



Attached for your review and comment, as well as assistance, is a draft of the model application template and instructions that are being developed to assist states in submitting a child health plan under Title XXI of the Social Security Act.

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

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

Assistance from the states, advocates and other interested parties, in the form of comments and input on the attached documents, is greatly appreciated and all suggestions will be taken into consideration.

Please note that under the law, a state must have an approved state plan for a fiscal year in order to receive an allotment that year. In order for the Department to determine allotments for FY 98, state plan applications should be submitted as soon as possible. The length of time from submission to approval will vary depending upon the quality of the plan and the extent to which requirements under the law are met. We cannot guarantee that we will be able to approve plans submitted after July 1 before the close of the fiscal year. Therefore, the sooner a state submits its plan, the more quickly Health Care Financing Administration (HCFA) will be able to approve it, and the sooner states will have access to their allotments. For States with approved plans, the allotment under Title XXI is available for up to three years.

Comments on the template may be submitted to the HCFA at the following address:

Center for Medicaid and State Operations
Health Care Financing Administration
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Family & Children's Health Programs Group
Mail Stop - C4-14-16

We hope that you find this information helpful in the development of the State Children's Health Insurance Program. If you need further assistance or have questions regarding this information, please contact your HCFA regional office or Rick Fenton in HCFA's Family and Children's Health Programs Group at 410-786-5920.

DRAFT - 9/12/97

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

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

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

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

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

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

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

The application template includes the following sections.

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

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

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

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

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

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

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

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

DRAFT - 9/12/97

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

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

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

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

HCFA Regional Office Administrators

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

DRAFT - 9/12/97

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

SECTION SPECIFIC INSTRUCTIONS (For attached model application template)

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

Introduction

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

Guidance

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

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

Introduction

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

Guidance

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

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

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

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

DRAFT - 9/12/97

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

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

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

Section 3. General Contents of State Child Health Plan

Introduction

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

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

Guidance

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

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

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

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

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

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

Section 4. Eligibility Standards and Methodology

Introduction

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

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

Guidance

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

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

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

DRAFT - 9/12/97

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

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

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

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

Section 5. Outreach and Coordination

Introduction

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

Guidance

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

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

This section may also include discussions of the following:

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

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

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

DRAFT - 9/12/97

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

Section 6. Coverage Requirements for Children's Health Insurance

Introduction

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

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

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

Guidance

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

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

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

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

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

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

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

DRAFT - 9/12/97

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

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

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

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

- 6.2.1. - 6.2.28. Check each box the state elects to provide coverage for in its child health assistance plan.

The following are clarifications of certain types of services:

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

DRAFT - 9/12/97

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

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

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

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

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

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

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

DRAFT - 9/12/97

above and describe the coverage provided by the alternative delivery system in an attachment.

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

Section 7. Quality and Appropriateness of Care

Introduction

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

Methods for Evaluating and Monitoring Quality

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

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

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

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

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

Tools for Evaluating and Monitoring Quality

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

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

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

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

Guidance

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

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

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

Section 8. Cost-Sharing and Payment

Introduction

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

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

Guidance

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

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

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

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

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

DRAFT - 9/12/97

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

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

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

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

DRAFT - 9/12/97

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

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

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

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

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

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

Introduction

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

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

Guidance

- Section 9.1.** Identify and list the specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children. It is suggested the state identify a minimum of 5, but no more than 10 strategic objectives.
- Section 9.2.** Specify at least one performance goal and performance measure for each strategic objective. We plan on developing, in conjunction with the states, advocacy groups, and other interested parties, national standards for performance measures. We will be working with states to develop the most useful measures. In the interim, we are proposing examples that may be useful for states in designing their performance measures. In the hope of consistent reporting among states, and for the aggregation of national results, we suggest that each performance goal and performance measure be described as reflected in Section 9.3.
- Section 9.3.** Briefly describe how the plan's performance will be measured objectively and independently. Check all appropriate measures the state will be utilizing.

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

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

DRAFT - 9/12/97

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

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

HEDIS 3.0 Reporting Set Measures Relevant to Children and Adolescents

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

DRAFT - 9/12/97

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

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

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

For the annual assessment:

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

For the evaluation:

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

DRAFT - 9/12/97

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

Section 10. Annual Reports and Evaluations

Introduction and Guidance

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

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

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

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

Section 10.1. These assurances address the annual assessment.

