

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

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

State/Territory: OHIO

(Name of State/Territory)

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

Barbara Sears, Director, Ohio Department of Medicaid

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

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

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

Name: Barbara Sears

Position/Title: Director, Ohio Department of  
Medicaid

Name: Ogbe Aideyman

Position/Title: Chief, Bureau of Health  
Plan Policy

Name: Icilda Dickerson

Position/Title: Chief, Bureau of  
Long Term Services  
and Supports

\*Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information

collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**Introduction:** Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children’s Health Insurance Program (CHIP). In February 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

**Federal Requirements for Submission and Review of a Proposed SPA.** (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a “clean” copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children’s Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state’s program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children’s Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage;

benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

**Program Options.** As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

#### **Medicaid Expansion- CHIP SPA Requirements**

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

#### **Medicaid Expansion- Medicaid SPA Requirements**

States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child

health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer  
Centers for Medicare & Medicaid Services  
7500 Security Blvd  
Baltimore, Maryland 21244  
Attn: Children and Adults Health Programs Group  
Center for Medicaid and CHIP Services  
Mail Stop - S2-01-16

**Section 1. General Description and Purpose of the Children’s Health Insurance Plans and the Requirements**

**1.1.** The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

**1.1.1.**  Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State’s Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

**1.1.2.**  Providing expanded benefits under the State’s Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

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

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

Effective April 1, 2010, the State participated in the performance bonus payment options under Section 104 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, for FFY 2009-2013 by providing for the following:

- 1) Use of the same application and renewal forms for Medicaid and CHIP,
- 2) Elimination of the asset test,
- 3) Elimination of the in-person interview,
- 4) Continuous eligibility for children, and
- 5) Presumptive eligibility for children under section 1920A of the Social Security Act for children identified under Section 1902(a)(10)(A) of the Social Security Act.

Effective January 1, 2014 the State began using Modified Adjusted Gross Income (MAGI) for determining eligibility for children as a result of the Affordable Care Act



(ACA) of 2010. A new eligibility system was created to support MAGI eligibility determinations and to streamline the application and approval process.

As of February 2015 passive renewals for eligibility determinations began to comply with the ACA requirements for MAGI categories of Medicaid.

The State's new eligibility system allows for better identification of children eligible for Medicaid via CHIP, so they can be reported separately from children eligible for Medicaid. This allows CHIP eligible children (optional targeted low-income children) to be reported and claimed at an enhanced rate, and other new eligibles to be reported and claimed at the state's standard FMAP.

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

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

**1.1.3.**  A combination of both of the above. (Section 2101(a)(2))

**1.1-DS**  The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

**1.2.**  Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

**1.3.**  Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice

the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

- 1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan

Effective Date: January 1998

Implementation Date: January 1998

SPA #OH-17-0038 Purpose of SPA: CHIP and Lead Hazard Control Activities

Proposed effective date: July 1, 2017

Proposed implementation date: July 1, 2017

- 1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

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Ohio's CHIP MAGI SPAs:

TN No: Approval Date Effective Date

OH-14-0011, Approved 8/21/14, Effective 1/1/14

SPA Group: XXI Medicaid Expansion

PDF #: CS3

Description: Eligibility for Medicaid Expansion Program

Superseded Plan Section(s): Supersedes the current Medicaid expansion section 4.0

OH-14-0012, Approved 8/21/14, Effective 1/1/14

SPA Group: Establish 2101(f) Group

PDF #: CS14

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

Superseded Plan Section(s): Incorporated within a separate subsection under section 4.1

- Section 2. **General Background and Description of Approach to Children's Health Insurance Coverage and Coordination**

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

**2.1.** Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified, by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

The table below shows trends in the three-year averages for the number and rate of uninsured children in Ohio based on the Current Population Survey (CPS), along with the percent of change from 1996-1998 through 2010-2012.

Period	Uninsured Children Under  Age 19 Below 200 Percent  of Poverty		Uninsured Children Under Age  19 Below 200 Percent of  Poverty as a Percent of Total  Children Under Age 19	
	Number  in Thousands	Std. Error	Rate	Std. Error
1996 - 1998	189	28.7	6.0	.9
1998 - 2000	186	28.5	5.8	.9
2000 - 2002	157	21.8	5.4	.7
2002 - 2004	156	21.7	5.2	.7
2003 - 2005	153	21.6	5.2	.7
2004 - 2006	131	20.0	4.5	.7
2005 - 2007	134	20.0	4.6	.7
2006 - 2008	122	19.0	4.3	.7

2007 - 2009	154	21.0	5.3	.7
2008 - 2010	159	15.0	5.6	.5
2009 - 2011	170	16.0	6.0	.5
2010 - 2012	151	15.0	5.4	0

The Ohio Department of Medicaid (ODM) uses the CPS, but augments this information with its own survey (the Ohio Family Health Survey). For additional information related to this data, see the State's CHIP annual report performance objectives.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

**2.2. Health Services Initiatives-** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

Pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act, the Ohio Department of Medicaid (ODM) will partner with the Ohio Department of Health (ODH) to enhance and expand the State's current lead abatement program through the use of CHIP HSI funds. ODH will administer all aspects of the program with ODM's oversight.

#### PROJECT 1 – LEAD ABATEMENT ACTIVITIES

The following outlines the lead abatement activities, proposed eligibility, project prioritization and conditions of enrollment for homes included in the initiative:

##### Phase 1: Properties with Lead Hazard Control Orders

Currently there are an estimated 1,200 homes across the state under lead hazard control orders that may be eligible for lead abatement assistance through the CHIP-HSI. Potential program participants will be identified from an existing inventory of homes that are under an order issued by ODH or one of its delegated local boards of health. At the start of the project, ODH will contact owners of these homes by phone or letter to solicit participation in the program.

##### Monitoring and Oversight

To help ensure a successful program, ODH will contract with a third party vendor or vendors to be selected through a competitive bid process to provide daily oversight and management of all aspects of the project. Vendor activities will include participant enrollment, income verification, lead testing services, generation of lead abatement specifications and coordinating and bidding lead abatement activities. The vendor or vendors selected will have previous experience in operating and managing a

project the same size and scope as this project. ODH has a project management outline and quality assurance processes in place that it will use to oversee the work of the contractor.

