submitted a Title XXI plan to extend health coverage to children in families with gross incomes up to 150 percent of the Federal Poverty Level (FPL) in the State's Fiscal Year from July 1998 through June 1999. As part of this plan, the income limit will automatically increase to 175 percent of the FPL on July 1, 1999, then to 200 percent of FPL on July 1, 2000. KidsCare will operate as a separate state health insurance program.

- Under the State's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), children in families with the following income limits would be covered: up to 140 percent FPL for children under age 1, up to 133 percent FPL for children ages 1 to 6, and up to 100 percent FPL for children age 6 or over born after September 30, 1983.

Children Covered Under Program

- The State expects to cover 28,800 children by the end of September 1999 and 49,900 by the end of September 2000. By the end of September, 2001, when the program is fully phased in, 63,100 children are expected to be covered.

Administration

- This program will be administered by the State Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS).

- The State is planning to submit an amendment for a sliding fee scale premium for families with income above 150% of the FPL with the target effective date of July 1, 1999.

Health Care Delivery System

- Arizona will provide KidsCare services through established AHCCCS health plans and State employee Health Maintenance Organizations (HMOs) that elect to participate in the program. American Indians may choose to receive services through the Indian Health Service (IHS), 638 tribal facilities, one of the AHCCCS plans, or one of the participating State employee HMOs. Under this plan, beginning October 1, 1999, the State will use a portion of the 10 percent Title XXI administrative funds for direct services provided by participating community health care clinics and hospitals that serve predominantly low income children.

Benefit Package

- The benefit package will be the same service package offered to State employees by the least expensive commercial HMO (Intergroup), enhanced to include dental and vision benefits. If a KidsCare eligible chooses to receive services through a direct service provider, AHCCCS will provide any KidsCare services not provided by these entities on a fee-for-service basis. If a Native American selects the IHS or a tribal facility, AHCCCS will provide any KidsCare services not provided by these entities on a fee-for-service basis off-reservation.

Cost Sharing

- A $5 copayment on the non-emergency use of the emergency room will be assessed for all members. This copayment can be waived if the member cannot afford to pay.

- Health plans will include information in the Member Handbook about the maximum amount that a family must pay for copayments and the fact that they do not have to continue to pay once the cap on a family's out-of-pocket costs is reached. AHCCCS will also flag the member's records so a hospital emergency room can verify that a copayment should not be collected. If for some reason the cap is exceeded, AHCCCS will reimburse the family for the exceeded amount.

Crowd-Out Strategy

- Children must be without group health insurance for six months in order to be eligible for KidsCare. Eligibility workers will obtain a declaration as to whether the family member or employer has voluntarily discontinued employer-sponsored dependent insurance coverage in order to allow a child to participate in KidsCare. (Exceptions to the six-month period of uninsurance will be granted for newborans and if coverage was lost due to involuntary loss of employment.) In addition, AHCCCS will select a monthly sample of approved KidsCare cases (approximately 350 every 6 months) and interview the employer. If problems are discovered in 10 percent or more of the cases, corrective action will be taken.

Coordination Between CHIP and Medicaid

- The State intends to enroll KidsCare applicants who appear to be Medicaid eligible into KidsCare pending verification of Medicaid eligibility. If a child who has been approved for KidsCare is subsequently determined to be eligible for Medicaid, he or she will be sent a notice stating that the KidsCare eligibility is terminated and Medicaid eligibility is approved. The child will be made Medicaid eligible back to the first day of the month in which the child applied. The member will receive a Medicaid card, including a card carrier listing covered services, and a member handbook listing all services.

- If a child was approved for KidsCare pending a Medicaid eligibility determination and the child is determined Medicaid eligible, the Medicaid eligibility will override the KidsCare eligibility in the automated system and KidsCare capitation paid will be claimed at the Medicaid matching rate rather than the KidsCare matching rate.

- If the Medicaid eligible child is enrolled in an AHCCCS health plan under KidsCare, the child will remain in the health plan following the transfer to Medicaid. If the child is enrolled with a direct services provider under KidsCare, the child will be auto-assigned to

an AHCCCS health plan if a pre-enrollment health plan choice was not made following the application for Medicaid. If the family did not have an opportunity to make a pre-enrollment choice, a choice notice will be sent to the family following the auto-assignment to a health plan.

Outreach Activities

- The Governor's Outreach Work Group met several times to develop a comprehensive outreach plan. AHCCCS has established an Outreach Coordinator position to ensure that coordinated outreach efforts will include Medicaid, state-only funded programs, and the KidsCare program. Both the Governor's Office and AHCCCS are working with tribal entities to inform Native American families about KidsCare.

- Outreach efforts and the distribution of applications will be targeted to those agencies, organizations and other entities that currently serve targeted low income children. Organizations distributing the applications and information about KidsCare will be offered training to assist with completing the application form and collecting information. An applicant will also receive assistance to complete the application form by calling the AHCCCS 24-hour toll-free number.

Financial Information

Total Title XXI Reserved Allotment (FFY 1998) -- $113,138,521
Enhanced Federal Matching Rate -- 75.73%

First Year Costs (FFY 1999):
State Share -- $10,101,000
Federal Share -- $31,725,100
Total -- $41,826,100

Second Year Costs (FFY 2000):
State Share -- $17,003,000
Federal Share -- $53,402,800
Total -- $70,405,800

Third Year Costs (FFY 2001):
State Share -- $21,337,000
Federal Share -- $67,015,100
Total -- $88,352,100

CALIFORNIA TITLE XX1 STATE PLAN SUMMARY

Background

- On November 19, California submitted a Title XXI State Plan to expand insurance coverage to children within the State. The State will expand coverage through three programs:

  1) Expansion of their Title XIX program, known as Medi-Cal, by implementing a resource disregard and by making children under age 19, who were born before September 30, 1983, eligible if they are at 100 percent or less of the Federal Poverty Level (FPL).

  2) Expansion of their State program, known as the Access for Infants and Mothers (AIM), which would cover infants up to age 1 from 200% to 250% of FPL.

  3) A State program , known as Healthy Families, which will provide coverage of children from ages 1 through 19 with family incomes from 100 up to 200 percent of FPL.

- The State implemented the Medicaid expansion March 1, 1998, and plans to implement the insurance program by July 1, 1998.

Administration

- California will use the Managed Risk Medical Insurance Board (MRMIB) as the oversight agency for the Healthy Families Program . Administrative duties for this program will be contracted through a private vendor. The MRMIB currently administers three health insurance programs in the State, among them the AIM program. The other two programs it administers are the Major Risk Medical Insurance Program, a program for medically uninsurable people, and the Health Insurance Plan of California, a small employer purchasing pool.

- The Department of Health Services will be responsible for implementing the outreach and the Medicaid changes proposed in the Title XXI State Plan.

Health Care Delivery System

- Delivery of health services to Healthy Families members will be through managed care organizations. Most of the participating plans will be HMOs, but it is possible that one or more preferred provider organizations (PPOs) will also participate. The delivery system for the AIM program is virtually identical to that of Healthy Families, with nine health care service plans participating, providing statewide coverage.

- To assure that health care providers currently serving low-income families are given the

opportunity to participate in the program, MRMIB will encourage private managed care plans to subcontract with safety net providers by allow ing the health plan in each county that has the highest percentage of traditional and safety net providers in its provider network to charge a discounted premium; by allowing County Organized Health Systems and local initiatives to participate; and by giving priority in awarding contracts to plans with significant numbers of providers who serve uninsured children.

- The delivery system for targeted low-income children served by Medi-Cal will be consistent with the existing Title XIX State Plan.

Benefit Package

- Health Families and AIM members will receive similar benefits to those provided to California's state employees under the California Public Employees Retirement System (CalPERS). The State will also provide enhanced services beyond the CalPERS package, including comprehensive dental and vision coverage, screening and initial treatment services though the Child Health and Disability Prevention (CHDP) program, and treatment for severely ill children in a non-managed care delivery system.

- Coverage for the Medi-Cal expansion is the Title XIX benefit package.

Cost Sharing

- In the Healthy Families Program, premiums will be charged within the Title XXI limits. Families who prepay three months of premiums will not have to pay for the fourth month.

- In the Healthy Families Program, no copayments will be charged for prenatal, well baby, well child, or immunization services. The copayment for all other services is $ 5. The amount of copayments a family will pay in a given year for health services is limited to $250.

- Enrollees in the AIM program will pay premiums equal to 2% of the family's annual income. No copayments are charged for AIM services.

State Action to Avoid Crowd-out and Outreach Activities

- Children are ineligible for Healthy Families if they have been covered under employer-sponsored coverage within the prior three months, or if they are eligible for Medi-Cal or Medicare coverage. To participate in AIM, infants must not have employer-sponsored coverage or no-cost Medi-Cal at the time of application.

- California has planned a multifaceted approach to outreach. DHS will administer a $20 million media and outreach initiative. It will subcontract for a media campaign with a private entity and with community based organizations, health brokers and insurance agents to directly identify and assist potential enrollees in filling out the joint application

form for the Medi-Cal and the Healthy Families programs. A $ 25 application assistance fee will be paid to these organizations for each beneficiary that is enrolled in one of these programs. Additionally, California will conduct a provider education campaign in support of its outreach campaign.

Additional Information

- For Federal Fiscal Year (FFY) 1998, the State is proposing to spend $ 35,661,234, with $ 26,850,179 in benefits. The Federal enhanced matching rate is 66.03 percent. Approximately 34,000 children are anticipated for enrollment in the expanded Medi-Cal program in FFY 1998. The anticipated enrollment in Healthy Families in FFY 1998 is approximately 60,000 children.

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CALIFORNIA TITLE XX1 STATE PLAN SUMMARY

Background

- On November 19,.California submitted a Title XXI State Plan to expand insurance coverage to children within the State. The State will combine a Medicaid expansion with an insurance purchasing pool and an insurance purchasing credit, and also seeks Title XXI match for a State program known as the Access for Infants and Mothers (AIM) program. The State would cover children from age 1 to 19 with family incomes up to 200% of the federal poverty level (FPL) through the insurance program, and infants up to age 1 from 200% to 250% of FPL through the AIM program. In addition, children ages 14 to 19 with family incomes 85% to 100% of FPL would become eligible for the State's Medi-Cal program through a Medicaid expansion.

- The State intends to implement the Medicaid expansion by March 1, 1998, and the insurance program by July 1, 1998.

Administration

- California plans to use the Managed Risk Medical Insurance Board (MRMIB) as the mechanism for providing coverage to Healthy Families members. The MRMIB currently administers three health insurance programs in the State: The Major Risk Medical Insurance Program, a program for medically uninsurable people; the Health Insurance Plan of California, a small employer purchasing pool; and the Access for Infants and Mothers Program, a program for uninsured pregnant women and their newborns.

- For the majority of eligible families, MRMIB will offer access to health plans through a subsidized purchasing pool. MRMIB will use two mechanisms to provide managed care to low-income children: A health insurance purchasing pool and an insurance purchasing credit for children whose families have access to (but do not have) employer-sponsored coverage.

Health Care Delivery System

- Delivery of health services to Healthy Families members will be through managed care organizations. Most of the participating plans will be HMOs, but it is possible that one or more preferred provider organizations (PPOs) will also participate.

- To assure that health care providers currently serving low-income families are given the opportunity to participate in the program, MRMIB will encourage private managed care plans to subcontract with safety net providers, will allow the health plan in each county that has the highest percentage of traditional and safety net providers in its provider network to charge a discounted premium, will allow County Organized Health Systems and local initiatives to participate, and will give priority in awarding contracts to plans with significant numbers of providers who serve uninsured children.

Benefit Package

- In the insurance program, Health Families members will receive coverage like that provided to California's state employees under the California Public Employees Retirement System (CalPERS). The State will also provide enhanced services beyond the CalPERS package, including comprehensive dental and vision coverage, screening and initial treatment services though the Child Health and Disability Prevention (CHDP) program, and treatment for severely ill children in a non-managed care delivery system.

Cost Sharing

- In the insurance program, families with one child with incomes from 100% to 150% of FPL will pay premiums of $4 to $7 per month (depending on the plan), and families in that income range with two or more children will pay $8 to $14 per month. In the 150% to 200% of FPL range, families with one child will pay $6 to $9, families with two children will pay $12 to $18, and families with three or more children will pay $18 to $27. Families who prepay three months of premiums will not have to pay for the fourth month. Families will also have access to plans with higher premiums, but will be expected to pay the premium differential.

- In the purchasing credit program to help families buy into employer-sponsored insurance, the amounts charged for coverage will be no greater than the amounts charged under the high end of the purchasing pool coverage.

- Enrollees in the AIM program will pay premiums equal to 2% of the family's annual income for coverage of the pregnant woman and infant through age one.

- MRMIB will establish copayment levels in amounts that reflect the copayment levels for the CalPERS plan. However, no copayments will be charged for prenatal, well baby, well child, or immunization services. The amount of copayments a family will pay in a given year is limited to $250. The copayment for most services (office visits, prescriptions) is $5.

State Action to Avoid Crowd-out and Outreach Activities

- Children are ineligible for the insurance program if they have been covered under employer-sponsored coverage within the prior three months, or if they are eligible for Medi-Cal (at no cost) or Medicare coverage. To participate in AIM, infants must not have employer-sponsored coverage or no-cost Medi-Cal at the time of application.

Potential Issues

- The proposal includes administrative costs of 25.6%, well above the Title XXI limit of 10%. In addition, the State categorizes enrollment contractor and application assistance fees as benefits costs.

- The $5 copayment proposed for most services is above the "nominal" Medicaid level of $3. The State projects that adjusting the $3 level for inflation, using the California Consumer Price Index, would allow for a copayment level of $7.

- The State plans to simplify Medicaid eligibility (to parallel Title XXI) by removing resource requirements. The State requests enhanced Title XXI matching for the additional Title XIX costs.

- The program has a coverage "firewall" -- a prohibition against covering children who has employer-sponsored coverage within three months prior to applying for the program.

- Under the insurance purchasing credit option, the State requests the employer-sponsored coverage to be 95 percent actuarially equivalent to coverage under the purchasing pool. MRMIB is authorized to purchase supplemental coverage for services excluded from the employer's plan.

COLORADO TITLE XX1 STATE PLAN SUMMARY

Background

- On October 14, Colorado submitted a Title XXI State Plan to expand children's access to health coverage by implementing state legislation and building on the experience and infrastructure of the Colorado Child Health Plan, an existing program providing basic medical services to low-income children. The Colorado Child Health Plan will adopt an expanded benefits package and additional features which will bring it into compliance with Title XXI. This Title XXI program will be called the Child Health Plan Plus (CHP+). Coverage will be provided to children ages 0 through 17 with family income at or below 185 percent of the Federal Poverty Level (FPL).

Administration and Phases

- The Colorado Department of Health Care Policy and Financing will administer CHP+ with subcontracts to the Colorado Child Health Plan and the Colorado Foundation for Families and Children.

- This State Plan represents the first of a two-phase approach to implementing the CHP+. The first phase, called CHP+, entails expanding the current Colorado Child Health Plan from outpatient benefits to a comprehensive benefit package delivered through HMOs. The Colorado Child Health Plan provider network will serve children who live in areas of the State without HMO coverage. During the first phase, eligibility and enrollment systems and information management infrastructure will be built, marketing and outreach campaigns will be implemented, and identification of additional moneys for the State match will be attempted to plan for the implementation of phase two.

- The State anticipates coverage of 23,000 new children by the year 2000.

Health Care Delivery System

- Delivery of health services to CHP+ members will be primarily through HMOs. The existing Colorado Child Health Plan currently maintains its own statewide provider network. This network will be expanded to care for children who are eligible for CHP+ but who have not yet been enrolled in an HMO, or those children who live in areas where no HMO service is available. CHP+ will offer 12-months guaranteed eligibility

Benefit Package

- Colorado is using a benchmark-equivalent package. The actuarial value of the proposed benefit package exceeds the actuarial value of all three benchmark benefit packages.

- The HMO benefit package will include hospital and emergency room transport; inpatient services; outpatient/ ambulatory surgery; medical office visits (including physician,

mid-level practitioner, and specialist visits; laboratory and x-ray services; preventative care; maternity care (prenatal, delivery, and inpatient well baby care); neurobiologically-based mental illnesses; mental health care (institutional and outpatient care); alcohol and substance abuse; physical, occupational, and speech therapy; durable medical equipment; organ transplants, home health care; hospice care; outpatient prescription drugs; skilled nursing facility care; vision services; audiological services, intractable pain; autism coverage; and nutrition services.

- The Child Health Plus provider network will provide a similar benefit package but will not include organ transplants; hospice care; autism coverage; and skilled nursing facility care.

Cost Sharing

- Premiums for families through 100 percent FPL will be waived. For families between 101 percent and 150 percent with one child, premiums will be $9/child/month, and for families with two or more children, $15/family/month. Between 150 percent and 169 percent FPL, families with one child will pay $15/child/month, and families with two or more children will pay $25/family/month. For families between 170 percent and 185 percent FPL with one child, they will pay $20/child/month and families with two or more children will pay $30/family/month. In addition, the State will inform the families of the 5 percent limit on cost-sharing and provide a mechanism for families to stop paying once that limit has been reached.

- Copayments for the HMO package and the provider network package are slightly different. No cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. No child in a family with income less than 150 percent FPL will incur cost sharing that is not permitted under 1916(b)(1).

State Action to Avoid Crowd-out and Outreach Activities

- Legislation for the existing Colorado Child Health Plan denies coverage to any child who is eligible for Medicaid. The mechanism which is currently in use will be used by CHP+. CHP+ applicants will be screened for Medicaid eligibility. Application information will be shared between Medicaid and CHP+ if the county social service agency and the family agree to do so; therefore, initial processing can begin. CHP+ eligibility staff will follow up on these referrals with clients and will notify county eligibility staff that they have made a referral. Children who appear to be Medicaid eligible will only be enrolled in CHP+ after they have received a denial letter from a county office.

- In addition, the CHP+ application, like the existing current Colorado Child Health Plan's application, will ask the applicant to report any health insurance coverage. If the family reports creditable coverage, the child will be found ineligible. Providers contracting with CHP+ will be required contractually to notify the plan whenever they have reason to believe a member has coverage other than CHP+.

- The CHP+ will be marketed statewide as a full benefit health plan following seven primary strategies: direct appeal to eligible families through press releases, public service announcements, and video; outreach through school districts; outreach through employers; outreach through collaboration with local county agencies; outreach through regional health and social agencies; outreach through other state programs; and outreach through collaboration with the Colorado Foundation for Families and Children.

Financial Information

Total CHIP allotment -- $41.8 million
Enhanced Federal matching rate -- 66.38%

First year costs:
State Share -- $1.6 million
Federal Share -- $3.1 million
Total -- $4.7 million

CONNECTICUT TITLE XXI STATE PLAN SUMMARY

BACKGROUND

On January 15, 1998 Connecticut submitted a Title XXI State Plan to expand coverage for uninsured children through the combination of a Medicaid expansion for children and the creation of a separate state health insurance program. State legislation authorizes the HUSKY Plan and the HUSKY Plus Plan.