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

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

Section 10.3. Self-explanatory

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

GLOSSARY

Adapted directly from SEC. 2110. DEFINITIONS.

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

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

DRAFT - 9/12/97

- (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

DRAFT - 9/12/97

mental diseases, or

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

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

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

ADDITIONAL DEFINITIONS- For purposes of this title:

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

DRAFT - 9/12/97

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

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

CHILDREN'S HEALTH PROGRAM: NEXT STEPS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- **By October 1, 1997, define and clarify new law.** Issue guidelines or regulations consistent with the new law to states to guide them as they implement their programs. This will clarify question such as:
 - *What is a "generally available" state employee health plan?*
 - *Does the most popular HMO include those with state or Federal employees?*
 - *What does "well-child care" mean?*
 - *How should states and the Federal government develop and review the actuarial memorandum that states will use in the program?*
- Set up systems to review programs, oversee payment, and collect and disseminate states' annual reports.

STATES

- **By October 1, develop program plan.**
- Target uninsured children. Examples include:
 - *Develop programs in communities with few employers who offer coverage*
 - *Establish program for children who age out of Medicaid*
 - *Use unemployment offices to tag children whose parents are between jobs.*
- Set up good systems for covering for children. They could, for example:
 - *Develop special networks with children's hospitals*
 - *Ask the nation's leading insurers to participate.*
- Develop efficient outreach and enrollment processes. They could, for example:
 - *Coordinate eligibility workers with new program and Medicaid*
 - *Make eligibility the same as that for the School Lunch program*
 - *Use simple application.*
- Coordinate the new program with existing coverage options. They could, for example:
 - *Allow only children without access to employer-based insurance to participate*
 - *Have an automatic enrollment process for children who show up for the new program but are actually eligible for Medicaid.*

FOUNDATIONS

- **Outreach.** There seems to be considerable interest among foundations. They could:
 - *Develop school-based methods to educate families about insurance options, such as enlisting the PTA or sending brochures on insurance options home with children*
 - *Sponsor public media campaigns about options available to states.*
- **Work with states to develop plans:**
 - *Packard Foundation may create a clearinghouse for implementation ideas*
 - *Alpha Center and the Robert Wood Johnson Foundation could share their experience in encouraging innovative programs in states like Florida.*
- **Monitor state activities.** Foundations are in a good position to research the new programs. They could:
 - *Sponsor special survey on detailed health insurance coverage in the states*
 - *Track and report on insurance trends in states*

CHILDREN'S GROUPS

- **Encourage states to cover a wide range of children and benefits**
 - *Provide information and examples of why benefits like vision and hearing are important to children.*
 - *Identify good state employee health plans and encourage states to pick them.*
- **Ensure that adequate quality provisions are put in place.** For example, they could:
 - *Develop a data bank on states' quality programs.*
- **Outreach**
 - *Use volunteer networks to go to places likely to have uninsured children to help them enroll.*

PRESIDENT, FIRST LADY, CABINET SECRETARIES

- **Participate in public events with Governors, community leaders, and children's groups** to promote the new law and to educate parents about how best to access coverage in their particular state
- **Ensure timely, coordinated planning stage** by encouraging coordination among key players such as the Secretaries of DHHS, Labor, and Education, Governors, state legislature representatives, providers, and children's groups.

THE WHITE HOUSE
WASHINGTON

Want to Dole
Gingrich

December 27, 1994

Dear Bob:

While we could not achieve broad-based agreement on a health reform initiative last year, there can be little disagreement that we still face the enormous problems of increasing health care costs and decreasing coverage. We need to confront these problems on a bipartisan basis and address the insecurities that too many Americans have about their health care. I am writing to reiterate my strong desire to work with you in this regard.

I remain firmly committed to providing insurance coverage for every American and containing health care costs for families, businesses, and Federal, State, and local governments. In the upcoming session of Congress, we can and should work together to take the first steps toward achieving these goals. We can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term Federal deficit.