#### Eligibility Criteria

ODH will ensure property owners and families do not qualify for any other federal funding sources for lead hazard control before qualifying them for this program. Property owners and families are eligible for participation in the program if all the following criteria are met:

- 1) The property owner must demonstrate proof the occupants' income is at or below 206% of the federal poverty level (FPL) following federally published guidelines based on household size. However, consideration will be given to occupants whose income exceeds this threshold if there are no other financial resources available to the family for lead abatement activities as determined by ODH;
- 2) The property is subject to a lead hazard control order issued by ODH or one of its delegated boards of health; and
- 3) The property is the primary residence for at least one Medicaid-eligible child under 19 years of age or a pregnant woman.

#### Prioritization of Participants

The goal of the program is to assist Ohio families and property owners with addressing lead hazards in the home environment by providing the services needed to eliminate or control lead hazards. Property owners and families in all of Ohio's eighty-eight (88) counties are eligible for participation in the program if they meet the qualifications as outlined above.

ODH and ODM will prioritize services to property owners and families whose properties are subject to lead orders issued by ODH or one of its delegated boards of health in Phase 1 of the project. These properties have undergone a thorough lead investigation and lead risk assessment which has identified hazards contributing to an eligible child's elevated blood lead level of 10 micrograms/deciliter or higher. Property owners and families who fail to qualify for any other housing assistance program or those who reside in counties where there are no other sources of funding available will receive higher priority for services.

Upon enrollment, referrals will be prioritized in the following order and grouped by geographic location when possible.

- 1) Properties under a lead order housing a Medicaid-eligible child under six years of age with lead poisoning requiring medical intervention;
- 2) Properties under a lead order where multiple children have been poisoned over time and a Medicaid-eligible child under six years of age resides;
- 3) Properties under a lead order in which a newly poisoned Medicaid-eligible child under six years of age resides;
- 4) Properties that are the primary residence for at least one Medicaid-eligible child under 19 years of age or a pregnant woman; and
- 5) Properties that are subject to a Notice of Noncompliance and Order to Vacate and have been

known to poison at least one child under six years of age. The state will not use HSI funds for any properties that are vacant.

#### Conditions of Enrollment

Properties considered for enrollment must meet all the following conditions prior to the initiation of lead abatement activities. The property shall be:

- 1) Constructed prior to 1978 as verified by the county auditor's records;
- 2) Covered by homeowners insurance with copies of the policy submitted as proof;
- 3) Covered by flood insurance if the property is located in a flood plain with copies of the policy submitted as proof;
- 4) Occupied by tenants or owner-occupants at or below 206% of the FPL. Special consideration may be given to families whose income exceeds the guideline as approved by ODH and ODM up to 250% of the FPL with property owner contribution required;
- 5) Occupied by tenants or owner-occupants who have at least one Medicaid-eligible child under nineteen (19) years of age or pregnant woman, or a child under nineteen (19) years of age or pregnant woman who spends an average of 6 hours or more in the unit. (Copies of birth certificates will be used to document age of children); and
- 6) Current on all property taxes or have a tax payment plan in place.

#### Income Verification and Enrollment

The purpose of the intake and enrollment process is to ensure the owners, tenants, or owner-occupants meet all qualifications for participation in the program through the collection of required documents and completion of enrollment forms. During intake and enrollment, the program process and expectations will be outlined to the participants.

During the enrollment process, ODH will determine if the occupants of the property include at least one Medicaid-eligible child under nineteen (19) years of age or pregnant woman as described in the conditions of enrollment, above. Once a week, ODH will generate a list of potential participants and will provide it to ODM to determine Medicaid enrollment status. If the potential participants are Medicaid-enrolled as verified by ODM, ODH will inform the third-party vendor to proceed with the program services. If the vendor initiates these services more than six months after enrollment verification, ODM will verify the eligibility of the occupants again before the vendor performs abatement activities.

If the potential participants are not enrolled in Medicaid or covered by any other creditable health care insurance program, the third-party vendor(s), ODH and ODM will take steps to assist them with completing enrollment materials and selecting and obtaining access to health care providers serving Medicaid-eligible children, pregnant women, and unborn children. ODH will also ensure that as lead investigations are performed for children whose lead levels are equal to or greater than 10 µg/dL, enrollment materials are completed for any children who qualify for Medicaid but are not enrolled.

On a case-by-case basis, owner-occupant participants whose income exceeds 206% FPL may be selected for participation in the program provided eligibility criteria are met and the participant(s) are willing to

provide a 10% property owner contribution toward the cost of the project.

**Property Owner Contribution**

The following table depicts property owner contributions as required for participation in the program. The contribution total is based on the overall projected costs of the project based on an estimated cost of the work. The program will accept in-kind contributions from the property owner. Examples include the following: relocation expenses, the cost of the clearance examination, and any in-kind repair work. Exceptions to the owner’s contribution requirement will be considered in accordance with Section 9.10. Rental property owners shall be required to provide the owner contribution, not the tenant.

Property Type	% Owner contribution required	Acceptable contributions	Contribution amount assuming LHC avg. project cost of \$10,000
Rental	50	Occupant relocation expenses (required), lead hazard control repair work, rehab repairs, clearance examination	\$5,000
Owner-occupied; owner’s income >206% FPL	10	Occupant relocation expenses, lead hazard control repair work, clearance examination	\$1,000

**Tenant Relocation Services**

During the course of the lead abatement activities, it may be necessary for the occupants to relocate to ensure their health and safety. The average time frame for completion of lead abatement activities is projected to be 5 to 10 calendar days. Families will be allowed to return to the property upon completion of a successful clearance examination.

Relocation will be carried out in accordance with the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and in accordance with the HUD guidelines (located at [https://portal.hud.gov/hudportal/HUD?src=/program\\_offices/healthy\\_homes/lbp/hudguidelines](https://portal.hud.gov/hudportal/HUD?src=/program_offices/healthy_homes/lbp/hudguidelines) ). Occupants who must vacate the property while the work is ongoing will be treated fairly and equitably. The third-party vendor team will have the responsibility of assisting with identification of alternate housing for displaced families, and will make every effort to identify friends or family members who may be able to provide temporary housing while work is ongoing. When temporary housing is needed, the family will be assigned housing that takes into consideration their specific needs, using HUD occupancy standards for the size and makeup of the household, considering accommodation for disabled

family members, and offering the same accessibility features as the housing in which they currently reside. The vendor will strive to relocate the family in a nearby location, especially to maintain the same school district if applicable.

At the time relocation occurs, and for the duration of the work, ODH will provide to the residents a per diem allowance to cover meals, lodging and transportation. ODH will establish the per diem amount based on the U.S. General Services Administration's Per Diem Rates for Ohio.