Under Part A of the HUSKY Plan, Medicaid eligibility will be expanded to include children ages 14 through 18 with household incomes up to 100 percent of the federal poverty level (FPL), using an income disregard of 85 percent. (As of June 1, 1997 the Medicaid program covered children ages 0-13 in families with incomes up to 185% of FPL. Expansion for children 14-16 was effective 7/1/97; for children ages 16-18, effective 1/1/98.)

Part B of the HUSKY Program creates a separate state health insurance program for children through age 18 with household incomes up to a gross income level of 235 percent of the FPL. The State will apply an income disregard of up to 65 percent of family income to effectively bring coverage to 300 percent of the FPL. Children who are eligible for HUSKY Part B and who require intensive physical or behavorial health services will also receive medically necessary services under HUSKY Plus.

The State also makes a buy-in option available to children in families with incomes above 300 percent of FPL with no federal or state subsidy. No Federal funds will be claimed for HUSKY Part B Services provided to children in households above 300 percent of the FPL.

CHILDREN COVERED UNDER PROGRAM

Connecticut expects to cover approximately 15,000 additional children under its HUSKY program by June 2000.

ADMINISTRATION and HEALTH CARE DELIVERY SYSTEM

A. **HUSKY Part A** - The current administration of the Medicaid program will continue under the State Medicaid Agency. Connecticut currently operates a 1915(b) waiver titled "Health Connect."

B. **HUSKY Part B** - State will contract with managed care plans through competitive bidding process.

C. **HUSKY Plus** - ***For children with special physical health needs***, the plan will be jointly administered by the Connecticut Children's Medical Center (CCMC) and the Yale New Haven Children's Hospital (YNCH) in conjunction with the Yale University School of Medicine. CCMC and YNCH will serve as the coordinating organizations but services will be provided by the entities under contract to provide Title V services. The advisory committee established by the Department of Public Health for Title V of the Social Security Act will be the Steering Committee for the HUSKY Plus Plan along with

representatives from the Departments of Social Services and Children and Families.

For children with intensive behavioral health needs, the Yale Child Study Center will provide assessment services, case management, and develop and organize a statewide network of providers. The plan will be responsible for all aspects of benefit management under HUSKY Plus, including the direct reimbursement of HUSKY Plus providers through contractual arrangements including, but not limited to, fee for service reimbursement.

BENEFIT PACKAGE

The State is using a benchmark coverage benefit package based on the State employee coverage. The coverage is based on the most generous benefits offered under the three state employee options (Blue Cross, MD Health Plan, and Kaiser Permanente). The HUSKY Plus benefit package is not available to State employees who already have health care coverage.

A. **HUSKY Part A** - Medicaid Benefit Package

B. **HUSKY Part B** - Includes the following services: hospital inpatient and outpatient, physician, surgical, clinic, health center, ambulatory, prescription drugs, Lab and x-ray, prenatal care, family planning and supplies, inpatient mental health, outpatient mental health, durable medical equipment, disposable medical supplies, home and community-based services, nursing care, abortion (to save life, rape, or incest), dental, inpatient and outpatient substance abuse, enabling, emergency transportation.

C. **HUSKY Plus**- Provides services for children with special physical health needs and special behavioral health needs. Children must be eligible for HUSKY Part B with gross household incomes under 300 percent of the FPL.

COST SHARING

Premiums:

HUSKY Part A:	None
HUSKY Part B:	For incomes up to 235 percent of the FPL: None For incomes that exceeds 235 percent of the FPL before income disregards are applied: $30 child/up to $50 family monthly

CoPays:

HUSKY Part A:	None
HUSKY Part B:	For incomes that exceed 235 percent of the FPL before income disregards, the following apply: Emergency care-- No copay unless service determined non-emergency under State law, then $25 is charged. $5 for practitioner visits $6 for brand name drugs, $3 for generic drugs

The HUSKY Plan has no deductibles and coinsurance.

Maximum Aggregate Cost Sharing (premiums and copays):
There is a $650 maximum for families with gross income (before disregards) between 185 percent and 235 percent of the FPL. There is a $1,250 maximum for families with gross incomes that exceed 235 percent of the FPL before income disregards. The State's cost sharing limits are consistent with the statutory limits of Title XX1.

STATE ACTION TO AVOID CROWD-OUT

A person is ineligible for HUSKY Part B if they have been covered by employer-sponsored insurance within the last six months. This may be extended to twelve months if the Commissioner determines that six months is insufficient to deter applicants or employers from discontinuing employer-sponsored dependent coverage. However, an application may be approved if the reason for loss of employer-sponsored insurance is unrelated to the availability of the HUSKY Plan or any of ten other reasons which include the loss of employment.

OUTREACH ACTIVITIES

The State will work with the Children's Health Council, Medicaid Managed Care Council, Infoline of CT and local CAP agencies to develop outreach mechanisms. Outreach will include radio and TV ads, direct mail campaign, brochures/flyers, video, toll-free number, web sites, State presentations and mail-in applications.

Allotment: $34,968,061
Enhanced Matching Rate: 65%
Projected Budget: 1998 - $2,892,101 (State-only funds)

DELAWARE TITLE XXI PROGRAM
FACT SHEET

Name of Plan: Delaware Healthy Children Program (DHCP)

Date of Plan Submitted: June 30, 1998

Date Plan Approved: September 1, 1998

Effective Date: October 1, 1998

Background

- On June 30, 1998, Delaware submitted a proposal to implement its children's health insurance program (CHIP) which will expand health insurance coverage to children under age 19 in families with incomes up to 200 percent of the Federal Poverty Level (FPL), who are not eligible for Medicaid, through a separate state health insurance program.

- Delaware's current Medicaid program, which is run under an 1115 waiver, covers children up to age 6 in families with incomes up to 133 percent of the FPL and children from age 6 through age 18 in families with incomes up to 100 percent of the FPL.

Children Covered Under Program

- The State expects to insure an additional 10,513 children by October 1, 1999.

Administration

- This program will be administered by the Delaware Department of Health and Social Services, Division of Social Services.

Health Care Delivery System

- Enrollment will be managed using the State's existing statewide Section 1115 waiver, the Diamond State Health Plan (DSHP). Delaware will use the existing health benefits manager as the enrollment broker and the existing managed care organizations (MCOs) as service delivery providers.

Benefit Package

- The State employee health plan will be used as the benchmark plan for DHCP. All services provided in the State employee health plan will be provided in the DHCP. In addition to the services provided in the benchmark, the DHCP will cover over-the-counter medications and additional mental health and substance abuse services. Although the benchmark plan has copays for certain services, there will only be copays for non-emergent use of the emergency room in the DHCP.

- The service package will be provided through the fully capitated MCOs participating with the DSHP. Services will be provided statewide and will not vary based on geography.

Cost Sharing

- There is a $10 monthly premium for families with incomes between 101 percent and 133 percent of the FPL, a $15 monthly premium for families with incomes between 134 percent and 166 percent of the FPL, and a $25 monthly premium for families with incomes between 167 percent and 200 percent of the FPL.

- There is a $10 co-payment per emergency room visit. This fee is waived if the visit results in immediate inpatient hospitalization or if a prudent layperson would interpret the need for the visit to the ER to be an emergency.

Crowd-Out Strategy

- Children are not eligible for the program unless they have been without health coverage in the preceding six months. However, exceptions to this requirement are made for good cause.

Outreach Activities

- The State plans to use the following methods of finding, notifying and assisting eligible children to enroll in DHCP:
  - continue to outstation State Medicaid staff to complete Medicaid and DHCP applications;
  - form partnerships with community based organizations that can help provide outreach to children and their communities and service areas;
  - use non-traditional outreach strategies such as fliers on pizza boxes and fast food trays; and
  - use cost effective media such as mailings, newspapers, busses, and public service announcements on radio and TV.

Coordination Between CHIP and Medicaid

- The State is using a single application form, incorporating the Title XXI program into the Medicaid form. Eligibility will always be determined by staff under the administration of the Title XIX program using abbreviated, mail-in applications and out-stationing eligibility staff at various sites. Eligibility and redetermination of eligibility will be consistent with the State's Medicaid program. A common computer eligibility system will also be used.

- Individuals will be enrolled in MCO's using the same health benefits manager and the same process of enrollment as is used by Delaware's Diamond State Health Program. Individuals will be given a time frame to choose an MCO, and then, in the absence of any indication of choice, will be automatically assigned to an MCO based on location and availability of providers.

Financial Information

Total CHIP Allotment	$8,093,758
Enhanced Federal Matching Rate	65%

First Year Costs (January 1, 1999 - September 30, 1999):
State Share -- $2,535,431
Federal Share -- $4,708,655
Total -- $7,244,086

Second Year Costs (October 1, 1999 - September 30, 2000)
State Share -- $4,298,754
Federal Share -- $7,983,401
Total -- $12,282,155

FLORIDA TITLE XXI AMENDMENT SUMMARY
Fact Sheet

Name of Plan:	**Florida Kidcare Program**
Date Plan Approved:	**March 6, 1998**
Date Amendment Submitted:	**July 17, 1998**
Date Amendment Approved:	**September 8, 1998**

Background

- On March 6, 1998, Florida's Title XXI plan was approved. This combination plan expanded Medicaid coverage to children ages 15 through 19 in families with incomes up to 100 percent of the Federal Poverty Level (FPL) and expanded the existing Healthy Kids program, which provides subsidized premiums for children in families with incomes up to 185 percent of the FPL, to additional counties throughout the State, with modifications deisigned to meet the requirements of the Title XXI legislation.

- On July 17, 1998, Florida submitted an amendment to its Title XXI plan. The amendment expands eligibility for Healthy Kids to children in families with incomes up to 200 percent of the FPL, adds the MediKids program, and the Children's Medical Services (CMS) Network. Between this amendment and the original plan, health care coverage will be expanded to approximately 150,000 children by July 1, 1999. The entire program is called the Florida Kidcare Program.

  The amendment to Florida's CHIP plan includes the following components:

  - Extension of the current Florida Healthy Kids program to all counties throughout the State, with modifications designed to meet the requirements of the Title XXI legislation. The Healthy Kids program is a school-based health insurance program. There are no income limitations for participation in Healthy Kids, but Title XXI will provide subsidized premiums for children in families with incomes up to 200 percent of the FPL. The State expects to have approximately 107,000 children enrolled in Florida Healthy Kids by July 1, 1999.

  - Creation of the MediKids program for children up to age 5 in families with incomes below 200 percent of the FPL. The MediKids program was created to capture the non-school aged children that the Healthy Kids program does not capture. The MediKids program uses the Medicaid benefit package and has periodic open enrollment periods. Once determined eligible for the program, a child must enroll in a Medicaid managed care plan or the MediPass program, Florida's primary care case management program. The State expects to have

approximately 11,000 children enrolled in MediKids by July 1, 1999.

- The Children's Medical Services (CMS) Network will cover children under the age of 18 with special health care needs in families with incomes below 200 percent of the FPL. CMS allows children to have specialists as their primary care doctor without any special authorizations. The State expects to have approximately 7,500 children enrolled in the CMS network by July 1, 1999.

Administration and Phases

- The Healthy Kids, MediKids and CMS programs will be administered by the legislatively created Florida Healthy Kids Corporation (FHKC), a not-for-profit organization which operates subject to the supervision and approval of a board of directors, chaired by the Insurance Commissioner or his designee, and composed of twelve other members.

Health Care Delivery System

- Florida Healthy Kids services are delivered through state licensed managed health plans that meet the requirements of the Department of Insurance and the Agency for Health Care Administration. These health plans are responsible for developing service delivery networks, claims processing and payment and risk assumption.

  A child that is eligible for MediKids will have a choice between a Medicaid participating HMO and MediPass.

  The CMS Network providers are the same providers as those who serve Medicaid children under the MediPass option for children with special health care needs. CMS contracts with providers to offer a full range of services for these children. Families are offered a choice of primary care providers in the network. The CMS Network provides the standard Medicaid benefit package to its enrollees.

Benefit Package

- The Healthy Kids benefit package is the existing program benefit package that was cited in the Title XXI legislation as being an acceptable child health coverage program. This benefit package includes a full range of inpatient and outpatient services. Limitations are placed on psychiatric, rehabilitation and physical therapy inpatient admissions; alcohol and drug services; chiropractic services; podiatric services; outpatient rehabilitation services; and durable medical equipment and remedial devices. Dental services may be covered at the county's option.

- The MediKids benefit package and the CMS Network benefit package is the same as the Medicaid benefit package.

Cost Sharing

- Cost sharing is part of the Kidcare Program. Premiums for Title XXI participants will range from $5 to a $15 maximum per household.

- There will not be copayments for children in the MediKids or CMS programs. Copayments are charged in the Healthy Kids program for a number of services and they reflect Title XXI requirements.

- The plan states that cost and utilization rates will be monitored on a quarterly basis to ensure that costs associated with utilizing health care services do not exceed the five percent maximum.

- It is the responsibility of the family to detail their expenditures and to request exemption from cost-sharing responsibilities and for reimbursement of out-of-pocket expenses that exceed the allowable limit. Should a family spend in excess of five percent of their annual income they will receive a letter from the State telling them that they are no longer responsible for cost-sharing. If a family exceeds the 5 percent limit, they will be reimbursed for excess expenses from the Corporation.

Coordination Between CHIP and Medicaid

- The Healthy Kids corporation will screen all Kidcare applications for Medicaid eligibility. Children who appear eligible will be processed for Medicaid eligibility by Department of Children and Families eligibility specialists. These specialists are on-sight and co-located in areas where families apply. All other children will be enrolled in the appropriate Kidcare program

State Action to Avoid Crowd-Out and Outreach Activities

- The Kidcare Program requires that children are uninsured at the time of application and requires state residency. However, there is no waiting period of uninsurance for eligibility. Florida has agreed to study the Healthy Kids program's impact on crowd-out. If there is a problem, the State will implement a crowd-out policy.

- Florida has convened a workgroup which consists of state agency representatives, advocates and other parties, to develop a comprehensive outreach strategy for its child health programs, including Title XIX and Title XXI programs. This workgroup will make recommendations for improving outreach to Medicaid, and recommend a simplified eligibility form and enrollment process for all child health programs.

- The Healthy Kids corporation has contractual arrangements with school districts for marketing and outreach. Outreach activities of the program are shared among the Corporation, local steering committees, schools and participating health plans.

FLORIDA TITLE XXI PLAN SUMMARY

Background

- On December 4, 1997, Florida submitted a Title XXI State Plan which proposes a combination Title XIX and XXI program.

- Medicaid coverage for children ages 15 through 19 will be extended from the current family income level of 28 percent of the Federal Poverty Level up to 100 percent.

- The current Florida Healthy Kids program will be extended to additional counties throughout the State, with modifications designed to meet the requirements of the Title XXI legislation. There are no income limitations for participation in Healthy Kids, but Title XXI will provide subsidized premiums for individuals at or below 185 percent of the Federal Poverty Level. Children must be in school to be eligible for the program. Eight new counties have been selected for implementing Healthy Kids during SFY 1997-1998. Additional counties that may be considered are currently engaged in planning activities. A maximum of 118,725 children will be enrolled during each year.

Administration and Phases

- Florida considers this plan to be only a beginning. The 1998 regular session of the Florida Legislature will convene in March, 1998, during which time options will be debated for fully implementing comprehensive health care coverage for children. The extension of Medicaid coverage for children ages 15 to 19 anticipated in this plan submission will require legislative review and ratification during this legislative session. The State anticipates submitting amendments to this initial plan by early summer.

- The Agency for Health Care Administration is Florida's designated single state agency for the Medicaid program.

- The Florida Healthy Kids is administered by the legislatively created Florida Healthy Kids Corporation (FHKC), a not-for-profit organization which operates subject to the supervision and approval of a board of directors, chaired by the Insurance Commissioner or his designee, and composed of twelve other members.

Health Care Delivery System

- The health care delivery system for the Medicaid expansion will be the same as is currently provided to the Medicaid population, but it is not described in this application.

- Florida Healthy Kids services are delivered through state licensed managed health plans that meet the requirements of the Department of Insurance and the Agency for Health Care Administration. These health plans are responsible for developing service delivery networks, claims processing and payment and risk assumption. Plans are selected through a competitive bidding process. Currently there are twelve health plans contracting with the Corporation.

Benefit Package

- The benefit package for the Medicaid expansion is the Medicaid benefit package.

- The Healthy Kids benefit package is the existing program benefit package that was cited in the Title XXI legislation as being an acceptable child health coverage program. This benefit package includes a full range of inpatient and outpatient services. Limitations are placed on psychiatric, rehabilitation and physical therapy inpatient admissions; alcohol and drug services; chiropractic services; podiatric services; outpatient rehabilitation services; and durable medical equipment and remedial devices. Dental services may be covered at the county's option.

Cost Sharing

- There is no cost sharing for the Medicaid expansion.

- Cost sharing is part of the Healthy Kids Program. Premiums for Title XXI participants will range from $5 to a $15 maximum per household. Copayments are charged for a number of services. The State does say that copayments will be modified to reflect the Title XXI legislation, specifically copayments for mental health services will be reduced to $3, which is reflected in the attached benefit package. However, there are other copayments, i.e., those for emergency services and corrective lenses, which would not be in compliance with Title XXI. So, it is not clear that the attached benefit package is for the Title XXI Program to be implemented.

  In the application, copayments are $3. for outpatient office visits, with the exception of well child care visits and routing hearing and vision screening for which no copayments are charged. There is also a $3 copayment for outpatient mental health visits; outpatient rehabilitation services; home health services; refractions; and prescription drugs.

- The plan states that cost and utilization rates will be monitored on a quarterly basis to ensure that costs associated with utilizing health care services does not exceed the five percent maximum. Should a family spend in excess of the five percent of their annual income, the child's family will be reimbursed for excess expenses from the Corporation. However, it will be the responsibility of the family to detail their expenditures and request reimbursement of out-of-pocket expenses that exceed the allowable limit.

State Action to Avoid Crowd-Out and Outreach Activities

- Once the Medicaid expansion has occurred, the Healthy Kids Corporation will review children who are currently enrolled in the program for potential Medicaid eligibility. Children who appear eligible will be processed for Medicaid eligibility by eligibility specialists provided by the Department of Children and Families.

- The Healthy Kids Program requires that children are uninsured at the time of application and requires residency. There is no waiting period of uninsurance for eligibility.

- Florida has convened a work group of state agency representatives, advocates and other parties to develop a comprehensive outreach strategy for its child health programs, including Title XIX and Title XXI programs that will make recommendations for improving outreach to Medicaid, and recommend a simplified eligibility form and enrollment process for all child health programs.