We look forward to talking with you in the upcoming weeks about a bipartisan effort to deliver health care reform to the American public. Hillary and I send our best wishes for a safe and happy holiday season.

Sincerely,

Bill Clinton

The Honorable Robert Dole
United States Senate
Washington, D.C. 20510

↓ Did everything through:

- ① Enactment of ~~Clinton~~ Kerschman - Kennedy law
- ② Enactment of children health program in Balanced Budget
- ③ Enactment of structural & quality reforms in Balanced Budget
- ④ Enactment of Medicare/Medicaid savings to reduce deficit

President Continues to Fight to Expand Health Care Coverage for Our Nation's Children

Today, the President announced that he is committed to assuring that the balanced budget agreement's children's health plan have meaningful benefits and that it include the Senate-passed 20 cent tobacco tax which increases the investment for children's health care from \$16 billion to \$24 billion. This would represent the largest investment in children's health since Medicaid passed over thirty years ago. In making this announcement, the President outlined the principles he will use in evaluating children's health coverage emerging from the Budget Agreement:

- **That coverage is meaningful:** from checkups to surgery -- children should get a full range of benefits to ensure that children receive the care they need to grow up strong and healthy. It cannot be a meaningful benefit if it does not include prescription drugs, vision, hearing, and mental health coverage. It must also ensure that families are not forced to shoulder excessive costs for their children.
- **That it supplements not supplants coverage:** these funds must be used wisely. This investment should cover children who do not currently have insurance; it should not replace public or private money that already covers children.
- **That it includes revenue from the Senate-passed tobacco tax:** in an overwhelming bipartisan basis, the Senate passed a 20 cent tobacco tax and allocated revenue from this tax for children's health. Including these additional revenues in the children's health initiative will not only further reduce the number of uninsured children, but it will serve as a financial barrier to help prevent our children from starting smoking in the first place.

Today's announcement builds on the President's previous successes in strengthening health care coverage for children.

- **Children and Immunization.** As the President announced today, 90 percent or more of America's toddlers in 1996 received the most critical doses of each of the routinely recommended vaccines -- surpassing the goal set by the President in 1993.
- **Children and Tobacco.** The President issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. Each day about three thousand children become regular smokers and 1,000 of them will die from a tobacco-related illness. According to former FDA Commissioner David Kessler, the possibility of a comprehensive, public health oriented settlement with the tobacco industry could not have come about without the President's leadership in this area.
- **Children and the Kassebaum-Kennedy Law.** By signing this bill into law last year, the President helped millions of American children keep their health care coverage when their parents lose or change jobs.
- **Children and the Environment.** Earlier this year, the President signed an Executive Order to reduce environmental health and safety risks to children by requiring agencies to strengthen policies and improve research to protect children and ensure that new regulations consider special risks to children.

Children and Medicaid. Throughout his Administration, the President has fought to preserve and strengthen the Medicaid program; its coverage of about 20 million children, makes it the largest single insurer of children. The Administration has partnered with states through Medicaid waivers to expand coverage to hundreds of thousands of children.

PRESIDENT BILL CLINTON: STRENGTHENING AMERICA'S HEALTH CARE SYSTEM

Protecting and Strengthening The Nation's Health Care System

- * Enacted the ^{Kassebaum-Kennedy} ~~Kennedy-Kassebaum~~ health insurance reforms that will benefit as many as 25 million Americans. This law will enable individuals to keep their health insurance coverage when they change jobs. Workers will no longer fear losing their health insurance if they or a family member have a pre-existing conditions. This law also includes several other key provisions that will: ensure that Americans can renew their health care coverage, guarantee access to health care for small businesses; strengthen efforts to combat health care fraud, waste, and abuse.
- * **Strengthened Medicare Trust Fund.** The President's 1993 economic package included policy and structural changes that extended the life of the Trust Fund by three years (which were enacted without one Republican vote).
- * **Protected the Medicaid guarantee for children, elderly, pregnant women, and people with disabilities.** The President vetoed the Republican's proposal to block grant the Medicaid program, guaranteeing health care coverage or benefits to 37 million beneficiaries. The President also presided over the approval of 12 Medicaid waivers to cover 2.2 million previously uninsured Americans.
- * **Established protections for mothers and their newborns.** Today, some health plans refuse to pay for anything more than a 24-hour hospital stay, and some recommend releasing mothers as few as 8 hours after delivery. The President signed into law common sense legislation that requires health plans to allow new mothers to remain in the hospital for at least 48 hours following most normal deliveries and 96 hours after a Caesarean section.
- * **Signed into law mental health parity provisions.** The President signed into law legislation to prohibit health plans from establishing separate lifetime and annual limits for mental health coverage.