#### Coordination of Lead Abatement Activities

The project will require that lead abatement activities be completed only by licensed lead abatement contractors or lead workers, with contractor oversight provided by ODH and its project oversight vendor(s). Work specifications written by a licensed lead abatement contractor or lead abatement project designer employed or contracted by the third-party vendor(s) will dictate the scope of work. The licensed lead abatement contractor or lead abatement worker will control all identified lead hazards using a combination of lead abatement and interim control measures to ensure that all units abated under this project are lead-safe.

Lead-based paint, dust, and soil remediation and associated renovation activities will include, but shall not be limited to, door and window treatments and replacement, floor treatments, paint removal, paint stabilization and repainting, encapsulation, enclosure, specialized cleaning, soil replacement or covering, and any innovative lead hazard reduction method approved by ODH.

For the purposes of this initiative, lead abatement does not include work that does not reduce a lead hazard or work not performed by a certified lead abatement professional. Ohio's lead abatement HSI will not involve the replacement of water service lines to homes. The State will not utilize the HSI funding to assess lead hazards in drinking water in most cases, as the vast majority of pediatric blood lead poisoning cases in the state continue to be related to exposure to lead in paint. The assessor will typically ask about other potential sources, such as: time spent in other countries; pottery; cosmetics; foods, spices, and candies; soil; and drinking water. Generally, testing of other potential sources is rare unless there is a strong indication that they may be contributing to lead exposure. If the investigation determines that the source of lead exposure in the homes is from the water, and not from lead in the paint or soils, ODH will utilize HSI funds to install water filters in the home and will look to funding sources other than this HSI to fully abate the problem.

Minimal rehabilitation work is permitted under this project if it is necessary to protect the integrity of the lead abatement work. In cases where ODH determines that the lead abatement work will fail without additional minor repairs, and certifies that the repairs are essential to maintain the integrity of the lead abatement work, these repairs will be covered. All services necessary for repair integrity will follow the minimum standards as established by HUD for lead-based paint hazard control and/or health homes grants (located at [http://www.hud.gov/offices/lead/library/lead/PGI-2008-02\\_Doing\\_Minimal\\_Rehab.pdf](http://www.hud.gov/offices/lead/library/lead/PGI-2008-02_Doing_Minimal_Rehab.pdf)) and any subsequent amendments to the HUD guidelines. Some examples of minimal rehabilitation work include: repairing leaking plumbing, reducing moisture intrusion, repairing flashing on a leaking chimney, installing deadbolts and/or other locks for site



protection, and repairing or replacing defective gutters and downspouts.

After the scope of work has been determined, the lead abatement activity work will be bid and awarded by the third-party vendor to licensed lead abatement contractors who have been approved to work with the project. The vendor will select the lowest, most reasonable bid taking into consideration the location of the project, the capability of the contractor to meet project timelines and any other factor that may impact the flow of the project.

After the contractor is selected, work specifications will be discussed with the contractor. ODH and its third party vendor(s) will closely monitor the project and ensure compliance with HUD's Lead Safe Housing Rule, the HUD Guidelines, and all federal, state, and local regulations and guidance. In addition, contractors shall comply with all applicable local, state and federal regulations. Project monitors will conduct random onsite visits to properties undergoing work to ensure that contractors utilize proper lead abatement activity work practices, and that they do not utilize prohibited practices during the lead abatement activities.

#### Post Lead Abatement Activities

At the completion of the lead abatement activity services, a licensed lead risk assessor will perform a clearance examination in accordance with Ohio regulations and the procedures outlined in this document. The lead risk assessor who conducts the examination will be employed or contracted by the third party vendor(s). Re-examinations will be performed when an initial clearance examination fails. Costs for re-examinations will be the responsibility of the lead abatement contractor who performed the lead abatement activities, and will be deducted from the payment for the lead abatement activities.

ODH's field staff will review each clearance examination as part of the quality assurance process. Laboratory results will be requested the same day, particularly in cases where the family has been relocated to temporary housing. The family will return to the property when the property passes clearance.

The following standards will be utilized when determining hazardous levels and the clearance standards for determining a unit is safe for re-occupancy:

Material Tested	Hazard level (at or above level listed)
Bare soil (child play area)	At or above 400 ppm of lead
Bare soil (other areas)	At or above 1,200 ppm of lead
Dust - Floor	At or above 10 micrograms per square foot of sampled area
Dust – Porch floor	At or above 40 micrograms per square foot of sampled area
Dust – Window sill	At or above 100 micrograms per square foot of sampled area
Dust – Window trough	At or above 100 micrograms per square foot of sampled area
Paint (tested by XRF)	Equal to or greater than 1.0 micrograms per square centimeter on deteriorated sampled surface
Paint (tested by lab analysis)	Equal to or greater than 0.5% by weight or 5,000 ppm of lead in paint

### Project Activity Sequence

The following table details the sequencing of the project activities, the responsible party for each activity, and the estimated activity time frame. It is estimated that each project will take approximately 90 days to complete.

Production Activity	Agency/Person Responsible	Day	Estimated # of days to complete activity
1. Identification and Prioritization of unit – prequalification and transfer to vendor	ODH Program Coordinator	0	7
2. Intake and Enrollment of potential program participants and/or occupants; gather other required documentation	Vendor	7	21
3. Coordination of Lead Inspection/Risk Assessment Activities- lab analysis of samples and generate LI/RA report	Lead Risk Assessor (contracted or employed by vendor)	28	14
4. Coordination of Lead and Health/Safety work specifications, obtain State Historic Preservation Approval	Vendor	42	14
5. Pre-Lead Hazard Control Services- Bid processing and contractor scheduling	Vendor	56	14
6. Lead hazard control and health/safety work	Lead abatement contractor (contracted through vendor)	70	14
7. Coordination of Clearance examination- laboratory analysis, and report	Lead Risk Assessor (contracted or employed by vendor)	84	6

8. Post lead hazard control services	Vendor; property owner	90	-
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Phase 2: Targeted Areas – Primary Prevention

As the project progresses and many of the homes with lead orders receive lead abatement services, the focus of the project will shift from secondary prevention to a primary prevention approach. Project units will be identified from specific target areas. The same eligibility criteria and enrollment processes for enlisting a property into the project in Phase 1 will apply in Phase 2. Again, property owners and families who fail to qualify for any other housing assistance program or those who reside in counties where there are no other sources of funding available will receive higher priority for services. The State has defined specific target areas in Ohio where there is a high percentage of predicted elevated blood lead levels as defined in Ohio’s targeted testing plan developed by the Ohio State University Statistical Consulting Service in 2013.