- Healthy Kids has contractual arrangements with school districts for marketing and outreach. Outreach activities of the program are shared among the Corporation, local steering committees, schools and participating health plans.

GEORGIA TITLE XXI PROGRAM
FACT SHEET

Name of Plan:	Georgia CHIP
Date Plan Submitted:	May 29, 1998
Date Plan Approved:	September 3, 1998
Effective Date:	September 1, 1998

Background

- On May 29, 1998, Georgia submitted a proposal to implement a children's health insurance plan which will expand health care coverage to children through age 18 in families with incomes below 200 percent of the Federal Poverty Level (FPL) who are not eligible for Medicaid through a separate state health insurance program.

- Georgia expects to enroll 20,783 children in the CHIP program in FY 1999, 58,475 children in FY 2000, and 66,732 children in FY 2001.

Administration and Phases

- This expanded coverage for children will be administered by the Georgia Department of Medicaid Assistance (DMA).

- The implementation date for Georgia CHIP is September 1, 1998. The marketing and outreach effort was rolled out for a pilot area of the state in August to begin developing public awareness prior to implementation.

- Benefit coverage in the pilot area will begin November 1, 1998. If all systems are operating correctly, the statewide marketing and outreach campaign will begin in November 1998. Applications will be accepted statewide on December 1, 1998 for benefit coverage effective January 1, 1999.

Health Care Delivery System

- Georgia's CHIP program will be delivered by the current Medicaid providers.

Benefit Package

- Georgia's CHIP benefit package will be the BlueChoice Health Care Plan, the state's largest HMO, with added services to bring the coverage to equal a Medicaid look-alike, with the exception of non-emergency transportation and targeted case management.

Cost Sharing

- There is no cost sharing for children under age 6. For children over age 6, there is a monthly premium of $7.50 for one child and $15.00 for two or more children.

State Action to Avoid Crowd-Out

- A child will be denied eligibility if it is determined that he or she is currently covered under any health insurance, is eligible for Medicaid, is a member of a family that is eligible for health benefits coverage under a State health benefit plan based on a family member's employment with a public agency in the State, or voluntarily dropped coverage under an employer plan during the last three months.

- The CHIP application will contain questions about current and past coverage under group health plans and family members employment with State Agencies. Employer information will also be validated by checks of wage record data with the Georgia Department of Labor (DOL) when available.

- Once children are enrolled, there will be periodic checks of the DOL files to determine if there have been changes in employers. In addition, as claims are paid, if the provders report coverage under other health plans, eligibility will be terminated if the coverage meets any of the four criteria listed above.

Outreach Activities

- Outreach efforts will be completely coordinated for Georgia CHIP and Medicaid, so that those children who are eligible for Medicaid will be reached and enrolled in Medicaid, and those children eligible for Georgia CHIP will be reached and enrolled in Georgia CHIP.

- The State will use the nationally-recognized Right From the Start Medicaid (RSM) outreach strategies for Georgia CHIP. RSM outreach workers will have a variety of program information on both creditable and non-creditable coverage and other ways to access health care services, as well as all pertinent information on both Medicaid and Georgia CHIP.

Financial Information

Total CHIP Reserved allotment --$125,283,859
Enhanced Federal Matching rate -- 72.33%

First year (FFY 99) costs -- $19,917,318
State share --$5,511,122
Premiums -- $1,417,864
Federal share --$14,406,196
Total Net Cost -- $19,917,318
Total Cost (with Premiums) -- $21,335,182

Expo and State and County fairs.

- The State is also working with seven community coalitions to draft an application for a Robert Wood Johnson (RWJ) outreach grant.

Financial Information

ALLOTMENT: $70,865,233
ENHANCED MATCHING RATE: 72.99%
PROJECTED BUDGET: FFY 98 (if all targeted children enroll)

	Total Cost	State Cost
FFY 98	$14,959,084	$4,054,992
FFY 99	$42,625,397	$11,632,471
FFY 00	$60,230,504	$16,436,904

Updated 6/23/98

Cost Sharing

- Medicaid rules will apply for cost sharing.

State Action to Avoid Crowd-out

- Indiana's Title XXI Medicaid expansion which limits family income to 150% of FPL reduces the possibility of crowd-out since many of the lower income families do not have the option of employer-based health insurance.

- Poverty level children with other insurance will be covered by the State under the regular Medicaid matching rate, thereby reducing the incentive for families to drop coverage.

- At the time of application or recertification, parents must attest to the lack of current coverage and indicate when the child last had coverage. The State will monitor this information. The State plans to develop further recommendations to prevent substitution of public coverage for private coverage in their Phase 2 program which will be submitted as an amendment at a later time.

Outreach Activities

- Short-term outreach efforts include: evaluating the viability of a toll-free telephone number, analyzing the number of uninsured children per county, reviewing equipment specifications and technical needs so that local providers and agencies can purchase compatible equipment, developing a simplified shortened Medicaid application, undertaking a media campaign to inform public about the program.

- Outreach and case management will be provided by DFC directors in individual counties. DFC is currently evaluating different out stationing models, including a co-location model and several alternative options. Local DFC directors have considerable flexibility in fashioning outstation designs and are required to work with organizations which include: Head Start, First Steps, community action programs, community health centers, child care voucher agents, disproportionate share hospitals, public school system school lunch program, county hospitals, WIC clinics, MCH clinics, IV-D prosecutor staff, township trustees, and community multi-service centers.

- Long-term outreach efforts include establishing continuous coverage and presumptive eligibility one-year pilot projects; coordinating the heightened outreach campaign among the various State agencies, promoting new outreach efforts at a myriad of community service and health service meetings, analyzing a business study that addresses the feasibility of instituting a telephone interviewing process, delinking Medicaid from TANF and Food Stamps in the computer system, and establishing presence at Indiana Black

INDIANA TITLE XXI STATE PLAN

Background

On April 17, 1998, Indiana submitted a Title XXI Plan to expand Medicaid eligibility to children under the State's Medicaid Title XIX Plan. The State will expand Medicaid eligibility to include:

- Effective 10/1/97, children born before 10/1/83 between the ages of 14 through 18 up to 100% of the Federal Poverty Level (FPL); and

- Effective 7/1/98, children ages 0 through 18 up to 150% FPL.

Eligible children will receive the full Medicaid benefit package. All Medicaid program policies will apply. Indiana expects to initiate expanded eligibility July 1, 1998.

Children Covered under Program

- The State expects to cover approximately 23,750 children in year one, 49,250 children in year two and 57,950 in year three.

- Indiana's current Medicaid State plan covers infants up to 150% FPL, children under 6 up to 133% FPL and children 6 through 18 to 100% FPL.

Administration

- This expanded coverage for children is administered by the Office of Medicaid Planning and Policy, Indiana Family and Social Services Administration.

- Individuals apply for Medicaid at one of the 105 DFC offices throughout the State.

Health Care Delivery System

- The State currently has an approved 1915(b) waiver titled "Hoosier Healthwise" comprised of a primary care case management system and a risk-based managed care system. Primary medical providers (PMPs) provide preventive and primary medical care, and furnish authorizations and referrals for most specialty services.

- Children eligible for Medicaid through the Title XXI expansion will be integrated into these managed care networks, thereby assuring they have a medical home.

Benefit Package

- The current Medicaid benefit package will be provided.

Financial Information

Total CHIP allotment -- $123,141,631
Enhanced Federal matching rate -- 65%

First year costs:
State share -- $6,194,584
Federal share -- $11,504,227
Total -- $17,698,811

Health Care Delivery System

- Care will be provided through the current delivery system for the Title XIX program. When the State's 1115 demonstration waiver program is implemented (MediPlan Plus), individuals will be transitioned in the same manner as current Title XIX participants.

Benefit Package

- The Medicaid benefit package will be provided.

Cost Sharing

- Medicaid rules will apply.

State Action to Avoid Crowd-Out and Outreach Activities

- The State will closely monitor the implementation of the Medicaid expansion under Title XXI to assess what effect the program has on existing health benefits coverage of optional targeted low-income children. If the State should find that families are dropping privately financed coverage to enroll in Medicaid, the State will take corrective action to prohibit that practice.

- The program will be fully integrated with the State's current Medicaid program; therefore, the procedures currently in place for the identification of third party coverage will be employed for this population as well.

- The State will utilize a number of measures to encourage eligible children to enroll, utilize, and stay in the health care system. These measures include:

  - Review of automated records to identify eligible participants followed by notification to individuals.

  - Development of a new simplified application process and procedure to support widespread offsite enrollments including sites at Federally Qualified Health Centers (FQHCs), disproportionate share hospitals, local health departments, and WIC sites.

  - Community health care providers, hospitals, clinics, emergency rooms, pharmacies, schools, local health departments, hospitals, pharmacies, etc. will be utilized to the fullest extent practical to identify potentially eligible individuals, for education, and distribution of material.

  - The Department of Public Aid will send a notice to all non-assistance Child Support families informing them of the program and of locations where the family could enroll the child.

ILLINOIS TITLE XXI STATE PLAN

FACT SHEET

Background

- On January 6, 1998, Illinois submitted a Title XXI Plan to provide expanded benefits under the State's Medicaid Title XIX Plan. The Title XIX Plan amendments required to implement the Title XXI program were submitted under separate cover on February 23, 1998. The State proposes to expand Medicaid eligibility to children between the ages of 0 and 19 and who are from families with incomes above the March 31, 1997 Medicaid eligibility standard and at or below 133 percent of the Federal Poverty Level (FPL). The State anticipates that the program will serve an additional 40,400 children by June 1998. Eligible children will receive the full Medicaid benefit package. All Medicaid program policies will apply.

- At the end of 1997, Illinois covered 767,000 children under its Medicaid program. Prior to the Title XXI expansion, the income level at which children were eligible for Medicaid in Illinois varied based on the age of the children. Under the expansion, the threshold income level has been simplified so that all children in Illinois with incomes up to 133% of the FPL can be covered. The State now only covers children up to age 6.

- Illinois will initiate expanded eligibility retroactive to January 5, 1998.

Administration and Phases

- This expanded coverage for children will be administered by the State's Maternal and Child Health (Title V) program in the Illinois Department of Human Services. Outreach and case management will be provided through the *Family Case Management* program which conducts these activities for low-income families that include a pregnant woman, infant, or young child.

- This State Plan Amendment represents the first stage of the Illinois Child Health Initiative to be implemented under Title XXI. Phase I is defined as expanding the Medicaid Program eligibility to uninsured children between 0 and 19 years of age who are from families with incomes above the March 31, 1997 Medicaid eligibility standard and at or below 133 percent of the FPL. The State anticipates that the program will serve an additional 40,400 children. Phase I will be retroactive to January 5, 1998.

- Later in 1998, the State intends to submit plan(s) to expand coverage further by way of the HHS approval process. A legislative task force has been established to make a recommendation for expansion of health benefits coverage for targeted low income children up to 200 percent of FPL.

- Children who have access to private health insurance will generally be excluded from CHIP. Exceptions to this exclusion will be granted for "hardship" cases. Determinations regarding both access to private coverage and hardship exceptions will be made by "self-reliance specialists." The specialists will determine whether a child has access by evaluating the available private coverage against HIPAA standards for "creditable coverage." If the private coverage does *not* meet HIPAA standards, a child who meets all eligibility criteria will be enrolled in CHIP. If the coverage *does* meet the HIPAA standards, the child is presumed ineligible for CHIP and the family is notified. At this point, if the family requests it, the self-reliance specialist will consider whether hardship or extenuating circumstances exist, based on factors including family income, special needs and expenses, and premium costs. All determinations regarding hardship are documented, and applicants have the right to an appeal to a hearing officer.

Outreach Plan

- The State will integrate outreach for expanded enrollment with current Medicaid enrollment efforts.

- The outreach plan is being developed by the Deputy Director of the Department of Health and Welfare. Current efforts include mailing postcards to potential enrollees describing Title XXI. The mailing list was comprised of families who have lost cash assistance between April and December 1997.

- After the Task Force determines the nature of the long term Title XXI program, it will be responsible for developing recommendations for an appropriate outreach program.

Financial Information

Total CHIP Reserved Allotment -- $15,883,789
Enhanced Federal Matching Rate -- 78.71%
The State is proposing to spend 100 percent of its allotment.

IDAHO'S TITLE XXI STATE PLAN SUMMARY

Background

- On February 17, 1998, Idaho submitted a Title XXI State Plan to expand Medicaid coverage to optional targeted low-income children up to age 19.

- Currently, the State is providing services to Title XXI-eligible infants and children up to age 19 in families with incomes up to 160 percent of the FPL. State legislation has reduced the CHIP income threshold to 150 percent of the FPL, effective July 1, 1998.

- The State will convene a Children's Health Insurance Program Task Force to evaluate the current Title XXI program and recommend alternatives to the State for the program in the long term. The State has been informed that any changes to the approved plan must be approved by HCFA prior to implementation.

- The CHIP plan has an effective date of October 1, 1997.

Administration

- The program will be administered by the State Medicaid Agency.

Health Care Delivery System

- The State will utilize its current Medicaid delivery system to deliver services to the expansion population.

Children Covered Under Program

- The State is expecting to enroll 4,875 children in its Title XXI program.

Benefit Package

- The standard Medicaid benefits package will be offered to the expansion population. The benefit package will include inpatient and outpatient hospital, inpatient psychiatric, physician services, dental services, other practitioners, clinic services, home health, family planning, lab and x-ray services, prescriptions, and EPSDT services.

Cost Sharing

- There will be no premiums or cost-sharing for enrollees.

State Action to Avoid Crowd-Out

- Because the State's primary outreach for Title XXI eligibility will be the Medicaid eligibility and enrollment system, potential Title XXI eligibles will first be evaluated for Medicaid eligibility and enrolled if appropriate.

Iowa is using CHIP funds to expand Medicaid.

IOWA TITLE XXI PROGRAM
Fact Sheet

Name of Plan: Iowa Medicaid Expansion

Date Plan Submitted: June 1, 1998

Date Plan Approved: September 1, 1998

Effective Date: July 1, 1998

Background

- On June 1, 1998, Iowa submitted a proposal to expand Medicaid coverage to children ages 6 through 18 in families with incomes up to 133 percent of the Federal Poverty Level (FPL).

- Iowa's current Medicaid program covers infants, up to one year of age, in families with incomes up to 185 percent of the FPL, children under age 6 in families with incomes up to 133 percent of the FPL, children ages 6 through 14 in families with incomes up to 100 percent of the FPL, and children ages 15 through 18 in families with incomes up to 37 percent of the FPL.

- This expansion will provide coverage to children ages 6 through 14 in families with incomes between 100 percent and 133 percent of the FPL, and to children ages 15 through 18 in families with incomes between 37 percent and 133 percent of the FPL.

- As of April 1, 1998, there were 95,189 children receiving Medicaid in Iowa. Iowa expects its CHIP program to cover an additional 15,500 children by the end of June 1999.

Administration and Phases

- Iowa implemented its CHIP program on July 1, 1998.

- This expanded coverage for children will be administered by the Iowa Department of Human Services (D.H.S.) in Des Moines and through the 104 D.H.S. offices located in the 99 Iowa counties.

Health Care Delivery System

- Iowa's current Medicaid health care delivery system will be used for its CHIP program.

Benefit Package

- The State's current Medicaid benefit package will be provided.

Cost Sharing

- There is no cost sharing under this proposal.

State Action to Avoid Crowd-Out

- The State anticipates that many of the children who will be covered through the expansion will be siblings of younger children who are already receiving coverage through Medicaid.
- If experience proves that "crowd-out" is significant, the State will develop strategies to address it.

Outreach Activities

- Currently, the State conducts many activities to promote the enrollment of children in the Medicaid program such as brochures, posters and TV spots, and health clinics are conducted by several State agencies through a variety of means.
- On May 14, 1998, a Request for Proposal (RFP) was released to contract for the development and implementation of an outreach program.
- Through this contract, the Iowa D.H.S. plans to provide education to provider associations, State agencies, and advocacy groups such as Native American Tribal Councils, Hispanic and African-American organizations, and refugee resettlement programs. Applications will also be available for distribution by these groups.

Financial Information

Total CHIP Reserved allotment --$32,468,807
Enhanced Federal Matching rate -- 74.63%

First year (FFY 99) costs -- $13,101,568
State share --$3,323,868
Federal share --$9,777,700

KANSAS TITLE XXI PROGRAM
FACT SHEET

Name of Plan:	HealthWave
Date Plan Submitted:	July 14, 1998
Date Approved:	September 1, 1998
Effective Date:	July 1, 1998

Background

- On July 14, Kansas submitted a proposal to implement a children's health insurance program, HealthWave, which will expand health care coverage to low-income children in families with incomes up to 200 percent of the Federal Poverty Program (FPL), who are not eligible for Medicaid, through a separate state health insurance program.

Children Covered Under Program

- The State expects to enroll approximately 30,000 children in CHIP by December 31, 2000.

Administration

- This program will be administered by the Kansas Department of Social and Rehabilitation Services.

- Eligibility will be continuous for 12 months and re-established annually.

Health Care Delivery System

- The State will contract with entities that will include insurance companies, health maintenance organizations, nonprofit dental service corporation, or nonprofit hospital and medical insurance corporations.

Benefit Package

- The state employee benefit package will be used as the benchmark plan. In addition to the benefits provided in the state employee benefit package, all medically necessary services will be provided. The CHIP benefit package is equivalent to the State of Kansas EPSDT benefit package.

Cost Sharing

- Families above 150 percent FPL must pay a monthly premium. This premium will be $10.00 per month for families with incomes between 151 and 175 percent of the FPL and $15.00 per month for families with incomes between 176 and 200 percent of the FPL.

Crowd-Out Activities

- Children are ineligible for CHIP if they are currently covered by any other health insurance, or if they have been covered by health insurance in the previous six month period and such coverage was terminated without good cause.

- The CHIP application will be reviewed to determine if the child already has health insurance coverage. It will also be reviewed to identify other public or private health insurance programs for which the child may qualify.

Outreach Activities

- The State will market its CHIP program as a separate health insurance product. The State will coordinate marketing efforts with state and local governmental entities as well as local community programs.

- The public schools will be the main focus of outreach to families with targeted low-income children.

- There will be a toll free number to access enrollment information.

- Public program sites will participate as access points to the program and provide enrollment materials and assistance.

Coordination between CHIP and Medicaid

- The eligibility process for Title XIX and Title XXI will be coordinated through the use of a joint application. All applications will be reviewed for Title XIX eligilibility.

- The application and supporting documentation will be sent to a central clearinghouse. The Medicaid State agency will administer the portion of the clearinghouse responsible for Medicaid determination. Contracted staff will be responsible for CHIP determinations.

- Families will enroll their children in a health plan through the Medicaid Fiscal Agent after eligibility determination has been finalized.