A single census tract in the following metropolitan areas will be included for initial targeting, as the highest predicted probabilities of Elevated Blood Lead Levels (EBLLs)  $\geq 5\mu\text{g/dL}$  in children occur in the heart of the primary urban areas of Ohio.

Phase 2 Initial Target Areas:

- Cleveland (Cuyahoga County)
- Cincinnati (Hamilton County)
- Columbus (Franklin County)
- Akron (Summit County)
- Toledo (Lucas County)
- Youngstown (Mahoning County)

These areas have a large proportion of older homes, a large proportion of African-American residents, a low proportion of educated residents, and low income-to-poverty ratios. The primary residence for Medicaid-eligible and low-income children (under the age of 19) is often located in these areas.

ODH or its designee will conduct community outreach efforts to identify properties to enroll in the project. These outreach efforts will include direct mailings to families residing in the target area, flyers and postings in community areas, and other effective outreach activities as determined by ODH and ODM.

PROJECT 2 – LEAD-SAFE HOUSING REGISTRY

ODH will create the Lead-Safe Housing Registry by using HSI funds to add a lead-safe housing component to the existing Ohio Housing Finance Agency (OHFA)’s Ohio Housing Locator website (<https://www.ohiohousinglocator.org/>). OHFA currently maintains a statewide rental registry and rental housing locator. The rental locator provides information on rental housing availability for the economically disadvantaged, the elderly and those seeking smoke-free housing. Lead-safe will be added

to the existing filtering criteria on the registry. To be included on the registry, the property owner or operator must maintain the rental property as lead-safe following U.S. Environmental Protection Agency (EPA) requirements. The lead-safe maintenance activities must be conducted in accordance with current federal law (40 CFR 745, Subpart E Lead Renovation, Repair and Painting Rule). Ohio is not a delegated state to oversee this program for the U.S. EPA; therefore, the U.S. EPA would enforce the work practices.

Once the lead-safe activity is completed, the property needs either a cleaning verification or lead clearance. This will be evidenced by records (made available on request) that provide information on the lead-safe activities that were done in compliance with the Lead Renovation, Repair and Painting Rule at 40 CFR 745, Subpart E, and that clearance or cleaning verification was conducted after the lead-safe activities were done. Rental properties listed on the Lead-Safe Housing Registry must be inspected annually to remain on the registry and listed as lead-safe.

At the completion of lead abatement work funded as part of this project, a rental property owner must ensure the property is registered on the proposed Lead-Safe Housing Registry on the Ohio Housing Locator website in accordance with requirements outlined in the Ohio Administrative Code. The vendor must ensure the property owner is aware of the registry requirements.

A significant component of the Ohio Lead-Safe Housing Registry will be marketing the free resource to the economically-disadvantaged population in the state. As part of the State's overall work plan, ODH is developing a statewide multimedia marketing plan to ensure that the public is aware of the registry and uses it to identify low cost, lead-safe rental housing. ODH is also developing a smaller but still significant marketing plan that targets rental unit owners or operators to encourage them to list their lead-safe properties on the registry. As noted above, all rental units made lead-safe within the scope of this HSI will be required to list their rental properties as lead-safe on the Ohio Housing Locator website.

## Metrics

Key Metrics the state will track and report to CMS monthly:

- Number of houses identified with children who have elevated blood lead levels
- The number of homes scheduled for lead hazard control.
- The number of homes in which lead hazard control has occurred.
- Number of houses abated for pregnant women.
- Number of houses abated for Medicaid-eligible children under the age of 19.
- Record of actual services provided in each house.
- Clearance testing results for each project.
- Percentage of Medicaid-eligible children receiving blood lead testing under EPSDT statewide and in this health services initiative.
- Percentage of children with elevated blood lead levels statewide and in this health services initiative.

Ohio assures that the State will report on agreed-upon metrics at regular intervals to CMS regarding the

progress of the HSI.

Allocation of the cost of Ohio’s Lead-Safe Housing Registry  
Ohio proposes using the ratio of total children under 19 compared to the total Medicaid-eligible children under 19.

**2.3-TC Tribal Consultation Requirements-** (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children’s Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

Ohio has a very small Native American population. There are no formal AI/AN groups or organizations in the state.

**Section 3. Methods of Delivery and Utilization Controls**

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

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services

basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to the CMS Regional Office servicing them for review and approval.

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

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding. If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

- 3.1. Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section

1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS Regional Office for review and approval. (Section 2103(f)(3))

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR, 457.490(b))

**3.2.** Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42CFR 457.490(b))

#### **Section 4. Eligibility Standards and Methodology**

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

**4.0.  Medicaid Expansion**

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

Age 0-5

- An insured or uninsured child age 0-5 at or below 141% FPL is Medicaid (Title XIX)
- An insured child age 0-5 above 141% FPL, but at or below 156% FPL is Medicaid (Title XIX)
- An uninsured child age 0-5 above 141% FPL, but at or below 156% FPL is CHIP 1 (Title XXI)
- An uninsured child age 0-5 above 156% FPL, but at or below 206% FPL is CHIP 2 (Title XXI)

Age 6-18

- An insured or uninsured child age 6-18 who is at or below 107% FPL is Medicaid (Title XIX)
- An insured child age 6-18 above 107% FPL, but at or below 156% FPL is Medicaid (Title XIX)
- An uninsured child age 6-18 above 107% FPL, but at or below 156% FPL is CHIP 1 (Title XXI)
- An uninsured child age 6-18 above 156% FPL, but at or below 206% FPL is CHIP 2 (Title XXI)

Income Limits (% FPL) (exclude 5pp disregard)	Medicaid (Title XIX funded)	Medicaid Expansion for Uninsured Children (Title XXI funded)	Separate CHIP for Uninsured Children (Title XXI Funded)
Ages 0-1	156%	141% - 206%	-
Ages 1-5	156%	141% - 206%	-
Ages 6-18	156%	107% - 206%	-

**4.1.  Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

**4.1.0**  Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

**4.1.1**  Geographic area served by the Plan if less than Statewide:

**4.1.2**  Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

**4.1.2.1-PC**  Age: \_\_\_\_\_ through birth (SHO #02-004, issued November 12, 2002)

**4.1.3**  Income of each separate eligibility group (if applicable):

**4.1.3.1-PC**  0% of the FPL (and not eligible for Medicaid) through \_\_\_\_\_ %



of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4  Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1.5  Residency (so long as residency requirement is not based on length of time in state):

4.1.6  Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7  Access to or coverage under other health coverage:

4.1.8  Duration of eligibility, not to exceed 12 months:

4.1.9  Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1  States should specify whether Social Security Numbers (SSN) are required.

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

4.1.9.2  Continuous eligibility

4.1-PW  **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of “lawfully residing” children and/or pregnant women. States may elect to cover (1) “lawfully residing” children described at section 2107(e)(1)(J) of the Act; (2) “lawfully residing” pregnant women described at section

2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

**4.1- LR**

**Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
  - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
  - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
  - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
  - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
  - (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
  - (vi) Aliens currently in deferred action status; or
  - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been

- granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;
  - (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
  - (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
  - (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

- Elected for pregnant women.
- Elected for children under age 21

**4.1.1-LR**  The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

**4.1-DS**  **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

**4.2. Assurances** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

- 4.2.1.**  These standards do not discriminate on the basis of diagnosis.
- 4.2.2.**  Within a defined group of covered targeted low-income children, these

standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

- 4.2.3.  These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

**4.2-DS** Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

- 4.2.1-DS  These standards do not discriminate on the basis of diagnosis.

- 4.2.2-DS  Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

- 4.2.3-DS  These standards do not deny eligibility based on a child having a pre-existing medical condition.

**4.3. Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Guidance: The box below should be checked as related to children and pregnant women.  
Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

**4.3.1. Limitation on Enrollment** Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

- Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2.  Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

**4.3.3-EL Express Lane Eligibility**  Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

**4.3.3.1-EL** Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

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

**4.3.3.3-EL** List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

**4.3.3.3-EL** List the component/components of CHIP eligibility that are determined under the Express Lane.

**4.3.3.4-EL** Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the

screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

**4.4. Eligibility screening and coordination with other health coverage programs**

States must describe how they will assure that:

- 4.4.1.  only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.
- 4.4.2.  children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))
- 4.4.3.  children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))
- 4.4.4.  the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)
  - 4.4.4.1.  (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))
- 4.4.5.  Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The

State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

**4.4-EL**

The State should designate the option it will be using to carry out screen and enroll requirements:

- The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.
- The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.
- The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

**Section 5. Outreach and Coordination**

**5.1.** (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State’s outreach efforts through Medicaid and state-only programs.

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

Ohio insures over 1 million children under the Medicaid and CHIP programs. Ohio's CHIP is a Medicaid expansion rather than a stand-alone program. Therefore, the boundaries between Title XIX and Title XXI are transparent to enrollees since the only

difference between a Medicaid and a CHIP enrolled child is their family's income and insurance status.

ODM maintains its partnership with the ODH's Bureau for Children with Medical Handicaps, Hemophilia, and HIV programs, whereby ODH pays the insurance premiums when it is cost effective and when families cannot afford to keep their employer-based insurance.

Beginning in 1992, ODH, through its BCMH, Hemophilia, and HIV programs, started paying health insurance premiums for families who could not afford to keep their employer-based insurance. ODH only pays insurance premiums where it is cost effective to maintain a person's private coverage.

The public health insurance purchasing programs screen potentially eligible candidates to determine that the people for whom health insurance is being purchased are not eligible for Medicaid prior to purchasing. Outreach is done through public health nurses and the provider networks for the BCMH, Hemophilia, and HIV programs. While the Application for Health Coverage and Help Paying Costs (ODM 7216) is not an application for these health insurance purchasing programs, the information provided on the ODM 7216 can be used to initiate the exploration of eligibility for a health insurance purchasing program. Ohio passed four significant pieces of legislation in 1999 to provide certain patient protections for Ohio's health consumers. They are:

- 1) H.B.4, which includes the establishment of requirements for conducting internal and external review of health care coverage decisions made by health insuring corporations, and sickness and accident insurers;
- 2) H.B. 361, which includes regulations of aspects of enrollees' access to covered health care services;
- 3) H.B. 698, which includes revisions of the standards for using electronic signatures in records of health care facilities; and
- 4) S.B. 67, which enacts new laws to provide for the establishment, operation, and regulation of "health insuring corporations," to provide uniform regulations of providers of managed health care.

In 2010, the State began participating in the Social Security Administration (SSA) citizenship data exchange as part of the CHIPRA 2009 option under Section 211. This allows families a reasonable opportunity period of 90 days of Medicaid eligibility while the individual attempts to collect citizenship documentation or correct SSA information to meet the citizenship requirements for Medicaid.

The State participated in the performance bonus payments under Section 104 of CHIPRA 2009. Some of the enrollment and retention provisions include:

- 1) Use of the same application and renewal forms for Medicaid and CHIP;
- 2) Elimination of the asset test, and;



3) Elimination of the in-person interview.

Since 2010, the State added the following:

- 1) Presumptive eligibility for children, as described in Section 1920(a) of the Social Security Act. Presumptive eligibility is provided to all children described at 1902(a)(10)(A) of the Social Security Act. Presumptive eligibility for children is determined by County Departments of Job and Family Services and by qualified entities who help obtain an application for regular Medicaid coverage, and
- 2) Continuous eligibility for children under 1902(e)(12) of the Social Security Act. Continuous eligibility assures coverage to a child for 12 months, regardless of changes in circumstances other than the situations identified below:
  - a. The child is no longer a resident of the State of Ohio,
  - b. The child dies,
  - c. The child reaches age 19,
  - d. The child (age 18) or the child's representative requests disenrollment, or
  - e. The child has not paid premium amounts required for eligibility groups that require premium payments.

Working alongside Voices for Ohio's Children, Ohio has made significant strides in streamlining Medicaid eligibility. Some of the changes include the following: reducing the number of pages on applications; reducing the list of forms that must be distributed to the minimum required by law; making a definitions rule that applies consistently across Medicaid eligibility; identifying and combining all the conditions of eligibility that apply to all Medicaid covered groups into one rule (e.g., must be a U.S. citizen or qualified alien, must provide a Social Security number, must be a resident of the State of Ohio, etc.); identifying and combining all the general individual and county responsibilities into one rule; clarifying the steps for applying for and renewing benefits, and for reporting case changes; eliminating the application at redetermination; and implementing an online eligibility system to apply for Medicaid benefits.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

- 5.1.2.** (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

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

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

**5.2.** (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

Consumers complete the Application for Health Coverage and Help Paying Costs (ODM 7216) to apply for Medicaid. The application also serves as an application or referral for four other publicly funded programs: the Women, Infants and Children (WIC) Program, the Child and Family Health Services (CFHS) Program, the Children with Medical Handicaps (CMH) Program, and the Help Me Grow (HMG) Program. All four programs are administered by the Ohio Department of Health.