Financial Information

Total 1998 CHIP allotment -- $30,664,400
Enhanced Federal Matching Rate -- 71.8%

Federal Fiscal Year 1999 Costs:
Federal Share: $7,266,160
State Share: $2,853,840

MAINE TITLE XXI PROGRAM
FACT SHEET

Name of Plan:	Cub Care
Date Plan Submitted:	May 19, 1998
Date Plan Approved:	August 7, 1998
Effective Date:	July 1, 1998 (Title XIX expansion) August 1, 1998 (Title XXI)

Background

- Maine's Title XXI program will expand coverage to children through age 18 in families with incomes up to 185 percent of the Federal poverty level (FPL) using a combination of a Medicaid expansion and a State Child Health Insurance Plan (CHIP). The Medicaid expansion will cover children aged 1 through 18 in families with income up to 150 percent of the FPL; the Cub Care program will cover children in families with income from 151 percent of FPL to 185 percent of the FPL.

- Maine's current Medicaid program covers children from birth through 12 months with family income up to 185 percent of the FPL, children 1 through 5 in families with income up to 133 percent of the FPL, and children 6 through 18 in families with income up to 125 percent of the FPL.

Children Covered Under the Program

- Maine estimates enrolling 6,968 children in the both the Medicaid expansion and Cub Care by the end of the first year of the program. Maine expects enrollment to increase to 10,452 by the second year of the program.

Administration

- Maine's Department of Human Services (DHS) oversees the administration of the Medicaid program and will administer Cub Care in a similar manner. Three Bureaus within DHS will share functional responsibility for the program: the Bureau of Medical Services will have primary responsibility for administration and oversight; the Bureau of Family Independence will determine eligibility; and the Bureau of Health will conduct outreach and education activities.

Health Care Delivery System

- The Cub Care program will utilize the Medicaid delivery system, which differs according to county of residence. Beneficiaries in thirteen counties receive services through the fee-for-service system, with an HMO option available in ten of these counties. In the three remaining counties beneficiaries are required to participate in PrimeCare, a primary care case management program.

- The state has indicated its intent to submit a Medicaid state plan amendment to transition to mandatory managed care statewide in the Fall of 1998. This managed care program will use Managed Care Organizations to provide care. The Cub Care program will transition to statewide managed care according to the same phase-in schedule as Medicaid beneficiaries.

Benefit Package

- The current Medicaid package will be provided for both the Medicaid expansion and the Cub Care program.

Cost Sharing

- The Cub Care program will have sliding scale premiums for children in families with gross income above 151 percent of the FPL according to the following schedule:

- 151-160% FPL	5% of benefit cost per child ($5.00 per month), with a limit of 5% of the cost for 2 children ($10.00 per month) per family.
- 160-170% FPL	10% of benefit cost per child ($10.00 per month), with a limit of 10% of the cost for 2 children ($20.00 per month) per family.
- 170-185% FPL	15% of benefit cost per child ($15.00 per month), with a limit of 15% of the cost for 2 children ($30.00 per month) per family.

- Premiums will be limited to this predetermined percentage of the benefit cost, based on a sliding scale and number of children enrolled. Thus, the aggregate cost sharing for a family will not exceed 5 percent of a family's annual income, and indeed, based on initial calculations, the premium will not be higher than the equivalent of 1.6 percent of family income for those at the lowest end of the FPL range (150-185 percent of the FPL).

Crowd-Out Strategy

- Maine plans to use a combined Medicaid/Cub Care application and the Bureau of Family Independence will determine eligibility for both programs. Applicants will be enrolled in the appropriate program according to eligibility criteria.

- The joint application will request information about current and prior insurance coverage for the most recent three-month period. If applicants have lost coverage for reasons related to the availability of CHIP, eligibility will be denied. Children who lost coverage for reasons unrelated to CHIP will remain eligible. If the coverage termination complies with the following guidelines the children will be eligible for Cub Care:

  - the cost of the employee's share of family coverage exceeds 10 percent of family income;
  - the loss of coverage for the child was due to a change in employment, termination of COBRA coverage or termination was for a reason not in the control of the employee (parent); or a determination of good cause exception is made by DHS.

Outreach Activities

- The state will continue its current outreach activities under the Healthy Families Initiative, a program that uses EPSDT/immunization workers and public health nurses to identify health needs and increase awareness of Medicaid. These workers will be cross trained to target potential Cub Care eligibles and to assist with enrollment. Home visitation under this program will be expanded to target potential low-income children.

- Other outreach efforts include a targeted media and direct mail campaign, adaption of the Immpact system (an immunization tracking system) to collect information on insurance coverage; and a streamlined combination application for Medicaid and Cub Care.

Coordination Between CHIP and Medicaid

- The Cub Care program will be administered by DHS, the Department responsible for administering the Medicaid program. Applicants for both program will use the same simplified eligibility form and enrollment process, which will be conducted by the Bureau of Family Independence. Those determined to be Medicaid eligible will be placed in the Medicaid program. Children enrolled under the Medicaid expansion eligibility criteria and those enrolled under Cub Care criteria will be given distinct eligibility codes in order to track coverage under both programs.

Financial Information

Total CHIP Allotment for FY 1998 -- $12,490,186
Enhanced Federal Matching Rate -- 76.23%

FY 1998 (3 months)
Federal Share -- $635,452
State Share -- $195,421
Total (incl. admin costs) -- $830,873

FY 1999
Federal Share -- $8,123,966
State Share -- $2,498,374
Total (incl. admin costs) -- $10,622,340

MARYLAND TITLE XXI STATE PLAN

Background

- On April 30, 1998, Maryland submitted a Title XXI Plan to expand Medicaid eligibility to children up to age 19 in families with incomes at or below 200 percent of the Federal Poverty Level (FPL). Eligible children will receive the full Medicaid benefit package and all Medicaid program policies will apply.

- Maryland expects to initiate expanded eligibility on July 1, 1998.

Administration and Phases

- This expanded coverage for children will be administered by the State's Department of Health and Mental Hygiene.

- In addition to expanding benefits to children under Title XXI, the State will be transitioning children receiving services under the Maryland Kids Count program into Medicaid on July 1, 1998. Maryland Kids Count is a Section 1115 demonstration project which provides primary and preventive care services to children born after September 30, 1983 who do not meet Medicaid eligibility requirements and whose family income is below 185 percent of the FPL. The State previously requested to cover these children under CHIP; however, the maintenance of effort (MOE) provision under Title XXI (Section 2105(d)) does not allow states to adopt Medicaid eligibility standards that are more restrictive than those in effect on March 31, 1997. The State is not requesting enhanced match for these children in their CHIP proposal.

Children Covered Under Program

- The State plans to cover 15,500 children under Title XXI by the end of SFY 1999.

Health Care Delivery System

- Care will be provided through the current delivery system for the Title XIX program, HealthChoice, a Section 1115 demonstration project. Most of the population will be required to choose a Managed Care Organization (MCO) for delivery of health care services.

Benefit Package

- The Medicaid benefit package will be provided.

Cost Sharing

- There is no cost sharing.

State Action to Avoid Crowd-Out

- Any individual who is covered by employer-based health insurance, or who has voluntarily refused or terminated employer-based health insurance within the preceding six months, is ineligible for the program.
- Maryland will verify insurance coverage and availability by requesting data during the

application process; performing data matches between the Medicaid Recipient file and private insurers' beneficiary files; and reviewing selected sample cases.

Outreach Activities

The State will utilize many strategies to identify and enroll eligible children, which includes:

- A grassroots information dissemination campaign involving a collaboration with State agencies, advocacy and community-based groups and provider organizations.

- A public media and advertising campaign, which will include television, radio, billboards, mass transit posters, newspapers and a press conference.

- A redesign of the application and eligibility determination process.

Financial Information

Total CHIP allotment --$61,643,199
Enhanced Federal matching rate -- 65%

First year costs:
State Share -- $8.4 million
Federal Share -- $15.6 million
Total -- $24 million

MASSACHUSETTS TITLE XXI PLAN SUMMARY

Background

- On January 15, 1998, Massachusetts submitted a Title XXI State Plan to expand children's access to health coverage by expanding Medicaid eligibility to children in families with incomes up to 150 percent of the Federal poverty level (FPL) and by creating a separate state health insurance program, the Family Assistance Plan, for children in families with incomes between 150 percent and 200 percent of the FPL. The Family Assistance Plan includes direct coverage and financial assistance to enable families to participate in employer-sponsored health insurance (ESI). The State implemented a streamlined eligibility process, which includes a gross income test, and an eligibility expansion to 133 percent of the FPL through a Section 1115 demonstration on July 1, 1997.

- The State intends to implement their children's health insurance program during July 1998, and has requested access to their allotment beginning on October 1, 1997.

Administration

- The plan will be administered by the Single-State Agency.

Individuals Covered Under Program

- Massachusetts expects to cover an additional 37,100 children under their CHIP plan by the end of FY 1999.

- In addition, the State expects to provide assistance to 6,000 adults through the employer-sponsored health insurance portion of the Family Assistance Plan.

Health Care Delivery System

- Health care services will be provided to the Medicaid expansion eligibles and to eligibles of the direct coverage option of the Family Assistance Plan through the existing Medicaid managed care delivery network, which consists of Primary Care Case Management, Health Maintenance Organizations and a mental health and substance abuse managed care contract.

- Participants in the Premium Assistance Option will obtain services through contractual arrangements of the ESI.

Benefit Package and Cost Sharing

- Children eligible for Medicaid will receive the State's regular Medicaid benefit package and have full protection from cost-sharing.

- Children in families with incomes between 150 percent and 200 percent of the FPL will be eligible for either a direct coverage option or financial assistance for ESI coverage, which is the premium assistance option. The direct coverage option will provide FEHBP-equivalent benchmark coverage These children will not be assessed co-payments, but there will be a monthly premium of $10 per child to maximum of $30 per family.

- Under the Premium Assistance Option, service delivery and access will be limited to the contractual arrangements of the qualifying health plans of families with access to employer sponsored insurance plans. The ESI plans will have to meet a Title XXI benchmark benefit level. Children in families with access to cost-effective ESI family coverage will have to utilize ESI. Premiums will be up to $10 per child per month to a maximum of up to $30 per month. There is no cost sharing for well baby and well child services, nor will there be cost sharing in excess of the 5 percent of income statutory limit.

State Action to Avoid Crowd-out and Outreach Activities

- Proposed outreach includes school-based campaigns, community-wide enrollment campaigns, creation and distribution of promotional materials, and funding community-based organizations through mini-grants to assist in enrollment of hard to reach individuals. There will be coordination and activity initiation with other state agencies and collaboration with primary care providers.

- This program builds upon their current Medicaid demonstration which includes provisions to preserve and enhance ESI coverage. The Title XXI plan would continue support for private coverage.

    - Families that are currently insured with existing ESI coverage will be able to obtain premium assistance through the existing Medicaid 1115 demonstration at the regular rate of Federal match.

    - If a family has access to employer sponsored insurance but is currently not enrolled, and family coverage is determined to be cost-effective, then financial assistance would be available through the Title XXI plan to enable these families to obtain ESI.

    - The State will be monitoring the enrollment practices relating to ESI and the direct coverage option. The State will also be studying statewide trends in ESI access and employee participation in ESI. If it is determined that crowd out is occurring the State will implement a 3-month period of no insurance coverage or HCFA and the State will collaborate on an alternative corrective action.

Financial Information

Total CHIP Reserved Allotment -- $42,847,242
Enhanced Federal Matching Rate -- 65%
First Year Costs: (FFY 1998)
State Share -- $6.7 million
Federal Share -- $12.5 million
Total -- $19.2 million

MICHIGAN'S TITLE XXI PLAN SUMMARY

Background

- On December 29, 1997 Michigan submitted a Title XXI State plan in order to implement a new State Child Health Insurance Program called "MIChild." The program was implemented in select parts of the State on May 1, 1998.

- On April 17, 1998 Michigan submitted an amendment to their Title XXI plan in order to make some programmatic changes to MIChild and to expand Medicaid eligibility. As a result of the amendment, Michigan's Title XXI program now has both a Medicaid expansion and the State program ("MIChild").

- MIChild provides comprehensive health care coverage to all children under age 19 who reside in families whose incomes are at or below 200 percent of poverty and who are uninsured. Michigan estimates that there are approximately 133,000 that will be eligible for the MIChild program.

- Medicaid eligibility is being expanded to children 16 through 18 year of age through 150% of poverty.

- Michigan's Medicaid program currently provides coverage to children over the age of 6 in families with incomes below 100% of poverty; children between the ages of 1-5 in families with incomes below 133% of poverty; and infants to age 1 in families with incomes at or below 185% of poverty.

Administration

- Michigan has a single administrative contractor that is responsible for most MIChild administrative duties. Final eligibility determination is made by State staff. The administrative contractor is responsible for interacting with the medical benefits providers and the State Department of Community Health.

Health Care Delivery System

- Michigan has multiple managed care providers offering MIChild medical benefits. Licensed insurers that offer a preferred provider product and HMOs may choose to contract with the State at any time, provided that all the State standards are met (these standards will be more stringent than normal licensing standards.

Benefit Package

- The benefit package for MIChild is the same as the state employee's benefit package. The benefit package is a comprehensive benefit package that includes a variety of hospital and physicians services (including acupuncture therapy).

Cost Sharing

- Michigan will **not** impose premium or co-payments on families with incomes less than or equal to 150 percent of poverty

- Michigan will charge premiums and co-payments for children in families with incomes between 151 and 200 percent of poverty. The State will have the family of the children keep track of their expenses and when they have reached their 5% limit they will notify the health plan and the health plan will make certain that they are not charged and more premiums or co-payments.

- Families with one child will be required to pay a premium of $8 per month. Families with two or more children will pay a maximum premium of $16 per month.

- The following co-payments will be applied:

  $5 for each non-formulary prescription not prior authorized
  $5 for each pair of glasses or contact lenses
  $5 for simple dental extractions and stainless steel crowns
  $5 for each physical therapy visit

State Action to Avoid Crowd Out and Outreach Activities

- Michigan will use a single application and children who are found eligible for Medicaid will be enrolled in Medicaid. A child who is eligible for Medicaid is ineligible for MIChild. The final Medicaid eligibility determinations will be made by State eligibility workers.

- The MIChild application form will include a request for information regarding other insurance coverage for each child. The contractor will not enroll any child who has creditable group health coverage, access to employer-sponsored creditable health coverage, or any child who has dropped coverage in the previous six months. The State will allow for certain exceptions to the 6 month look back unless the reason for dropping the coverage is approved by the State. The State will utilize tape matches to determine if employer coverage is in place but was not reported by the family.

- In addition, MIChild will refer custodial parents to an institution or group that has an interest in the outcome of the court case and who have relevant knowledge to impart upon the court, otherwise known as a Friend of the Court. The Friend of the Court will pursue court ordered medical support by an absent parent. The child will still be enrolled in MIChild for first six months. If at the end of six months, the parent has been actively pursuing the support (as indicated by the Friend of the Court verification) the child will continue to be enrolled in MIChild. If the parent has not been actively pursuing the medical support, the child will be disenrolled from MIChild.

- The State's marketing and outreach effort will be comprised of three components: general marketing through the use of demographically targeted media campaigns and existing information dissemination channels (demographic targeting maximizes the return for advertising dollars by matching the timing and the placement of advertisements to the habits of the target population); the solicitation of cooperation and outreach from programs/agencies/systems likely to have contact with target families; and the solicitation of community developed plans from existing county based multipurpose collaborative bodies.

Allotment and Enhanced Match Rate

- Michigan's total allotment is $92 million.
  The State share for FY98 is $11.1 million.
  The Federal for FY98 is $24.3 million.
  Total for FY98: $36 million.
  Michigan's enhanced matching rate is 67.51%.

MICHIGAN'S TITLE XXI PLAN AMENDMENT SUMMARY

On April 17 the State of Michigan submitted the following amendments to their title XXI plan:

- Expand eligibility for Michigan's Medicaid program to children 16 through 18 years-of-age through 150% of the Federal poverty level;
- Reduce family premiums for the MIChild program to $5.00 per month regardless of the number of children in the family;
- Eliminate all copays for MIChild covered services;
- Require final eligibility determinations to be made by State staff;
- Establish a twelve month lock-in to health plans with changes allowed in the first 30 days of enrollment and for cause thereafter.

MICHIGAN'S TITLE XXI PLAN SUMMARY

Background

- On December 29, 1997 Michigan submitted a Title XXI State plan in order to implement a new State Child Health Insurance Program called "MIChild."

- MIChild will provide comprehensive health care coverage to all children under age 19 who reside in families whose incomes are at or below 200 percent of poverty and who are uninsured. Michigan estimates that approximately 120,000 children will be covered under the MIChild program by FY 2000.

- Michigan's Medicaid program currently provides coverage to children over the age of 6 in families with incomes below 100% of poverty, children between the ages of 1-5 in families with incomes below 133% of poverty; and infants to age 1 in families with incomes at or below 185% of poverty.

Administration and Phases

- Michigan will have a single administrative contractor that is responsible for most MIChild administrative duties (including final eligibility determination for the MIChild Program). The administrative contractor will be responsible for interacting with the medical benefits providers and the State Department of Community Health.

Health Care Delivery System

- Michigan expects to have multiple managed care providers offering MIChild medical benefits. Licensed insurers that offer a preferred provider product and HMOs may choose to contract with the State at any time, provided that all the State standards are met (these standards will be more stringent than normal licensing standards.

Benefit Package

- The benefit package for MIChild is the same as the state employee's benefit package. The benefit package is a comprehensive benefit package that includes a variety of hospital and physicians services (including acupuncture therapy).

Cost Sharing

- Michigan is **not** imposing any co-payments.

- Michigan is charging premiums for children in families with incomes between 151 and 200 percent of poverty. The premium will be $5 a month regardless of the number of children in the family.

State Action to Avoid Crowd Out and Outreach Activities

- Michigan is using a single application and children who are found eligible for Medicaid will be enrolled in Medicaid. A child that is eligible for Medicaid is ineligible for MIChild.

- The MIChild application form includes a request for information regarding other insurance coverage for each child. The contractor will not enroll any child that has creditable group health coverage or any child who has dropped coverage in the previous six months, unless the reason for dropping the coverage is approved by the State. Families that have employer sponsored coverage available to them, but who are not availing themselves of this coverage will also not be enrolled in MIChild. The State will utilize tape matches to determine if employer coverage is in place but was not reported by the family.

- In addition, MIChild will refer custodial parents to an institution or group that has an interest in the outcome of the court case and who have relevant knowledge to impart upon the court, other wise known as a Friend of the Court. The Friend of the Court will pursue court ordered medical support by the absent parent. The child will still be enrolled in MIChild for first six months. If at the end of six months, the parent has been actively pursuing the support (as indicated by the Friend of the Court verification) the child will continue to be enrolled in MIChild. If the parent has not been actively pursuing the medical support, the child will be disenrolled from MIChild.