**5.2-EL** The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

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

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

**5.3. Strategies** Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

Ohio Medicaid is the State's major public health program for children. The program is a federal/state partnership serving low-income and/or uninsured families, many of whom are the poorest and most vulnerable citizens in Ohio.

The Ohio Medicaid Assessment Survey (OMAS) is conducted through a partnership among Ohio's colleges and universities, state and local government, and private sector organizations to provide health services research expertise and assist with improving the health of Ohio's Medicaid-eligible population. The survey provides data that is used to assess the impact of health care reform, and to assist with the efficiency of the Ohio Medicaid program. Results presented in 2015 revealed aggressive enrollment efforts resulted in Medicaid coverage of insured children increasing from 42 percent in 2012 to 46.1 percent in 2015.

ODM has strategic partnerships throughout the state of Ohio designed to galvanize the education and retention efforts. Ohio, like many other states, has redirected outreach efforts to focus on retaining consumers without a break in coverage. Below are some of the strategic partnerships:

- **Children in the Vanguard.** Children in the Vanguard is an initiative of the National Academy for State Health Plan Policy (NASHP) that focuses on children's coverage in the context of health care reform. Under this initiative, NASHP brings together state Medicaid, CHIP and Title V officials with advocates from states to focus on continuing progress on children's coverage as health care reform is implemented. The project also aims to foster complementary relationships between state officials and state advocates in working toward common goals around improving children's health coverage. Ohio's group consists of advocates from Voices for Ohio's Children and Children's Defense Fund, staff from the Ohio Departments of Medicaid, Education, Developmental Disabilities, and others. The goals of the Vanguard are to promote a positive image and messaging for the Medicaid program; promote and implement care coordination; and to develop a plan to improve retention and reduce churning.
- **Ohio Family and Children First (OFCF) Council.** OFCF is a partnership of state and local government communities and families that enhances the well-being of Ohio's children and families by building community capacity, coordinating systems and services, and engaging families. OFCF's vision is for every child and family to thrive and succeed within healthy communities. OFCF's purpose is to streamline and coordinate government services for children and families.
- **Additionally, ODM partners with ODH's Maternal and Child Health Program to focus on low-income women and children in socioeconomic, racial and ethnic groups that are disproportionately affected by poor health in geographic areas and populations of highest need. Currently there are 58 projects in 64 counties funded across Ohio.**
- **The Ohio Benefit Bank (OBB) is a web-enabled, counselor-assisted program that helps low income and moderate income Ohioans identify available benefits. Consumers have the opportunity to gain access to credits and benefits such as the Earned Income Tax Credit, Medicaid, Supplemental Nutrition Assistance Program (SNAP), child care subsidies, and home energy assistance.**

The OBB, in partnership with the Governor's Office of Faith Based and Community Initiatives and the Ohio Association of Foodbanks, works with local partners such as community or faith-based organizations, food banks or food pantries, health care providers and housing programs in order to customize the outreach programs to meet community needs. This initiative operates more than 400

Benefit Bank sites in Ohio.

- To support the uninsured, ODM's Consumer Hotline continues to provide application assistance and answers to general eligibility questions to help consumers with getting the care they need. In addition, local level efforts continue in the form of county staff assisting consumers with navigating the program. To target minority populations, materials are translated into Spanish and Somali, and are made available on the Internet and at the local CDJFSs. Additionally, Healthchek (EPSDT) and Pregnancy-Related Services (PRS) materials are translated into Spanish, Somali, and Arabic.
- The Self-Service Web Application is an online system that allows consumers to make an application for or renew assistance or to report case changes via the internet. The Self Service Web-Application is available 24 hours a day, 7 days a week.
- Training  
ODM continues to offer training and technical assistance to the County Departments of Job and Family Services regarding new program policy changes and expansions, reminders, errors and clarifications. Targeted training is offered to community-based organizations that addresses the basic concepts necessary to understand Medicaid. ODM also provides training and technical assistance to its sister state agencies, including the departments of Developmental Disabilities, Youth Services, Rehabilitation and Correction, Mental Health and Addiction Services, and Aging.

**Section 6. Coverage Requirements for Children’s Health Insurance**

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

**6.1.** The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

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

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

- 6.1.1.1.  FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

- 6.1.1.2.  State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

- 6.1.1.3.  HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,

- mental health services,
- vision services and
- hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

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

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If “existing comprehensive state-based coverage” is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for “existing comprehensive state-based coverage” must be described in the space provided for all states. (Section 2103(a)(3))

- 6.1.3.  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania.

Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4.  Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1.  Coverage the same as Medicaid State plan

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

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

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in  457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4.  Coverage that includes benchmark coverage plus additional coverage

6.1.4.5.  Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

- 6.1.4.6.**  Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

- 6.1.4.7.**  Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

**6.2.** The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

- 6.2.1.**  Inpatient services (Section 2110(a)(1))
- 6.2.2.**  Outpatient services (Section 2110(a)(2))
- 6.2.3.**  Physician services (Section 2110(a)(3))
- 6.2.4.**  Surgical services (Section 2110(a)(4))
- 6.2.5.**  Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6.**  Prescription drugs (Section 2110(a)(6))
- 6.2.7.**  Over-the-counter medications (Section 2110(a)(7))
- 6.2.8.**  Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9.**  Prenatal care and pre-pregnancy family services and supplies (Section



2110(a)(9))

- 6.2.10.**  Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11.**  Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12.**  Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13.**  Disposable medical supplies (Section 2110(a)(13))
- Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.
- 6.2.14.**  Home and community-based health care services (Section 2110(a)(14))
- Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.
- 6.2.15.**  Nursing care services (Section 2110(a)(15))
- 6.2.16.**  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17.**  Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
- 6.2.18.**  Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19.**  Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20.**  Case management services (Section 2110(a)(20))

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

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

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

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

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

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

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

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

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

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

**6.2-DC Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

**6.2.1-DC**  State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT<sup>1</sup>) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

**6.2.1.1-DC** Periodicity Schedule. The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific
- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

**6.2.2-DC**  Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

**6.2.2.1-DC**  FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT<sup>2</sup> codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

**6.2.2.2-DC**  State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

**6.2.2.3-DC**  HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to

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provide supplemental services, also attach a description of the services and applicable CDT codes)

- 6.2-DS**  **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

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

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

- 6.3.** The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

- 6.3.1.**  The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
- 6.3.2.**  The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

- 6.4.** **Additional Purchase Options-** If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

- 6.4.1.**  **Cost Effective Coverage-** Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services

initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

- 6.4.1.1.** Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))
- 6.4.1.2.** The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

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

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

- 6.4.1.3.** The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment

adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

Guidance: Check 6.4.2 if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

**6.4.2.**  **Purchase of Family Coverage-** Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

**6.4.2.1.** Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

**6.4.2.2.** The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

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

**6.4.3-PA: Additional State Options for Providing Premium Assistance** (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's

parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

- Yes  
 No

**6.4.3.1-PA** Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

**6.4.3.1.1-PA** Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

**6.4.3.1.2-PA** Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

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

**6.4.3.2.1-PA** If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

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

**6.4.3.2.3-PA** If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

**6.4.3.3-PA:** Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

**6.4.3.3.1-PA** Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

**6.4.3.4-PA:** Opt-Out and Outreach, Education, and Enrollment Assistance

**6.4.3.4.1-PA** Describe the State’s process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

**6.4.3.4.2-PA** Describe the State’s outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

**6.4.3.5-PA Purchasing Pool-** A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

- Yes
- No

**6.6.3.5.1-PA** Describe the plan to establish an employer-family premium assistance purchasing pool.

**6.6.3.5.2-PA** Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State’s CHIP plan.

**6.6.3.5.3-PA** Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

**6.4.3.6-PA Notice of Availability of Premium Assistance-** Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment



process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

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

## **Section 7. Quality and Appropriateness of Care**

**Guidance:** Methods for Evaluating and Monitoring Quality- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

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

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

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

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

Where States use managed care organizations to deliver CHIP care, recent legal

changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

**Tools for Evaluating and Monitoring Quality-** Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

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

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

**7.1.** Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

**7.1.1.**  Quality standards

**7.1.2.**  Performance measurement

**7.1.2 (a)**  CHIPRA Quality Core Set

**7.1.2 (b)**  Other

**7.1.3.**  Information strategies

**7.1.4.**  Quality improvement strategies

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section

2102(a)(7)(B))

- 7.2.** Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)
- 7.2.1.** Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))
- 7.2.2.** Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))
- 7.2.3.** Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))
- 7.2.4.** Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

**Section 8. Cost-Sharing and Payment**

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

**8.1.** Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

- 8.1.1.  Yes
- 8.1.2.  No, skip to question 8.8.

- 8.1.1-PW  Yes
- 8.1.2-PW  No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

**8.2.** Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

- 8.2.1.  Premiums:
- 8.2.2.  Deductibles:
- 8.2.3.  Coinsurance or copayments:
- 8.2.4.  Other:

**8.2-DS**  **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5

percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

**8.2.1-DS**  Premiums:

**8.2.2-DS**  Deductibles:

**8.2.3-DS**  Coinsurance or copayments:

**8.2.4-DS**  Other:

**8.3.** Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

**8.4.** The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

**8.4.1.**  Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

**8.4.2.**  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

**8.4.3**  No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

**8.5.** Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

**8.6.** Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

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

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

**8.7.1.** Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

- 8.7.1.1.**  State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- 8.7.1.2.**  The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
- 8.7.1.3.**  In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- 8.7.1.4**  The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

**8.8.** The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

- 8.8.1.**  No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2.**  No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3.**  No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4.**  Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5.**  No funds provided under this title or coverage funded by this title will include

coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

- 8.8.6.  No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

## **Section 9. Strategic Objectives and Performance Goals and Plan Administration**

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

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

Well-Child Visits in the First 15 Months of Life – 6 or More Visits

Numerator: 26,937

Denominator: 54,052

Rate: 49.84%

Data Source: Child Core Set Measures – MacPro (FFY 2016)

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Numerator: 134,381

Denominator: 208,175

Rate: 64.55%

Data Source: Child Core Set Measures – MacPro (FFY 2016)

Adolescent Well-Care Visit

Numerator: 154,325

Denominator: 371,434

Rate: 41.55%

Data Source: Child Core Set Measures – MacPro (FFY 2016)

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

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

The State's goal is to meet or exceed the NCQA Medicaid Self-Audited National 25th HEDIS Percentile for the performance measures.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

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

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children’s age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

**9.3.** Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State’s performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

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

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



- 9.3.7.5.  Mental health
- 9.3.7.6.  Dental care
- 9.3.7.7.  Other, list:

9.3.8.  Performance measures for special targeted populations.

9.4.  The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5.  The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State’s plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

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

9.6.  The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7.  The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

- 9.8.1.  Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2.  Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3.  Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4.  Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

**9.9.** Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Ohio Revised Code requires all state agencies to conduct a rule review at least every five years. During the five-year rule review, the public has an opportunity to comment on the rules at the public hearing (when applicable) and also during the Joint Committee on Agency Rule Review, representing the Ohio General Assembly. To further support the interaction between the public and ODM, ODM requires its offices to allow the public an opportunity to comment prior to a formal rule filing by initiating a clearance review. The clearance review affords ODM the unique ability to interact more closely with stakeholders and the public at large by refining program processes and simplifying rule language.

Additionally, Executive Order 2008-04S (Common Sense Business Regulations) requires all state agencies to review existing rules and processes; to treat those affected by their rules and regulatory processes as customers and treat them consistently across regions, offices, and departments; and to consolidate regulatory rules and processes.

ODM has institutionalized different forums to serve as a mechanism to actively receive community input. These ongoing workgroups facilitated by ODM include community partners in an advisory capacity and sister agencies.

- 9.9.1.** Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

Ohio has a very small Native American population. There are no formal AI/AN groups or organizations in the state that ODM interacts with regarding development and implementation procedures.