- The State's marketing and outreach effort will be comprised of three components: general marketing through the use of demographically targeted media campaigns and existing information dissemination channels (demographic targeting maximizes the return for advertising dollars by matching the timing and the placement of advertisements to the habits of the target population); the solicitation of cooperation and outreach from programs/agencies/systems likely to have contact with target families; and the solicitation of community developed plans from existing county based multipurpose collaborative bodies.

Allotment and Enhanced Match Rate

Michigan's total allotment is $92 million.
The State share for FY98 is $11.1 million.
The Federal share for FY98 is $24.3 million.
Total for FY98 is $36 million.
Michigan's enhanced match rate is 67.51%.

MINNESOTA TITLE XXI PROGRAM
FACT SHEET

Date Plan Submitted: April 29, 1998

Date Plan Approved: July 17, 1998

Effective Date: September 30, 1998

Background

- Minnesota's Title XXI plan proposes to expand Medicaid coverage to children under age 2 in families with incomes from 275 percent of the Federal Poverty Level (FPL) to 280 percent of the FPL. Minnesota has indicated that it intends to submit a plan amendment to cover additional uninsured children. This CHIP plan will allow the State to have access to its allotment while planning for future expansion.

Children Covered Under the Program

- The State will enroll a small number of children in the first three years of the program in order to access its allotment. The State estimates that only $176,585 in funds will be drawn down in the first year. These expenditures are to provide health insurance coverage and to cover start up costs while the State plans for future expansion to its CHIP plan.

Administration

- The Minnesota Department of Human Services will administer the program.

Health Care Delivery System

- Care will be provided through the current managed care delivery system for the Title XIX program.

Benefit Package

- The current Medicaid benefit package will be provided.

Cost Sharing

- No cost sharing is proposed.

Outreach Activities

- Because this expansion builds off of the current Medicaid program, Minnesota will utilize many of the already existing resources to inform and enroll potential eligibles. These outreach efforts include:

  - a toll free number for program inquiries and and eligibility questions;

  - application forms available at various community sites such as provider offices, school districts, public and private elementary schools, community health offices, WIC program sites and local human services agencies; and

  - targeted outreach efforts including media campaigns, partnerships between community hospitals and schools to identify uninsured children, and discussions with employers not offering health care coverage.

Financial Information

Total CHIP Allotment -- $28,403,279
Enhanced Federal Matching Rate -- 66.5%

Title XXI First Year Costs:
State Share -- $9,796
Federal Share -- $19,442
Total -- $29,238

Title XIX First Year Costs:
State Share -- $73,671
Federal Share -- $73,671
Total -- $147,342

MISSOURI'S TITLE XXI STATE PLAN SUMMARY

Background

- On September 26, Missouri submitted a Title XXI State Plan to expand insurance coverage to children within the State's existing Medicaid managed care delivery system, MC+.

- The State is proposing to use the Title XXI funding to expand Medicaid eligibility to children in families with income up to 300% of the Federal Poverty Level (FPL).

- The State proposes to begin enrollment and marketing on July 1, 1998 and providing health care services on September 1, 1998.

Administration

- The program will be administered by the State Medicaid agency.

Health Care Delivery System

- The State will utilize its current managed care program, Managed Care Plus (MC+), where available, to deliver services. MC+ is currently implemented in the eastern, central, western, and northwestern areas. It is expected to be implemented in the southeast region by August of 1998. Where managed care is not yet available, a fee-for-service system will be utilized. When MC+ is implemented in these areas, the population will be enrolled in managed care.

Benefit Package

- The standard Medicaid benefit package, with the exception of non-emergency transportation, will be offered. The benefit package will include: a full range of unlimited inpatient and outpatient services; emergency room services; dental services including orthodontics; hearing aids and related services; eye exams and glasses; private duty nursing; psychological and counseling services; physical, occupational, and speech therapy; all durable medical equipment; home health services; and all medically necessary behavioral health services.

Cost Sharing

- There will be no premiums and deductibles for enrollees.

State Action to Avoid Crowd-Out and Outreach Activities

- Children who have had private coverage within the last six months will have a six month waiting period for Medicaid coverage. Exceptions will be made in limited circumstances.

- Outreach and eligibility efforts will take place throughout the State at the State offices in every county. Free materials will also be available and used by other entities such as social welfare organizations, schools, and health care providers to assist in outreach efforts.

Eligible Population Size

- The State estimates that approximately 90,000 children would be eligible for enrollment in the Title XXI program by June 30, 1999.

Funding Information

- The State is proposing to spend 100 percent of their allotment.

- The State's allotment is $51, 686,405.

- The State's enhanced matching rate is 72.48 percent

MISSOURI STATEWIDE HEALTH REFORM DEMONSTRATION

FACT SHEET

Name of Section 1115 Demonstration:	Missouri Managed Care Plus (MC+)
Date Proposed Amendment Submitted:	September 2, 1997
Date Proposal Approved:	April 28, 1998
Proposed Implementation:	September 1, 1998

SUMMARY

On June 30, 1994, the Department of Social Services of Missouri requested section 1115 demonstration waivers to expand Medicaid eligibility to uninsured individuals with incomes up to 200 percent of the Federal Poverty Level (FPL). On September 2, 1997 the State submitted a proposed amendment to its proposal; on February 13, 1998, the State revised its section 1115 proposal and indicated that the new submission was to be treated as a stand-alone document. The approved demonstration will operate concurrently with the State's current section 1915(b) waiver, also known as Managed Care Plus (MC+).

The demonstration will expand eligibility to children eligible under Title XXI, working parents who are transitioning off of welfare and who have a Medicaid eligible child in the home, to absent parents who are participating in Missouri's Parent's Fair Share program with incomes up to 100 percent of the FPL, and to absent parents who are actively paying their legally obligated amount of child support. The State will lock-in these expansion eligible Medicaid beneficiaries for one year in their managed care delivery system, MC+. The benefits package for the adults will be more "commercially oriented" and will not include non-emergency transportation as a covered benefit.

ELIGIBILITY

- Adults transitioning off of welfare (TANF) who would not otherwise be insured or Medicaid eligible and with family income over 27 percent and up to 300 percent of the FPL. Coverage for this group will be limited to two years. After two years, they will have the option of continuing their coverage by paying the premium cost directly to the health plan for the remainder of the demonstration. The State and Federal governments will not financially participate in this arrangment.

- Uninsured non-custodial parents with family income up to 100 percent of the FPL who are current in paying their child support. Coverage for this group will be limited to two years.

- Uninsured non-custodial parents actively participating in Missouri's Parent's Fair Share program.

- Uninsured custodial parents with family income up to 100 percent of the FPL. Coverage for this group will be limited to two years.

- Uninsured women losing their Medicaid eligibility 60 days post-partum will be eligible for Women's Health Services, regardless of income level, for a maximum of two consecutive years.

- Children eligible under Title XXI and who do not receive a full Medicaid benefit package (i.e. do not receive non-emergency transportation as a covered benefit).

The following Medicaid recipients will be exempt under the section 1115 demonstration: dual eligibles, the permanently and totally disabled, individuals in nursing homes or Intermediate Care Facilities for the Mentally Retarded (ICF/MR), the mentally retarded, uninsured women eligible because of their pregnancy, the blind, IMD residents, Medicaid recipients currently participating in the 1915(c) waivers for the MR/DD and the AIDS population, and certain persons with private commercial insurance.

BENEFIT PACKAGE

- Working parents with children who are transitioning off of welfare, and low income uninsured non-custodial and custodial parents, will receive a benefit package equivalent to that offered to the employees of the State. For example, non-emergency transportation, which is not available to State employees, also will not be a covered benefit for this group.

- Uninsured women who are losing Medicaid eligibility 60 days post-partum will be eligible for a limited package of women's health benefits, regardless of income level, for two years. The Women's Health Services benefit package include contraception counseling, devices, pharmaceuticals, and implants; pap smears and pelvic exams, and sexually transmitted disease testing and treatment.

- Managed behavioral health care services will be provided for 30 inpatient days and 20 outpatient days per year. Services required in excess of this 30/20 day limitation will be paid on a fee-for-service basis.

ENROLLMENT/DISENROLLMENT PROCESS

- The State will use an enrollment broker, as under the current 1915(b) MC+ waiver, to help beneficiaries choose a plan.

- The State will use a centralized application procedure and State employees will determine eligibility.

- Beneficiaries will be locked-in to a health plan for 12 months following a 90-day period during which they can change health plans without cause. They will be notified at least 60 days before each enrollment of their option to change plans. Beneficiaries will be able to change plans at any time during the year for good cause as determined by the Department of Social Services.

- Eligible beneficiaries who do not choose a health plan will be automatically assigned to one.

- The State is proposing that all eligibility determinations and redeterminations be initiated through a direct mail process. Its toll-free telephone system would be expanded and interviews with prospective eligible beneficiaries would be conducted by phone. The local Division of Family Services offices will have program information available and will be able to provide assistance in completing the application but will not serve as the application site.

DELIVERY SYSTEM

- The delivery system for the expansion population will be the State's current 1915(b) waiver managed care delivery system.

QUALITY ASSURANCE

- The State is using HEDIS as their base for quality control data collection specifications. The State will also monitor the autoassignment rate, new enrollment by region, provider and recipient comments and concerns.

- The State will use Geo-Access or a GeoAccess-like program to monitor access.

- The State is proposing to contract with an independent peer review organization (PRO) or a PRO-like entity to perform an annual external review.

COST-SHARING

- Adults made eligible under the demonstration will participate in a cost-sharing arrangement. The beneficiary will be required to pay $10 for each provider visit and $5 per prescription.

- No co-payment will be required for Parent's Fair Share participants, and those under the Women's Health Program.

- There is no cost sharing for children.

MONTANA TITLE XXI STATE PLAN SUMMARY

Name of Plan: Montana's Children's Health Insurance Plan

Date of Plan Submitted: April 10, 1998

Date Plan Approved: September 11, 1998

Background

- On April 13, 1998, Montana submitted a Title XXI State Plan to expand coverage to children through a benchmark-equivalent benefit package. The State proposes to provide coverage for children under the age of 19 and with family income at or below 150 percent of the Federal Poverty Level (FPL).

Children Covered Under Program

- The State anticipates covering 9,120 children in 2000.

Administration and Phases

- The Health Policy and Services Division of the Montana Department of Health and Human Services will administer Montana's Children's Health Insurance Program.

- The State is requesting approval for their plan in the next legislative session and will amend the plan if required by legislative changes.

Health Care Delivery System

- Montana will seek contracts with indemnity insurance plans and health maintenance organizations. Families will be given a choice of which type of coverage they wish for their children, depending on availability of plans in their area.

Benefit Package

- Utah will offer benchmark-equivalent coverage. An actuarial analysis comparing the benefit package selected to the Basic Plan offered to employees of the State of Montana is provided.

- The benefit package will include inpatient and outpatient hospital services; emergency room services; physician services; surgical services; lab and x-ray services; well-child and well-baby services including age appropriate immunizations; prenatal and

prepregnancy services; abortion as permitted by law; prescription drugs; mental health and substance abuse treatment services; and hearing and vision exams.

Cost Sharing

- Montana will impose an annual enrollment fee as follows:
  - -No annual enrollment fee for families below 100% of FPL.
  - -A $12 annual enrollment fee for a family of one who is at or above 100% of FPL.
  - -A $15 annual enrollment fee for families of two or more who are at or above 100% of FPL.

- Montana will impose copayments as follows:
  - -No copayments for families below 100% of FPL.
  - -No copayments for well-baby or well-child care, including age-appropriate immunizations
  - -For families at or above 100% of FPL:
    - -$25 per admission for inpatient hospital services
    - -$5 per visit for emergency room visits
    - -$5 per visit for outpatient hospital visits
    - -$3 per visit for physician, mid-level practitioner, optometrist, audiologist, mental health professional or substance abuse counselor services
    - -$3 per prescription for generic drugs
    - -$5 per prescription for brand-name drugs

- Copayments will be capped at $200 per family per year. Families will receive an explanation of benefits from the insurer each time a claim is paid that specifies the amount of copayments that have been incurred during the year. Once the family reaches their limit, they can use this explanation of benefits to show providers that they are exempt from copayment. If a family exceeds the $200 limit, the family may contact the state for a refund.

State Action to Avoid Crowd-out

- The application will ask the applicant to report any health insurance coverage.

- A child will be found ineligible if the child's parent is employed by a state agency; if the child is not a U.S. citizen or Qualified Alien as defined under federal statute; if the child is eligible for Medicaid; if the child is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public health Service Act; or if the child has been covered under an individual or group health plan within the three months prior to application for CHIP except under certain circumstances.

- As a performance goal, the State will seek to maintain the proportion of children

≤150% of FPL who are covered under an employer-based plan. The State will measure and analyze the proportion of children ≤150% of FPL who are covered under an employer-based plan taking into account economic factors.

Outreach Activities

- The initial outreach for the program will be through direct mailings of enrollment information and applications to families. Families receiving the mailing will be children currently on the waiting list for the Caring Program for Children; Indian Health Services children who are uninsured; families who receive subsidized child care; families who have left the TANF program; and children participating in the Mental Health Access Plan.

- After legislative approval, outreach will be through direct appeals to eligible families through press releases, public service announcements and video; outreach through school districts; outreach through collaboration with local agencies, grass root organizations and providers; and outreach collaboration with statewide maternal child health organizations.

Coordination between CHIP and Medicaid

- All applications will be screened for Medicaid eligibility by the CHIP program. If the family is potentially eligible for Medicaid, information will be forwarded to the county public assistance offices to begin the Medicaid application process (unless the family indicates that they do not want this information forwarded.) Children who are potentially Medicaid eligible will be sent a CHIP denial letter and a full Medicaid application form. If a family is subsequently found ineligible for Medicaid, the family must send the Medicaid denial letter to the CHIP program in order to have CHIP eligibility determined.

Financial Information

Total CHIP allotment --$9,832,614
Enhanced Federal matching rate --79.39%

First year costs (July 1, 1998 -June 30, 1999):
State Share --$234,067
Federal Share --$901,630
Total --$1,135,697

Second year costs (July 1, 1999 -June 30, 2000):
State Share --$2,552,591
Federal Share --$9,832,614
Total --$12,385,204

NEBRASKA TITLE XXI PROGRAM
FACT SHEET

Name of Plan: Kids Connection

Date Plan Submitted: May 13, 1998

Date Plan Approved: August 7, 1998

Effective Date: May 1, 1998

Background

- On May 13, 1998, Nebraska submitted a Title XXI State Plan to expand Medicaid eligibility for individuals age 15 through 18 to 100 percent of the Federal poverty level (FPL).

- The State will use a more proactive approach to enroll eligible children ages 15 through 18 in families currently in households receiving public assistance. They will be identified to eligibility workers to activate Medicaid eligibility for them along with their younger siblings.

- This plan is Phase I of Nebraska's CHIP program. The second phase is currently under review by the Department of Health and Human Services.

Children Covered Under the Program

- Kids Connection will add an estimated 950 children by July 1, 1999.

Administration

- The Title XXI Program will be administered by the Nebraska Health and Human Services System.

Health Care Delivery System

- The existing Medicaid delivery system will be used to provide services.

Benefit Package

- The Medicaid benefit package will be provided.

Cost Sharing

- There are no cost-sharing requirements.

Crowd-Out Strategy

- The State's current procedures in place for the identification of third party coverage will be used for this population as well.

Outreach Activities

- A number of outreach efforts have been developed for Phase I of Kids Connection which include, but are not limited to the following :
    - using a one-page simplified Medicaid application form
    - allowing mail-in application forms
    - working with advocacy agencies in disseminating information on Medicaid eligibility and the application process to low income communities
    - using information pamphlets and brochures

Financial Information

Total CHIP 1998 allotment $14, 866,746
Enhanced Federal matching rate: 72.82%

First Year Costs:
State Share -- $89,000
Federal Share -- $229,000
Total -- $318,000

NEBRASKA TITLE XXI PROGRAM
FACT SHEET

Name of Plan: Kids Connection

Date Plan Submitted: May 13, 1998

Date Plan Approved: August 7, 1998

Effective Date: May 1, 1998

Background

- On May 13, 1998, Nebraska submitted a Title XXI State Plan to expand Medicaid eligibility for individuals age 15 through 18 to 100 percent of the Federal poverty level (FPL).

- The State will use a more proactive approach to enroll eligible children ages 15 through 18 in families currently in households receiving public assistance. They will be identified to eligibility workers to activate Medicaid eligibility for them along with their younger siblings.

- This plan is Phase I of Nebraska's CHIP program. The second phase is currently under review by the Department of Health and Human Services.

Children Covered Under the Program

- Kids Connection will add an estimated 950 children by July 1, 1999.

Administration

- The Title XXI Program will be administered by the Nebraska Health and Human Services System.

Health Care Delivery System

- The existing Medicaid delivery system will be used to provide services.

Benefit Package

- The Medicaid benefit package will be provided.

Cost Sharing

- There are no cost-sharing requirements.

Crowd-Out Strategy

- The State's current procedures in place for the identification of third party coverage will be used for this population as well.

Outreach Activities

- A number of outreach efforts have been developed for Phase I of Kids Connection which include, but are not limited to the following :
    - using a one-page simplified Medicaid application form
    - allowing mail-in application forms
    - working with advocacy agencies in disseminating information on Medicaid eligibility and the application process to low income communities
    - using information pamphlets and brochures

Financial Information

Total CHIP 1998 allotment $14, 866,746
Enhanced Federal matching rate: 72.82%

First Year Costs:
State Share -- $89,000
Federal Share -- $229,000
Total -- $318,000

NEVADA TITLE XXI PROGRAM
FACT SHEET

Name of Plan:	**Nevada ✓ Check Up**
Date Plan Submitted:	**March 11, 1998**
Date Plan Approved:	**August 13, 1998**
Effective Date:	**October 1, 1998**

Background

- Nevada's CHIP plan will create a separate state health insurance program to provide coverage to children up to age 18 in families with incomes at or below 200 percent of the Federal Poverty Level (FPL) who are not eligible for Medicaid.

- Nevada's current Medicaid program covers children up to age 6 in families with incomes up to 133 percent of the FPL and children age 6 and older born on or after October 1, 1983 in families with incomes up to 100 percent of the FPL.

Children Covered Under Program

- The State anticipates covering 43,500 new children in the first year of its CHIP program.

Administration

- Nevada ✓ Check Up will be administered by the Department of Human Resources, Division of Health Care Financing and Policy.

Health Care Delivery System

- Managed care organizations (MCOs) and other State qualified health care organizations will deliver the benefit package. MCOs must offer a contract to federally qualified health centers, rural health centers, public hospitals, and the University of Nevada School of Medicine at terms that are at least equal to their standard provider contracts.

- For areas not covered by an MCO, a fee-for-service benefit will be offered with the same benefit package.

- Medicaid covered services not included in the MCO benefit package will be provided under fee-for-service. These services include dental, non-emergency transportation, and school-based rehabilitative services.

Benefit Package

- Nevada ✓ Check Up will provide the same services as provided under Nevada's Title XIX State plan.

Cost Sharing

- For families above 175 percent of the Federal Poverty Level (FPL), there will be a quarterly premium of $50.

- For families between 151 percent and 175 percent of the FPL, there will be a quarterly premium of $25.

- For families at or below 150 percent of the FPL, the quarterly premium will be $10, under the guidelines specified in the statute. Families in this group will be given the choice of paying the maximum monthly charge each month, or the $10 quarterly fee.

Crowd-Out Strategy

- The application form includes questions regarding access to public and private health care coverage. The State will randomly verify health insurance coverage by contacting employers.

- A child will be found ineligible if he/she:
  - has creditable health coverage;
  - is eligible for health benefits coverage under a State health benefits plan based on a family members' employment with a public agency in the State; or
  - has had coverage under an employer plan on or after January 1, 1998, or for applications submitted after July 1, 1998, six months prior to application. The six month waiting period may be waived if the applicant provides evidence that the loss of insurance was due to actions outside the applicant's control (e.g., employer discontinues health benefits).

Outreach Activities

- The State has simplified the CHIP eligibility application which will be available statewide through schools, child care facilities, family resource centers, social service agencies, and other locations where eligible children and/or their parents frequent. An 800 number has been established and listed on the application as well as on posters and marketing brochures. In addition, there will be press and media coverage of the program roll out as well as public service announcements.

Coordination Between CHIP and Medicaid

- For families who complete the current CHIP application and have either incomes below that required for Medicaid or no more than 25 percent above the Medicaid income requirement, their application will be considered a Medicaid application. Those families who are determined not eligible for Medicaid could be enrolled in CHIP if they meet all of the State's Title XXI requirements.

- There will be close coordination between the Nevada ✓ Check Up program and Nevada's Medicaid program. Medicaid enrollees will be compared monthly with Nevada ✓ Check Up enrollees to ensure that a child is not enrolled in both programs.

Financial Information

Total CHIP Allotment -- $30,414,882
Enhanced Federal Matching Rate --65%

FY 1998 Costs:
State Share -- $3,057,000
Federal Share -- $5,678,000
Premium/Enrollment Fee --$540,000
Total -- $ 9,275,000

FY 1999 Costs:
State Share-- $16,553,000
Federal Share-- $30,742,000
Premium/Enrollment Fee -- $2,730,000
Total -- $50,025,000

NEW HAMPSHIRE TITLE XXI STATE PLAN

Name of Plan: Healthy Kids - Gold (Phase 1)
Healthy Kids - Silver (Phase 2)

Date of Plan Submitted: May 21, 1998

Approval Date: September 15, 1998

Effective Date: May 1998 (Phase 1)
January 1999 (Phase 2)

Background

- The State of New Hampshire submitted a Title XXI proposal to: 1)expand Medicaid to infants to age 1 with family gross income greater than 185 percent and equal to or less than 300 percent of FPL; and 2) implement and separate state health insurance program to cover children ages 1 to 19 with family gross income greater than 185 percent and equal to or less than 300 percent of the FPL.

Children Covered Under Program

- The State anticipates covering approximately 4,000 children by September 2000.

Administration and Phases

- The primary responsibility for the daily operations of the Title XXI program will be in the managed care unit of the Medicaid Administration Bureau.

- Phase 1 will expand Medicaid eligibility for newborns and infants from birth to age 1 in families with gross income greater than 185 percent FPL and equal to or less than 300 percent FPL with an additional disregard of 65 percentage points of the FPL. This program will be named Healthy Kids - Gold.

- Phase 2 involves purchasing health care coverage for children ages 1 to 19 in families with family gross income greater than 185 percent FPL and equal to or less than 300 percent of the FPL with an additional disregard to 65 percentage points of the FPL. Coverage will be purchased through the New Hampshire Healthy Kids Corporation. This plan includes an emphasis on perinatal care coverage for pregnant adolescent girls not previously served by the Healthy Kids Corporation. The phase 2 program will be named Healthy Kids - Silver.

Health Care Delivery System

- The phase 2 coverage for children will be administered by The Healthy Kids Corporation.

In 1993, the New Hampshire Legislature passed the Healthy Kids Act (RSA 126:H) to address the growing problem of uninsured children. The Act created the Health Kids Corporation, a private, non-profit, "*deemed to be a public instrumentality and... by the authority of the powers conferred by this chapter shall be deemed and held to be the performance of public and essential government functions of the state.*" The Healthy Kids Corporation provides comprehensive health and dental benefits which emphasize preventative and primary care for children. The goal has been to design and operate a program that would avoid the stigma often associated with Medicaid. Current coverage is underwritten by Blue Cross Blue Shield of New Hampshire for health benefits including mental health benefits, and Northeast Delta Dental for dental benefits. Selection of the insurance carrier was conducted through a formal competitive Request For Proposal.

Benefit Package

- Benchmark-equivalent coverage will be provided. An actuarial analysis comparing the benefit package to the Federal Employees Health Benefit Program was provided that demonstrated that the package was actuarially equivalent to a benchmark.

Cost Sharing

- There will be no cost-sharing in phase 1.

- Cost sharing in phase 2 will consist of premiums and co-pays. A mechanism will be implemented to ensure that cost-sharing for a family will not exceed 5% of the family income for a year. The family will be educated on the amount of their limit, how to track cost-sharing and how to contact the State once they equal or exceed their limit. The family will be sent a letter from the State advising them that cost-sharing will cease for the remainder of the current 12 month eligibility period. The family can present this letter to providers to show exemption from copayments.

- Families whose income is greater than 185% and equal to or less than 250% FPL will have a $20 per child per month premium. Families whose income is greater than 250% and equal to or less than 300% FPL will have a $40 per child per month premium. There will be a $100 cap on montly premiums for families with multiple children.

- Co-pays will consist of: $5 co-pay for office visits, $5 co-pay for generic prescription drugs, $10 co-pay for brand name prescription drugs and $25 co-pay for unauthorized or determined non-emergent use of an emergency room will be implemented. Providers are responsible for collection of co-pays. The office co-pay does not apply to well-child visits, preventative health visits, or dental check-ups, x-rays, sealants, cleanings, and fluoride treatments.

- A family's eligibility may be terminated after sixty days due to non-payment of premium except for pregnant teens. In addition, a family who fails to pay the montly premium will be locked out from reapplying for a 3 month period. This will apply to families who do

not meet the good cause provisions.

State Action to Avoid Crowd-Out

- An application will be disapproved if it is determined that the child was covered under a health insurance plan within the last six months. However, an application may be approved for good cause.

Outreach Activities

- The state will build on its successful practices and efforts of its current Medicaid voluntary managed care program as well as the Healthy Kids Corporation. The plan will also capitalize on the collaborative relationships already developed by Healthy Kids Corporation with schools and child care centers as well as expanding the existing network of social service agencies and advocacy groups beyond those that have traditionally worked with the state and Health Kids Corporation.

- Outreach materials include a variety of brochures, posters, flyers, and enrollment package materials. A broad-based public awareness campaign will be designed and directed towards parents of uninsured children and the community at large. The outreach effort will take advantage of seasonal and geographic differences and events, such as the start of the school year. Campaigns include cause-related marketing activities promoting child health such as immunization and lead screening outreach in addition to describing insurance.

Coordination Between CHIP and Medicaid

- Only eligible targeted low-income children will be covered under the Title XXI Plan. The state will ensure that there is coordinated effort between the current state sponsored Medicaid program and the coverage provided by its public private partnership with the Healthy Kids Corporation. By using a single point of entry and eligibility determination, the state will ensure those children eligible for coverage as funded by Title XXI or Title XIX, will be informed of their option to enroll and will receive the support necessary to complete the application.

Financial Information

Total CHIP allotment --$11,461,349
Enhanced Federal matching rate -- 65%

Federal Fiscal Year 1998 (May 1, 1998)
Federal Share $21,054.58
State Share $11,337.08

NEW JERSEY TITLE XXI STATE PLAN SUMMARY

Background

- On February 6, 1998, New Jersey submitted a Title XXI State Plan (NJKidCare Plans B & C) and a Medicaid Expansion (NJKidCare Plan A). The State's proposed effective dates are February 1, 1998, for the Medicaid expansion and March 1, 1998, for the separate state health insurance program.

- The Medicaid proposal (NJKidCare Plan A) expands Title XIX coverage for children under age 19 with family incomes up to 133 percent of the Federal Poverty Level (FPL). There are no cost-sharing provisions.

- The separate state health insurance program, which has two components, targets low-income children in families with incomes between 133 percent and 200 percent of the FPL pursuant to Title XXI. NJKidCare Plan B has no cost-sharing provisions for households with incomes up to 150 percent of the FPL. NJKidCare Plan C requires cost-sharing and co-payments for children in families with incomes between 151 and 200 percent of the FPL, which is consistent with the Title XXI statute.

Administration and Phases

- The Medicaid expansion proposal will extend Medicaid insurance coverage to an estimated 34,000 children by February 1999. A family of four with an income below $21,895 could qualify for the expanded Medicaid coverage.

- The separate state health insurance program, which requires family premiums of $15 a month, for families with incomes between 151 percent and 200 percent of the FPL, will extend coverage to an estimated additional 68,000 children by March 1999. A family of four with an income of $32,100 could qualify for the separate state health insurance program. That family would have a yearly maximum of $1,605 in copayments.

Health Care Delivery System

- The existing Medicaid delivery system will be used to provide services.

- The State plans to maintain a waiting list of eligible clients if the demand for services exceeds the projected enrollment for the separate state health insurance program. This list will be monitored by the State. The client will be given enrollment preference based on the date of application and income.

Benefit Package

- The Medicaid benefit package will be provided for Title XIX expansion.
- Benchmark coverage equal to the FEHBP Blue Cross/BlueShield plan will be provided for the separate state health insurance program.

Cost Sharing

- There is no cost-sharing for households below 150 percent of the FPL (NJ KidCare Plans A & B). Cost-sharing and co-payments will be required for children in families with incomes above 150 percent and up to and including 200 percent of FPL (NJ KidCare Plan C).

Crowd-Out

- A child with income greater than 133 percent of the FPL who meets the criteria for NJ KidCare coverage under Plans B and C must have been uninsured for a minimum of 12 months before becoming eligible for coverage.
- Exceptions will be granted for children who are losing Medicaid eligibility and have no other health care coverage at the time of termination.
- Exceptions will be made to the 12 month requirement in certain limited circumstances (for example, prior coverage was lost because an employer went out of business or the employee was laid off).

Outreach Activities

- The State describes a fourfold outreach effort involving 1) public awareness, 2) targeted outreach, 3) community education and 4) consumer education. There is also a commitment by the State to conduct outreach targeting special populations such as HIV and homeless populations.
- All outreach workers will be trained in eligibility requirements for Title XIX and XXI programs. Bilingual staff and/or language services will be offered to applicants when needed.

Financial Information

Total CHIP Reserved allotment --$88,440,626
Enhanced Federal matching rate --65%
First year costs:
State share --$9,034,802
Federal share --$16,778,919
Total --$25,813,721

NEW YORK TITLE XXI PLAN SUMMARY

Background

- On November 3, 1997, New York State submitted a Title XXI State Plan to expand children's access to health coverage by expanding enrollment in its existing Statewide Child Health Plus (CHPlus) program, which is based on a partnership between government and private insurers through the subsidization of private health insurance coverage. The CHPlus program currently provides coverage for children under the age of 19 with net household incomes at or below 185 percent of the Federal Poverty Level (FPL). The State anticipates that approximately 224,000 children will be enrolled in the program by the end of Federal FY 1998. Over 50,000 new uninsured children will be covered, since the State currently covers 171,000 children. The State also estimates that 360,000 children will be enrolled by March 2000.

- New York will implement its Title XXI Plan once all aspects of its plan are in full compliance with Title XXI requirements. The State has provided an effective date of April 15, 1998.

Administration

- The New York Department of Health will continue to administer the CHPlus program. Insurers will be chosen to participate in the program through a competitive RFP process, and will contract with the State to provide a managed care product.

Health Care Delivery System

- Health services to CHPlus members will be delivered through a managed care insurance product. Children will have a primary care provider who will coordinate his/her health care, including referrals to specialists when appropriate. To the extent possible, CHPlus providers will also be Medicaid managed care providers to ensure a link between the CHPlus program and the New York State Medicaid managed care program. Insurers will be selected in every geographic region of the State to assure Statewide coverage.

- A 60-day presumptive eligibility period will be available to applicant children as a means of providing services under CHPlus when a child appears to be eligible for the program, but pertinent documentation to establish eligibility is lacking.

- Recertification of eligibility must be performed on an annual basis, by the anniversary date of the child's enrollment. Children found to be eligible for Medicaid will be disenrolled from the CHPlus program, and, with the families' permission, information will be forwarded to Medicaid.

Benefit Package

- The package of services for the Title XXI program is the same benefits package currently offered by the CHPlus program. The benefit package includes inpatient services; outpatient services; physician services; surgical services; clinical services (including health center services) and other ambulatory health care services; prescription drugs; laboratory and radiological services; prenatal and pre-pregnancy family services and supplies; outpatient mental health and substance abuse treatment services; durable medical equipment; disposable medical supplies; home and community-based health care services; 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; emergency medical services; and certain therapeutic services.

Cost Sharing

- No premium contributions will be required from families with income levels at or below 150 percent of the FPL. A $9 per child per month premium will be imposed on families with income levels between 151 and 159 percent of the FPL, up to a family maximum of $36 per month. Families with income levels equal to or greater than 160 percent of the FPL will be required to contribute $13 per month up to a family maximum of $52 per month. No deductibles will be imposed.

- A number of copayments will be imposed, irrespective of income level. A $2 copayment will be required for all physician visits, except those provided on an inpatient basis and well-baby/well-child care. A $1 to $3 copayment may be charged for prescriptions, with the exception of insulin, which has no copayment. A $5 copayment may be charged for failure to notify an insurer within 24 hours of emergency room use, and a $10 fee may be charged for inappropriate emergency room utilization.

State Action to Avoid Crowd-out and Outreach Activities

- The State claims that a previous evaluation of the CHPlus program has shown that "crowd-out" has not been an issue--in the past, individuals have not been shown to drop employer-based coverage for the CHPlus program. Crowd out will continue to be analyzed from two perspectives. First using the Current Population Survey as a base, the proportion of children covered under an employer-based plan will be evaluated, and an analysis will be conducted to test for evidence of "crowding out." Second, the forms for CHPlus eligibility determinations will include a number of questions related to past employer-based insurance coverage. This will allow the State to track the number of children who have access to employment-based coverage and to ensure that children enrolling in CHPlus are uninsured and are not dropping employment-based coverage to enroll in CHPlus.

- If crowd out is found to be occurring after 9 months, one or both options below will be employed:

  1) define children with access to employer-based coverage (with at least 50 percent employer contribution for a comprehensive benefit plan) as ineligible for CHPlus; and/or

  2) impose a required period of uninsurance for those who dropped employer-based insurance.

  The State will also comply with an alternative standard promulgated in regulation or policy guidance issued by the Secretary.

o Under the program, community outreach and marketing activities will be conducted through: a community outreach contractor that will be selected through a competitive RFP process; participating insurers; local social services agencies; and the New York State Department of Health (DOH). In addition, a Statewide media campaign will be conducted by the New York State DOH.

o Outreach and marketing of the program include: telephone hot lines to refer families to CHPlus and/or Medicaid, distributing brochures and posters, and conducting training sessions for interested organizations. Additional activities include health fairs, immunization drives, and the establishment of linkages with schools and community-based organizations. Insurers may use radio, television, billboards, newspapers, leaflets, posters, brochures, yellow page advertisements, letters, and verbal presentations by marketing representatives, as well as health fairs to market their product to eligible children. However, door-to-door distribution of material is not permitted.

Financial Information

Total CHIP Allotment -- $255,992,571
Enhanced Federal Matching Rate -- 65%

First Year Costs (i.e., 6 months of FFY 1998)
State share -- $46,194,591
Federal share -- $85,789,955
Total -- $131,984,546

NORTH CAROLINA TITLE XXI FACT SHEET

Background

- On May 14, North Carolina submitted its title XXI State plan. North Carolina has created a separate State health insurance program to provide coverage to uninsured children whose family income does not exceed 200 percent of the Federal Poverty Level (FPL). Enrollees whose annual income increases above 200 percent of the FPL to 225 percent FPL will be allowed to buy into the program for one year at full cost.

- The State estimates that over 71,000 children will be eligible for health insurance in the State through Title XXI. Projected enrollment in the first year of the program's operation is 35,000.

Administration and Phases

- The program is being managed by the North Carolina Department of Health and Human Services (NCDHHS). Benefits and claims processing will be administered by the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (TSECMMP). Eligibility determinations will be made by local departments of Social Services.

Health Care Delivery System

- The delivery system is fee-for-service with some managed care options. Optional Prepaid Health Plans (health maintenance organizations) are available under TSECMMP, but require additional premium contributions. Should these plans choose to eliminate these additional premiums so they may participate in Title XXI, they will also be made available to enrollees. Under no circumstances will managed care plans participating in the Title XXI program be permitted to require beneficiary cost-sharing above the limits specified by statute.

Benefit Package

- Beneficiaries will receive the State employee benefit package provided through TSECMMP. Children identified as having special health care needs will receive an enhanced benefit package that provides Medicaid-equivalent benefits. Dental, vision, and hearing services are also provided.

- Children are guaranteed 12 months of continuous enrollment, unless the child receives other insurance coverage during this time period.

Cost Sharing

- There are no deductibles, copayments, or premiums for children whose family income is at or below 150 percent FPL.

- Children in families with incomes from 150 to 200 percent FPL will be required to pay a $50 enrollment fee for one child or $100 for two or more children.

- Families above 150 percent FPL will pay the following copayments: $6 for prescription drugs; $5 for physician visits, clinic visits, dental and optometry visits (with the exception of preventative services for which there will be no copayment); $5 for outpatient hospital visits; and $20 for non-emergency emergency room use.

- The Division of Medical Assistance will notify the TSECMM, through the eligibility information system, of the limit to the amount of family's copayment. This will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of the family's annual income. The TSECMMP will track the amount of copayments paid by a family and will notify the family when that limit has been met. This notification can then be taken by the family on visits to providers so that they are not charged further copayments.

State Action to Avoid Crowd-Out and Outreach Activities

- Eligibility determinations will be made by local departments of social services. Upon application, the existing Title XIX eligibility information system will be queried to ascertain if the child has Medicaid coverage. If not, the application will first be processed for Title XIX eligibility. Should the child be determined ineligible, then Title XXI eligibility will be pursued.