**9.9.2.** For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

Not applicable

**9.9.3.** Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

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

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
  
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

### **CHIP Budget**

<b>STATE: OH</b>	<b>FFY Budget</b>
<b>Federal Fiscal Year</b>	2018
State's enhanced FMAP rate	96.95%
<b>Benefit Costs</b>	
Insurance payments	0
Managed care	521,163,978
<u>per member/per month rate</u>	177.02
Fee for Service	30,874,765
<b>Total Benefit Costs</b>	552,038,743
(Offsetting beneficiary cost sharing payments)	0
<b>Net Benefit Costs</b>	552,038,743
<b>Cost of Proposed SPA Changes – Benefit</b>	0
<b>Administration Costs</b>	
Personnel	3,244,000
General administration	0
Contractors/Brokers	25,768,000
Claims Processing	0
Outreach/marketing costs	0
Health Services Initiatives	5,000,000
Other	0
<b>Total Administration Costs</b>	34,012,000
10% Administrative Cap	61,337,638
<b>Cost of Proposed SPA Changes</b>	5,000,000
Federal Share	568,176,195
State Share	17,874,548
<b>Total Costs of Approved CHIP Plan</b>	586,050,743

**NOTE: Include the costs associated with the current SPA.**

Pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act, the Ohio Department of Medicaid (ODM) will partner with the Ohio Department of Health (ODH) to enhance and expand the State's current lead abatement program through the use of CHIP HSI funds to pay for lead abatement activities at an amount of up to \$5 million each year of the state fiscal year biennium. Approximately \$4.5 million of the \$5 million each year will be used for remediation and associated testing services for homes under lead hazard orders (Project 1). \$300,000 is dedicated for administrative costs to be provided to ODH for staffing resources. The remaining \$200,000 each year

<b>STATE: OH</b>	<b>FFY Budget</b>
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will be used to develop, support, and market a Lead-Safe Housing Registry for non-owner occupied rental housing by leveraging a current resource administered by the Ohio Housing Financing Agency (Project 2). ODH will administer all aspects of the program with ODM's oversight. All funding for the program will be in ODM's budget and ODH will administer contracts for the program and code purchase orders and invoices to ODM accounts.

The main source of funding currently used to assist Ohio property owners with addressing lead hazards is federal lead hazard control funding provided through the US Department of Housing and Urban Development (HUD). This funding is available to local and state units of government through a competitive grant program to local political subdivisions who are able to demonstrate a need and compete for limited federal dollars with over half of applicants not funded in the funding period. ODH and nine localities have been awarded HUD funding far short of the funding needed to fully address the state's needs.

The State provides assurances that the HSI program will only target children under the age of 19 and pregnant women. The State provides further assurances that funds under this HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

**The Source of State Share Funds:** 651425-General Revenue Fund

**Section 10. Annual Reports and Evaluations**

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at <http://www.nashp.org>. Per the title XXI statute at Section 2108(a), states must submit reports by January 1<sup>st</sup> to be compliant with requirements.

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

**10.1.1. ☒** The progress made in reducing the number of uninsured low-income children and

report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

- 10.2.  The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))
- 10.3.  The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.
- 10.3-DC  The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

**Section 11. Program Integrity (Section 2101(a))**

- Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.
- 11.1.  The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))
- 11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)
- 11.2.1.  42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2.  Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3.  Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4.  Section 1128A (relating to civil monetary penalties)
- 11.2.5.  Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6.  Section 1128E (relating to the National health care fraud and abuse data collection program)

**Section 12. Applicant and Enrollee Protections (Sections 2101(a))**

- Check here if the State elects to use funds provided under Title XXI only to provide expanded

eligibility under the State's Medicaid plan.

- 12.1. Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

- 12.2. Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.

- 12.3. Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

### **Key for Newly Incorporated Templates**

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)



**CMS Regional Offices**

<b>CMS Regional Offices</b>	<b>States</b>		<b>Associate Regional Administrator</b>	<b>Regional Office Address</b>
Region 1- Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal <a href="mailto:richard.mcgreal@cms.hhs.gov">richard.mcgreal@cms.hhs.gov</a>	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2- New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez <a href="mailto:michael.melendez@cms.hhs.gov">michael.melendez@cms.hhs.gov</a>	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3- Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher <a href="mailto:ted.gallagher@cms.hhs.gov">ted.gallagher@cms.hhs.gov</a>	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4- Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze <a href="mailto:jackie.glaze@cms.hhs.gov">jackie.glaze@cms.hhs.gov</a>	Atlanta Federal Center 4 <sup>th</sup> Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5- Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson <a href="mailto:verlon.johnson@cms.hhs.gov">verlon.johnson@cms.hhs.gov</a>	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6- Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks <a href="mailto:bill.brooks@cms.hhs.gov">bill.brooks@cms.hhs.gov</a>	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7- Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott <a href="mailto:james.scott1@cms.hhs.gov">james.scott1@cms.hhs.gov</a>	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8- Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen <a href="mailto:richard.allen@cms.hhs.gov">richard.allen@cms.hhs.gov</a>	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9- San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle <a href="mailto:gloria.nagle@cms.hhs.gov">gloria.nagle@cms.hhs.gov</a>	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103

Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly <a href="mailto:carol.peverly@cms.hhs.gov">carol.peverly@cms.hhs.gov</a>	2001 Sixth Avenue MS RX-43 Seattle, WA 98121
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## **GLOSSARY**

Adapted directly from Sec. 2110. DEFINITIONS.

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

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

23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
  - a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
  - b. performed under the general supervision or at the direction of a physician, or
  - c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

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

1. **IN GENERAL-** Subject to paragraph (2), the term ‘targeted low-income child’ means a child--
  - a. who has been determined eligible by the State for child health assistance under the State plan;
  - b. (i) who is a low-income child, or  
(ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
  - c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. **CHILDREN EXCLUDED-** Such term does not include--
  - a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
  - b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. **SPECIAL RULE-** A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. **MEDICAID APPLICABLE INCOME LEVEL-** The term ‘Medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical

assistance under Section 1902(1)(2) for the age of such child.

5. **TARGETED LOW-INCOME PREGNANT WOMAN.**—The term ‘targeted low-income pregnant woman’ means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

**ADDITIONAL DEFINITIONS-** For purposes of this title:

1. **CHILD-** The term ‘child’ means an individual under 19 years of age.
2. **CREDITABLE HEALTH COVERAGE-** The term ‘creditable health coverage’ has the meaning given the term ‘creditable coverage’ under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. **GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC-** The terms ‘group health plan’, ‘group health insurance coverage’, and ‘health insurance coverage’ have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. **LOW-INCOME CHILD -** The term ‘low-income child’ means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. **POVERTY LINE DEFINED-** The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. **PREEXISTING CONDITION EXCLUSION-** The term ‘preexisting condition exclusion’ has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. **STATE CHILD HEALTH PLAN; PLAN-** Unless the context otherwise requires, the terms ‘State child health plan’ and ‘plan’ mean a State child health plan approved under Section 2106.
8. **UNINSURED CHILD-** The term ‘uninsured child’ means a child that does not have creditable health coverage.