- Children are eligible for North Carolina's Title XXI program if they are uninsured. The State has defined uninsured as not having coverage under any private or employer-sponsored creditable health insurance plan for the six-month period immediately preceding the date the Title XXI program becomes effective. Six months after the program has been implemented, the definition of the term is modified to mean that the applicant has not had coverage for 60-days immediately preceding the date of the child's application. Exceptions will be made if the child has lost Title XIX eligibility due to a change in family income or the family has lost employer-sponsored coverage due to the termination of employment, cessation by the employer of employer-sponsored coverage, or cessation of the employer's business.

- Outreach will be coordinated at the State level through existing public/private partnerships, particularly through collaborative implementation efforts between local departments of health and social services. The statewide guidance for this effort will be provided through a committee co-chaired by the Division of Medical Assistance and the Division of Women's and Children's Health.

- The application process will be simplified through a series of initiatives including, a simplified application for both programs, decentralized enrollment through out-stationed staff, and application by mail.

Financial Information

First Year Costs (per the State's Budget):
Total CHIP allotment (1998) -- $79,528,899
Enhanced Federal Matching Rate -- 74.16%

First year costs:
Federal Share -- $44.8 million
State Share -- $15.6 million
Enrollment Fees -- $1.5 million
Total -- $61.9 million

OHIO XXI STATE PLAN

Background

- On December 23, 1997, Ohio submitted a Title XXI Plan for providing expanded benefits under the State's Medicaid Title XIX Plan. The State proposes to expand Medicaid eligibility to children up to age 19 from families with incomes at or below 150 percent of the Federal Poverty Level (FPL). Eligible children will receive the full Medicaid benefit package. All Medicaid program policies will apply.

- Ohio expanded eligibility on January 1, 1998.

Administration and Phases

- This expanded coverage for children will be administered as a Medicaid expansion. Outreach will be provided jointly through the Ohio Department of Health and the Ohio Department of Human Services.

- The State submitted 2 State Plan Amendments. The first amendment will expand Medicaid eligibility under section 1902(s)(10)(A) for optional targeted low-income children. The second amendment will expand coverage under section 1902 (accelerated SOBRA) and 1902(r)(2) for children who meet the income requirements for the expansion but who have creditable coverage. The State anticipates that the program will serve an additional 133,000 children.

- The State anticipates covering 133,000 children under the program.

Health Care Delivery System

- Care will be provided through the current fee-for-service delivery system for the Title XIX program. Once the State determines appropriate capitation rates, it may move new eligibles into the managed care delivery systems currently in place in 16 counties.

Benefit Package

- The current Medicaid benefit package will be provided.

Cost Sharing

- No cost sharing is proposed.

State Outreach Activities

- The State will utilize a number of measures to encourage eligible children to enroll, utilize, and stay in the health care system. These measures include:

- Surveying community agencies on how they conduct Medicaid eligibility outreach activities.

- Working with the Governor's Ohio Family and Children First initiative to improve Medicaid enrollment in Head Start program.
- Generating outreach ideas and sharing best practices in dialogue sessions with local groups.
- Developing media strategies for statewide education to Medicaid consumers and providers.
- Identifying age specific strategies based on different service utilization patterns of different age groups.
- Coordinating CHIP outreach efforts with welfare reform outreach activities.

Financial Information

Total CHIP allotment -- $115,764,112
Enhanced Federal matching rate -- 70.70%

First year costs:
State share -- $27,129,485
Federal share -- $65,462,612
Total -- $92,592,097

OKLAHOMA TITLE XXI STATE PLAN SUMMARY

Background

- On January 23, 1998, Oklahoma submitted a Title XXI State Plan to expand health insurance coverage to uninsured children through an expansion of the State's Title XIX Medicaid program, effective on December 1, 1997. Oklahoma proposes using title XXI to provide Medicaid coverage to children born on or after October 1, 1983 and pregnant women with family incomes at or below 185 percent of the Federal Poverty Level (FPL).

- This legislation is intended to utilize the State's Medicaid managed care programs as vehicles to expand health care coverage to this group. This expansion has the potential to increase eligibility to over 100,000 children and 4,000 pregnant women Statewide.

Administration and Phases

- This expanded coverage for children and pregnant women will be administered by the Oklahoma Health Care Authority.

- In an effort to increase participation in the program, a simplified application will be available to this group. In addition, face-to-face interviews as well as the asset test will be eliminated. Applications for the expanded program will be available at a wide variety of locations, including the Department of Human Services county offices, County Health Departments, WIC offices, public libraries, and school systems.

Health Care Delivery System

- Those eligible under the plan will enroll in either SoonerCare Plus (the State's HMO delivery system) or SoonerCare Choice (the State's Primary Care Case Management Program), depending on where they live. Information detailing where each program is offered will be provided with the application.

Benefit Package

- The Medicaid benefit package will be provided.

Cost Sharing

- Medicaid rules will apply

State Action to Avoid Crowd-Out

- The State will develop and implement a statistically-valid survey instrument to survey certain Medicaid beneficiaries in order to determine whether or not they **voluntarily** dropped existing private health insurance coverage due to the availability of publicly-funded CHIP coverage.

- Beneficiaries the State will survey will include children who: 1) enrolled on or after December 1, 1997, 2) were determined to be eligible at the State's new (higher) income eligibility standard, and 3) had no Third Party Liability indicator on their Medicaid application.

- Subsequently, the State will modify the "Simplified" Medicaid Application form in order to be able to collect and analyze data specific to any "previous health insurance coverage" which the Title XXI beneficiaries may have had prior to their application for Oklahoma Medicaid.

Outreach Activities

- The Oklahoma Health Care Authority is collaborating closely with the Department of Human Services, The Oklahoma Commission on Children and Youth, the Oklahoma State Department of Health, and the State Department of Education to develop and implement a comprehensive marketing and outreach plan.

- The marketing and outreach plan will consist of posters, postcards, public service announcements, fact sheets, press releases, and outdoor advertising. Though the major focus of the outreach campaign targets the uninsured population, it is hoped that these messages will also reach those currently eligible for medical services who are not participating.

Financial Information

Total CHIP Reserved allotment -- $81,568,137
Enhanced Federal Matching rate -- 79.36%
First year costs:
State share -- $3,766,456
Federal share -- $11,051,069
Total -- $14,817,525

OREGON'S TITLE XXI STATE PLAN SUMMARY

Background

- On March 2, 1998, Oregon submitted a Title XXI State Plan to expand insurance coverage to infants and children utilizing the Prioritized List of Services in the State's current managed care delivery system as approved under the State's existing section 1115 Medicaid waiver.

- The State is proposing to use Title XXI enhanced matching funds to provide services to children from birth to age 6 with incomes between 133 percent and 170 percent of the FPL and to children from age 6 to age 19 with incomes between 100 percent and 170 percent of the FPL.

- The State is proposing an effective date of July 1, 1998.

Administration

- The program will be administered by the State's Office of Medical Assistance Programs within the Department of Human Resources.

Children Covered Under Program

- The State is proposing to enroll approximately 17,000 children in its CHIP program by July 1, 1999.

Health Care Delivery System

- The State will utilize its current section 1115 Medicaid managed care delivery system, entitled the Oregon Health Plan (OHP), to deliver services to the expansion population. The delivery system is comprised of prepaid health plans (PHPs) and primary care case managers (PCCMs).

Benefit Package

- The State's benefit package will be based on the OHP Prioritized List of Health Services which is a modified Medicaid benefit packaged as allowed under Oregon's section 1115 Medicaid demonstration waiver for their entire Medicaid population. Medically necessary services are defined in the

Prioritized List.

- The comprehensive benefit package will include medically necessary inpatient and outpatient services; physician services; surgical services; clinic services; prescription and over the counter drugs; lab and x-ray services; prenatal and pregnancy services and supplies; inpatient and outpatient mental health services; durable medical equipment which may include, prosthetic devices, eyeglasses, hearing aids, and dental devices; disposable medical supplies; home and community-based health care services; nursing care services; dental services; inpatient and outpatient substance abuse treatment services; case management services for targeted populations; physical and occupational therapy; hospice care; medical transportation; and enabling services.

Cost Sharing

- There will be no premiums or deductibles for enrollees

State Action to Avoid Crowd-Out

- The State's eligibility determination and enrollment process will be coordinated with the OHP Medicaid application process. The existing OHP application will be amended to capture information to determine if the applicant is eligible for Medicaid or CHIP.

- The applications will first be reviewed for OHP Medicaid eligibility. If the application does not meet Medicaid criteria, then it will be processed to determine CHIP eligibility.

- The State will also screen for access to creditable health coverage other than Medicaid.

- The State will evaluate their crowd-out policy in the future by looking at the increase in the percentage of Medicaid-eligible children enrolled in Medicaid and the reduction in the percentage of uninsured children.

Outreach Activities

- The State will convene a task force of public and private partners to develop a consolidated Medicaid and CHIP outreach plan. To inform this effort, the State will have an outreach conference comprised of representatives from around the State to identify geographic and cultural communities on which to focus the outreach efforts. It is also expected that the conference will generate ideas for general and specific outreach activities.

Financial Information
Total CHIP Reserved Allotment --$39,131,718
Enhanced Federal Matching Rate --73.02%

First Year Costs (FY 98)
Federal Share --$1,476,891
State Share --$563,295
Total --$2,040,186

Second Year Costs (FY 99)
Federal Share --$15,749,082
State Share --$6,006,798
Total --$21,755,880

PENNSYLVANIA TITLE XXI STATE PLAN SUMMARY

Background

- On November 4,1997, Pennsylvania submitted a Title XXI State Plan which expands coverage to children within the existing Pennsylvania Children's Health Insurance Program (PA CHIP), implemented in May 1993. Pennsylvania is one of three states whose comprehensive benefit package was cited by Title XXI, section 2103(a)(3), as having sufficient coverage to meet the requirements for a State Child Health Insurance Plan. PA CHIP's Title XXI program will provide coverage to uninsured children through age 16 in families with incomes at or below 185 percent of the Federal Poverty Level (FPL).

- The current State program serves approximately 55,000 children. In anticipation of federal funding, approximately 1,500 children, who comprised the CHIP program waiting list, were enrolled in the program on October 1, 1997. Enhanced matching will be provided as of the effective date of the State's enacting legislation, which is anticipated by the end of June.

Administration and Phases

- The program is administered by the Commonwealth and overseen by a Management Team comprised of three members of the Governor's cabinet: the Insurance Commissioner, the Secretary of Health, and the Secretary of the Governor's Budget Office. Additionally, there is a Children's Advisory Council, chaired by the Secretary of Health. Membership on the Council includes the Secretary of Health, the Secretary of Public Welfare, the Insurance Commissioner, members of the Pennsylvania General Assembly, representatives from health care provider groups and a parent of an enrolled child. Its primary function is to oversee outreach activities.

- PA CHIP is considered to be the starting point for Title XXI. The State is planning on using feedback from a series of public forums, stakeholder discussion series, the Pennsylvania General Assembly, children and parents to analyze program options and provide the outline for the future development of Pa CHIP. Pennsylvania anticipates having 63,000 children enrolled in this program by the end of SFY 1999 (This 63,000 figure includes 55,000 children who were previously enrolled in Pennsylvania's state-only program.)

Health Care Delivery System

- PA CHIP is a statewide program with services provided through contracts with five health insurance companies. One is a state-licensed HMO, while the other four are non-profit subsidiary foundations of large health insurance providers that offer a range of managed care and fee-for-service products. Pa CHIP purchases coverage through a managed care model. Less than five percent of enrollees in rural areas do not have access to managed care programs and are served through fee-for-service.

Benefit Package

- The benefit package is the existing PA CHIP benefit package that includes a full range of inpatient and outpatient services. Inpatient hospitalization up to 90 days is covered; outpatient services; physician services; surgical services with the exception of cosmetic surgery; clinic services; prescription drugs; laboratory and radiological services; inpatient mental health services up to 90 days; outpatient mental health services up to 50 visits per year; durable medical equipment and remedial devices; home and community-based health care services; nursing care services; abortion to save the life of the mother or if the pregnancy is the result of rape or incest; dental services; case management; physical, occupational, and speech therapy; hospice care; and ambulance services when medically necessary.

- Children are guaranteed a minimum 12 months of coverage.

Cost Sharing

- There is no cost sharing.

State Action to Avoid Crowd-Out and Outreach Activities

- Pennsylvania requires that children be totally uninsured and ineligible for Medicaid to be eligible for PA CHIP. Participating contractors have the capacity to compare eligible families to their own company subscribers to verify whether the family has private or employer sponsored coverage.

- PA CHIP will eventually utilize a common application form for S-CHIP and Medicaid. Prior to implementation of this form, an insert will be added to existing CHIP applications to request additional information regarding income to assure that children are not enrolled in S-CHIP when they may be eligible for Medicaid.

- The State will conduct an annual analysis of crowd-out by asking potential enrollees questions regarding previous insurance coverage. Should the data indicate that 12 percent of the enrolled children are "crowd-out" children, the State will prepare an analysis to examine possible eligibility criteria options that may include, but not be limited to, implementing a waiting period prior to coverage by S-CHIP and denying coverage to children whose families have access to employer-based coverage in which the employer pays at least 50 percent of the cost of premiums. Following this analysis, the State will identify appropriate option(s) and will administratively implement corrective measures as possible for preventing crowd-out. If legislative changes are necessary to implement these corrective actions, the Governor will seek the passage of legislation.

- Each of the five health insurance companies under contract provide a range of outreach activities. Outreach activities include canvassing local businesses, day care centers, school

districts, hospitals, providers, legislative offices, religious organizations and churches, social service agencies, unions, and civic groups. Linkages to the Health Department's Maternal Child Health and other programs such as WIC and Special Needs programs, and the State's Medicaid programs have been developed to promote the Pa CHIP.

Financial Information

Total CHIP Reserved Allotment -- $117,486,712
Enhanced Federal Matching Rate 67.37%
First Year Costs :
Federal Funds $ 50.2 million
State Funds $ 24.3 million
Total $ 74.5 million

PUERTO RICO TITLE XXI PLAN SUMMARY

Background

- On March 30, 1998, Puerto Rico submitted a Title XXI Plan to expand benefits under the Medicaid plan. Many of the children that will be enrolled in Puerto Rico's Title XXI program are currently covered under Puerto Rico's public health system, which existed prior to July 1997 and receives no Federal funding.

- Puerto Rico's Title XXI program will provide coverage for children through age 18 with family income at or below 200 percent of the Commonwealth Poverty Level.

- Puerto Rico anticipates an average monthly enrollment of 165,411 by the end of FY 1998. Of these children, 91,125 are currently enrolled in Puerto Rico's public health system and 74,268 will be newly enrolled. Of the 165,411 estimated children to be enrolled, approximately 20,000 will be covered by the Federal CHIP allotment.

- The effective date of Puerto Rico's program is January 1, 1998.

Administration

- The Title XXI Program will be administered by the Department of Health, which also administers the Title XIX Program.

Health Care Delivery System

- Health services to children under Puerto Rico's Title XXI Plan will be delivered through a managed care insurance product and through the public health system in non-reform areas.

Benefit Package

- The package of services for the Title XXI program is the same benefits package currently provided through Puerto Rico's Medicaid program. The benefit package includes, but is not limited to: preventive ambulatory services, surgical, hospitalization, maternity, mental health, prescription drug services, dental, emergency room, rehabilitation, ambulance, laboratory testing and catastrophic coverage, including AIDS, TB, Cardiovascular, Cancer, Neonatal, and Intensive Care.

Cost Sharing

- There are no cost sharing requirements.

Commonwealth Action to Avoid Crowd-Out

- Puerto Rico will monitor for crowd-out by asking applicants about previous health insurance coverage. If crowd-out is determined to be a problem, Puerto Rico will develop a strategy to discourage crowd-out.

Outreach Activities

- A number of outreach efforts will be developed. The Puerto Rico Department of Health will develop a broad-based media campaign that will include public service announcements and press releases as a direct appeal to eligible children and families. These will be made available in simple, readable Spanish language, the main language in Puerto Rico. In addition, brochures, leaflets and posters that provide information on Title XXI services will be created and disseminated.

Financial Information

Total CHIP allotment -- $9,835,550
Enhanced Federal matching rate -- 65%

First Year Costs (January 1, 1998 through September 30, 1998)
State share -- $5,296,065
Federal share -- $9,835,550
Total -- $15,131,615

RHODE ISLAND TITLE XXI STATE PLAN

Background

- On January 5, 1998, the Rhode Island Department of Human Services submitted a Title XXI State Plan to expand its Medicaid program. The State's current Medicaid Section 1115 waiver program, entitled "RIte Care," was amended, effective May 1, 1997, to include this population. Rhode Island's Medicaid expansion will cover uninsured children between the ages of eight and eighteen in families with incomes up to 250 percent of the Federal poverty level (FPL) as specifically allowed for under the law. The following groups are eligible for enhanced matching payments under Rhode Island's Title XXI program: 1) children between the ages of 8 and 15 with family incomes between 100 percent and 250 percent of the FPL and 2) children between the ages of 15 and 18 with family incomes up to 250 percent of the FPL. The State estimates that there will be an average monthly enrollment of 3,000 children in their CHIP program.

Administration and Phases

- This expanded coverage will be administered by RIte Care.

- This expansion has been accomplished under an approved amendment to Rhode Island's Medicaid Section 1115 waiver, RIte Care, which was explicitly addressed in the Title XXI law. The program was implemented on May 1, 1997, and the State will receive enhanced match beginning on October 1, 1997.

Health Care Delivery System

- The State will contract with licensed Health Maintenance Organizations (HMO) for a comprehensive benefit package for the targeted low-income children.

Benefit Package

- The licensed HMOs will be Health Plans participating in RIte Care and the comprehensive benefit package will be the RIte Care benefit package.

Cost Sharing

- Individuals with family incomes between 185 and 250 percent of the FPL are subject to cost-sharing on a sliding scale, consistent with Title XXI standards.

State Actions to Avoid Crowd-Out and Outreach Activities

- In order to avoid crowd out, eligible children must be uninsured, and not have refused or dropped insurance coverage which have cost less than $150 per month in premiums per individual or $300 per month in premiums per family within one year prior to application.

- To effectively reach the target population, multiple outreach methods will take place. The first phase of outreach, a public information campaign, will last four months. The second phase of outreach will include follow-up and evaluation activities which will last approximately six months. The entire outreach plan will last ten months.

- The types of outreach activities that will occur include targeted mailings, distribution of materials to every school-age child in the State, using the print media, the Internet, piggy back mailings, public service announcements, television and radio interviews and a press conference.

- The State also has outreach activities planned for its non-English speaking populations including translating all print materials that are available to the general public into Spanish.

Financial Information

Total CHIP Reserved Allotment -- $10,687,168
Enhanced Federal Matching Rate -- 67.22%
First Year Costs:
State Share -- $907,186
Federal Share -- $1,860,314
Total -- $2,767,500

SOUTH CAROLINA TITLE XIX STATE PLAN AMENDMENT AND TITLE XXI STATE PLAN

Background

- On December 8, 1997, South Carolina submitted a Title XIX State Plan Amendment and a Title XXI State Plan for providing expanded benefits under the South Carolina Medicaid Agency's Title XIX Plan. South Carolina proposes using title XXI to provide Medicaid coverage to children who are under age 19 with family incomes at or below 150 percent of the Federal Poverty Level (FPL).

- The State began providing coverage to these children under their existing Medicaid program effective retroactive to August 1, 1997. South Carolina has submitted a Title XIX State Plan Amendment which requests approval to cover these children as Optional Targeted Low Income Children, using Title XXI funds, and to implement the option to provide 12-month continuous eligibility for Medicaid benefits to this group. The effective date for these changes is retroactive to October 1, 1997.

Administration and Phases

- This expanded coverage for children will be administered by the South Carolina Department of Health and Human Services.

- Initially, the State has elected to use Title XXI funds to expand Medicaid benefits to children up to 150 percent of the FPL. South Carolina anticipates submission of a plan amendment next year which will address how the State will approach children's health insurance for other low-income children at slightly higher levels of poverty.

- The State anticipates coverage of 75,000 new children.

Health Care Delivery System

- The existing Medicaid delivery system will be used to provide services.

Benefit Package

- The Medicaid benefit package will be provided.

Cost Sharing

- Medicaid rules will apply. There will be no cost-sharing for children.

State Action to Avoid Crow-Out and Outreach Activities

- Title XXI funds are being used to provide expanded eligibility up to 150 percent of the FPL under the State's Medicaid program. During the application process, potential beneficiaries will be asked about their current health insurance status. The State will continue to study crowd-out issues.

- Existing Medicaid outreach activities such as utilizing out-stationed eligibility workers will be focused on this group. In addition, a more comprehensive outreach effort will be implemented. Initial steps in that outreach involve a series of press conferences by the Governor and information outreach brochures developed by the Southern Institute on Children and Families, as well as, public service announcement and other efforts.

- A revamped application process, which is more accessible and "user friendly", is also part of the outreach activity. The application packages are being distributed through public schools, local offices of six related public agencies, health clinics (including FQHCs), pediatricians' and other primary care physicians' offices, pharmacies and state legislators' offices across the State.

Financial Information

Total CHIP Allotment -- $63.5 million
Enhanced matching rate -- 79.16%

First year costs:
State Share -- $6.5 million
Federal Share -- $24.6 million
Total -- $31.1 million

SOUTH DAKOTA TITLE XXI PROGRAM
FACT SHEET

Name of Plan: South Dakota Medicaid Expansion

Date Plan Submitted: June 5, 1998

Date Plan Approved: August 25, 1998

Effective Date: July 1, 1998

Background

- On June 5, 1998, South Dakota submitted a Medicaid-expansion proposal to implement Title XXI. South Dakota's current Medicaid program covers children ages 0-5 in families with incomes up to 133 percent of the Federal poverty level (FPL) and children ages 6-18 in families with incomes up to 100 percent of the FPL.

- The state will expand Medicaid eligibility to cover children ages 6 - 18 in families with incomes between 100 percent to 133 percent of Federal Poverty Level (FPL). This will result in seamless coverage for all children in families with incomes below 133 percent of the FPL.

Administration

- Eligibility will continue to be the responsibility of the Department of Social Services (DSS) and only DSS staff will be making eligibility determinations.

- The State began enrollment on July 1, 1998, and expects to enroll 7,352 children in its first year. South Dakota expects to increase enrollment by 5 percent each year thereafter.

Health Care Delivery System

- Most persons enrolled in Medicaid in South Dakota participate in PRIME, a 1915(b) waiver the state has operated since 1993. Each participating individual must choose a primary care provider, who in turn refers for specialty services, provides case management and 24-hour access. Rural health clinics, FQHCs and IHS clinics participate as primary care providers.

Benefit Package

- PRIME waiver services include, but are not limited to: EPSDT, physicians' services, inpatient and outpatient hospital services, prescription drugs, mental health and other medical services. Emergency services, family planning, dental, vision, chiropractic, nursing facility and other specialized services are not included in the managed care program and are provided on a fee for service basis.

Cost Sharing

- There is no cost sharing.

State Action to Avoid Crowd-Out

- In addition to verification of income, an eligibility screening will be completed to detect the presence of other insurance coverage. A key advantage of Medicaid expansion for CHIP is that children who would otherwise be turned away from coverage because of the existence of another, non-comprehensive, or high deductible insurance policy, will still be eligible for Medicaid at regular FMAP. Third party liability and benefit coordination for those children will insure that private dollars continue to be used for the health care costs of children.

- Families with private insurance and Medicaid eligible children will be encouraged to retain private insurance to ensure maximum coverage for the children and to avoid crowding-out private insurance resources.

- The State will monitor crowd-out through the Behavioral Risk Factor Surveillance System survey and through its third party liability system.

Outreach Activities

- The Department of Social Services has widespread availability with 41 full time and 22 itinerant offices staffed by DSS eligibility staff. Additionally, applications for Medicaid are available at each Disproportionate Share Hospital and FQHC participating in Medicaid.

- The state operates many programs that provide benefits to children. The Medicaid program has entered into a number of partnerships with these programs to extend Medicaid to low-income children. South Dakota has general eligibility workers who work with the Medicaid, Food Stamp and TANF programs and the Department has a combined, automated eligibility system for these programs to allow shared information and communication. Child protective services also assists families and individuals obtain Medicaid. Community Health Services offers high-risk pregnant women assistance with

Medicaid eligibility. The Children's Special Health Services Program and WIC have referral mechanisms to identify and enroll eligible children, which includes three tribally operated WIC programs on Indian reservations.

- Each Indian Health Service location is an enrolled Medicaid service provider and the physicians employed by IHS are primary care case managers. Each IHS Service Unit has procedures in place to verify Medicaid eligibility and allow referral to DSS for application and eligibility determination.

- Statewide outreach will involve identifying eligible children and mailing applications directly to families for completion. The state also plans personnel training at DSS and the hiring of additional people to assist in outreach and the processing of applications.

- A new shorter Medicaid application will be used by both Medicaid and CHIP children, and such applications will be accepted by mail.

- Local outreach to identify and enroll children will be made through DSS's Child Care Services and Child Support Enforcement programs.

Financial Information

CHIP allotment FY 1998 -- $7,538,311
Enhanced Federal matching rate -- 77.43%

Fiscal Year 1998 (July 1, 1998-September 30, 1998)
Federal Share $1,246,710
State Share $ 363,402

Fiscal Year 1999
Federal Share $4,986,840
State Share $1,453,609

approved June

TEXAS TITLE XXI FACT SHEET

Background

- On April 1, 1998, Texas submitted its Title XXI Plan, which will expand Medicaid eligibility to children between the ages of 15 and 18 in families with incomes below 100 percent of the Federal Poverty Level (FPL). All Medicaid policies will apply.

- Texas intends to implement its CHIP program on July 1, 1998.

- Texas currently provides Medicaid coverage to children up to age 1 to in families with incomes up to 185 percent of the FPL, children ages 1 to 5 in families with incomes up to 133 percent of the FPL, children ages 6 to 14 up to 100 percent of the FPL and children ages 15 to 19 up to 47 percent of the FPL.

Administration and Phases

- The State is studying options to further expand coverage to additional low-income families and to provide additional low-income children with access to health insurance. The State expects to submit an amendment to their CHIP program sometime in 1999.

Children Covered Under Program

- The State anticipates covering 57,488 children by FY 2000.

Health Care Delivery System

- Care will be provided through the current delivery system for the State's Medicaid program.

Benefit Package

- Eligible children will receive the full Medicaid benefit package currently provided by the State.

Cost Sharing

- There is no cost sharing.

Crowd Out Strategy and State Outreach Activities

- Texas will be monitoring enrollment in the program to determine the existence, if any, of crowding-out of private coverage.

- The State will utilize a number of mechanisms to identify and enroll eligible children in the health care system. These measures include:

    - EPSDT outreach workers will contact families to assist in getting EPSDT screens and services. The outreach workers will also talk with them about the potential eligibility of children ages 15-18.

- The State plans to work closely with the entire network of public health providers to disseminate outreach materials to providers so that they may supply information to families with potentially eligible children.

- The State will conduct home visits and both face-to-face and telephone interviews in approximately 500 local offices of the Texas Department of Human Services (TDHS).

- TDHS eligibility workers will be outstationed in clinics and hospitals.

- The State will provide referral services to potentially eligible individuals who make benefit inquiries when telephoning the State's TDHS Hotline.

- The State will publicize the program in government blue page listings in local telephone books and Worldwide Web Sites.

- Applicants for food stamps and Temporary Assistance to Needy Families will be screened for potential Medicaid eligibility.

Financial Information

Total CHIP Allotment --$561,475,805
Enhanced Federal Matching Rate --73.6%

First Year Costs (FFY 98):
Federal Share -- $7,213,522
State Share -- $3,362,411
Total --$10,575,933

UTAH TITLE XXI STATE PLAN SUMMARY

Background

- On April 2, 1998, Utah submitted a Title XXI proposal which would create a separate State health insurance program to expand coverage to children. The State proposes to provide coverage for children under the age of 19 in families with income at or below 200 percent of the Federal Poverty Level (FPL).

Administration and Phases

- The Utah Department of Health will administer the Utah Children's Health Insurance Program. The Division of Health Care Financing, within the Department of Health, will contract with the managed care organizations and purchase services from the health care providers.

- The State anticipates covering 21,000 children by FY 2000.

Health Care Delivery System

- Health services in the urban areas (Davis, Salt Lake, Utah and Weber counties) will be delivered by managed care organizations (MCO's). The State currently contracts with six MCO's for its Medicaid population.

- Health services in the rural areas (all other counties) will be delivered by providers on a fee-for-service basis. The State shows that nearly 100% of family and general practitioners and pediatricians participate in its Medicaid program and expects the same rate of participation for its CHIP program.

Benefit Package

- Utah will offer benchmark-equivalent coverage. The State's plan includes an actuarial analysis comparing the benefit package to the benefit plan provided to the employees of the State of Utah.

- The benefit package will include inpatient hospital; outpatient hospital; emergency department services; physician services; vision care; lab and radiology services; physical therapy and chiropractic; hearing services; podiatry services; end-stage renal disease dialysis; home health services; speech therapy; hospice services; durable medical equipment and supplies; abortions and sterilizations as permitted

by law; organ transplants; other outside medical services at the Health Plan's discretion; ambulance transportation; preventive services; family planning services; pharmacy services; mental health and substance abuse treatment; and dental services.

Cost Sharing

- There will be no premiums or enrollment fees charged to families. Utah is proposing two cost-sharing schedules:

  For families with incomes from 100% through 150% of FPL, the State proposes a cap of $500 or 5 percent of family income, whichever is lowest, per family per year out-of-pocket maximum. Copays are as follows:

  - $5 copay for an emergency room visit for emergent reasons
  - $10 copay for an emergency room visit for non-emergent reasons
  - $5 copay for outpatient office visits (no copay for well-baby care, well-child care and immunizations)
  - $2 copay for prescription drugs

  For families with incomes from 151% through 200% of FPL, the State proposes a cap of $800 or 5 percent of family income, whichever is lowest, per family per year out-of-pocket maximum. Some copays are as follows:

  - $30 copay for emergency room visit
  - 10% coinsurance for hospital services
  - $10 copay for outpatient office visits (no copay for well-baby care, well-child care and immunizations
  - $4 copay for generic and brand name prescription drugs on an approved list
  - 50% coinsurance for brand name drugs not on an approved list
  - No copay for laboratory services under $50 and x-ray services under $100
  - 10% coinsurance for laboratory services over $50 and x-ray services over $100
  - Vision and hearing screening services are covered at 100% of an allowed amount up to $30
  - 10% coinsurance for first 10 days of inpatient mental health services; 50% coinsurance for next 20 days of inpatient mental health services

- The State has a mechanism to ensure that once a family reaches their out-of-pocket maximum that the family may cease paying further copayments and coinsurance.

- The State will provide a quarterly report to families on out-of-pocket expenses incurred. Providers will be notified when a family has reached their out-of-pocket maximum. If a family incurs expenses that exceed the out-of-pocket maximum, the State will reimburse the family.

State Action to Avoid Crowd-out

- The application will request information about health insurance coverage for the children in the household. Every CHIP application will be going through the Medicaid eligibility determination process to determine if the child qualifies for Medicaid.

- A child will be found ineligible if the child is eligible for Medicaid (except for the Medically Needy program with an unmet spenddown); if the child is found to have access to insurance coverage or is already covered by a group health plan or other health insurance; or if the child has been voluntarily terminated from health insurance coverage within the three months prior to the application date for coverage under CHIP.

Outreach Activities

- The State will utilize many strategies to identify and enroll eligible children. These include:

    - Computer match of families already on Medicaid who have children without coverage and of families receiving child care assistance without Medicaid.
    - Medicaid eligibility workers already in place in over 98 locations will determine Eligibility for CHIP. These eligibility determination sites are located in hospitals, community health centers, local health departments, Department of Workforce Services offices and many other allied agencies.
    - Identify potentially eligible children through allied agencies, church groups, schools, hospitals, early intervention programs, Children With Special Health Care Needs Clinics and the Department of Workforce Development.
    - Disseminate information through community presentations, press coverage, toll-free telephone lines, brochures, flyers and postcards. Information will be disseminated by housing assistance organizations, hospitals, medical care sites, community-based organizations, employers not offering health insurance existing Medicaid outreach campaigns.

Financial Information

Total CHIP allotment --$24,247,390
Enhanced Federal matching rate --80.81%

First year costs:
State Share --$1,857,716
Federal Share --$7,615,593
Total --$9,473,309

WEST VIRGINIA TITLE XXI PROGRAM
FACT SHEET

Date Plan Submitted: June 18, 1998

Date Plan Approved: September 15, 1998

Effective Date: July 1, 1998

Background

- On June 18, 1998, West Virginia submitted its CHIP plan which will expand Medicaid eligibility for children between the ages of 1 and 5 in families with incomes up to 150 percent of the federal poverty level (FPL).

- West Virginia's current Medicaid program covers children up to age one in families with incomes up to and including 150 percent of the FPL, children ages one to six in families with incomes up to 133 percent of the FPL, and children ages six to 19 in families with incomes up to 100 percent of the FPL.

Administration

- As a Medicaid expansion the program will be administered by the same agency that administers the Medicaid program, the Bureau of Medical Services within the Department of Health and Human Resources.

- The current expansion represents Phase I of West Virginia's Children's Health Insurance Program. Phase II is currently in the planning stage.

Health Care Delivery System

- The delivery system for the Medicaid expansion will be the current Medicaid delivery system, which consists of both a mandatory HMO program and a mandatory primary care case management (PCCM) program. The HMO program is operational in 9 counties, the State will begin to offer services in six additional counties on October 1, 1998. The PCCM program is operational in all other counties.

Benefit Package

- The benefit package will be the current Medicaid benefit package.

Cost Sharing

- There will be no cost sharing.

Crowd-Out Strategy

- Eligibility determination will be the same for both the Title XXI expansion population and the Medicaid population. Prior coverage information will be obtained on the application

form and through applicant interviews.

Outreach Activities

- West Virginia currently outstations eligibility workers in selected hospitals, federally qualified health centers, and rural health clinics throughout the State. This effort will be refined to target children who may be eligible for Title XXI services. In addition, trained eligibility workers will be available at other sites around the State, such as schools and pediatric clinics.

- The state will also include information on Medicaid and Title XXI in all free or reduced lunch and textbook application, and the State's toll-free 24-hour hotline will include information on the Children's Health Insurance Program.

- The State has developed a simplified application form and will be expanding the sites where applications are available, such as libraries, churches, community centers, retail centers, etc. The new application is also provided in a self-mailing form.

- The State Department of Health and Human Resources is also working closely with the West Virginia Children's Health Coalition to focus on special outreach at the community level to children in rural areas and minority children in inner-city schools. Special outreach efforts will also include education of provider groups, child support enforcement workers, legal aid staff, and others.

Financial Information

Total CHIP Allotment -- $23,724,858
Enhanced Federal Matching Rate -- 81.57%

First Year Costs:
State Share -- $139,327
Federal Share -- $616,654
Total -- $755,981

WISCONSIN XXI STATE PLAN

FACT SHEET

Background

- On March 13, 1998 Wisconsin submitted a Title XXI Plan to expand Medicaid eligibility under Title XXI to children ages 15-18 in families with incomes below 100 percent of the Federal Poverty Level (FPL). Presently, the State covers Medicaid children under age 6 in families with incomes less than 185 percent of the FPL, and children ages 6-14 in families with incomes less than 100 percent of the FPL.

Children Covered Under Programs

- The State anticipates covering 2,000 children during the first year of this plan. The State also plans to amend this plan to expand coverage to additional uninsured children.

Health Care Delivery System

- Care will be provided through the current managed care delivery system for the Title XIX program.

Benefit Package

- The current Medicaid benefit package will be provided.

Cost Sharing

- No cost sharing is proposed.

State Action To Avoid Crowd-out and Outreach Activities

- The State will conduct various surveys and other studies on changes in the scope and extent of employer-based health insurance.

- The State will utilize a number of measures to encourage eligible children to enroll, utilize, and stay in the health care system. These measures will include:

  - expansion of school based clinics in 12 Milwaukee public schools in collaboration with Medicaid managed care Health Maintenance Organizations (HMOs);

  - funding of public health agencies to conduct outreach activities in coordination with schools, and

- inclusion of schools as potential outstation sites for eligibility workers.

Financial Information

Total CHIP Allotment -- $ 38,475,831
Enhanced Federal Matching Rate -- 71.19%

CY 1998 (6 months)
--Federal Share (Phase I)* ---- $1,084,672
--State Share (Phase I) ---- $438,958
--Total (includes 10% adm. costs) ---- $1,675,993

CY 1999
--Federal Share (Phase I) ---- $1,815,023
--State Share (Phase I) ---- $734,167
--Total (includes 10% adm. costs) ---- $2,804,109

CY 2000
--Federal Share (Phase I) ---- $1,306,000
--State Share (Phase I) ---- $528,270
--Total (includes 10% adm. costs) ---- $2,017,697

CY 2001
--Federal Share (Phase I) ---- $773,061
--State Share (Phase I) ---- $312,699
--Total (includes 10% adm. costs) ---- $1,194,336

CY 2002
--Federal Share (Phase I) ---- $215,594
--State Share (Phase I) ---- $87,206
--Total (includes 10% adm. costs) ---- $333,080

*Phase I refers to the expansion of coverage to children ages 15-18 in families with incomes under 100% of the Federal poverty level (FPL). In addition, the State has submitted a Phase II plan for approval that would further extend CHIP coverage.