Improving Health Care for Our Children

- * **Increased childhood immunizations to an historic high.** The President's childhood immunization initiative expands community-based educational efforts and makes vaccines more affordable. In 1995, fully 75 percent of two-year olds were immunized — a historic high.

174

- * **Protected kids from tobacco products and advertising.** Each day about three million children become regular smokers and 1,000 of them will die from a tobacco-related illness. To reduce this trend, the President issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. According to former FDA Commissioner David Kessler, the possibility of a comprehensive, public health oriented settlement with the tobacco industry could not have come about without the President's leadership in this area.
- * **Funds Full Participation in Women, Infants, and Children (WIC).** WIC provides nutritional assistance, nutrition education and counseling, health and immunization referrals, and prenatal care to those who would otherwise not get it. WIC participation has grown by 25% over the last four years and will serve 7.5 million by 1998, fulfilling the President's goal of full participation.
- * **Enacted laws to prevent and punish handgun violence.** Fought for the Brady Bill, which has already prevented more than 60,000 fugitives, felons, and criminals from buying handguns. The President expanded this bill to prevent individuals who commit acts of domestic violence from buying guns. Banned 19 of the deadliest assault weapons and stopped efforts to repeal the assault weapons ban. Every year at least 39,000 people die and 100,000 are treated in emergency rooms from gun violence.
- * **Helped Vietnam veterans whose children were born with spina bifida.** The President signed legislation to provide health care and rehabilitative training for children of Vietnam veterans who are born with spina bifida. The legislation will help thousands of children whose birth defects may be a result of their fathers' or mothers' service to our country.

Important Investments in Health Research

- * **Increased investment in biomedical research at the National Institute of Health (NIH) by an impressive 16 percent.** Funding for breast cancer research at NIH has increased by 76 percent and support for AIDS research funding has increased by 25 percent.
- * **Increased funding for AIDS research, prevention, housing, and treatment.** In the President's first term, he has presided over a 56 percent increase in spending on programs for people living with AIDS including: the Ryan White Care Act, research, State AIDS drug assistance programs that help patients buy new protease inhibitor drugs, and Housing Opportunities for Persons with AIDS that provides housing assistance for over 65,000 people.

Making Health Care More Efficient

- * **Reduced regulations.** The Vice President's reinventing government initiative has resulted in the elimination of 1,600 pages of regulations in the Department of Health and Human Services, a 23 percent reduction.
- * **Expedited the FDA review and approval of new drug products.** Under the President's watch, U.S. drug approvals are now as fast or faster than any other industrialized nation. Average drug approval times have dropped since the beginning of the Administration from almost three years to just over one year. In 1997, virtually all breakthrough drugs will be approved within six months without compromising safety standards.

~~THE CHALLENGES AHEAD~~

Included in Balanced Budget

Improving and Strengthening Our Medicare and Medicaid Program

- **Extending the life of the Medicare Trust Fund for at least a decade.** The President fought to ensure that the Budget Agreement -- which included \$115 billion in Medicare savings -- extended the life of the Medicare Trust Fund for at least a decade.
- **Modernizing Medicare and providing more choices.** The President's Medicare plan would increase the choices of plans for beneficiaries by adding a Medicare preferred provider organization option, a Provider Sponsored Organization (PSO) option, and HMOs with a point-of-service option. It also includes "competitive bidding" initiatives that will make Medicare a more prudent and effective purchaser of health care services. The President is working to ensure that these new choices are in the final budget agreement.
- **Adding new preventive benefits for Medicare beneficiaries.** The President's Medicare proposal added preventive benefits by providing for: full coverage of mammography screening, a colorectal screening benefit, diabetes case management, and preventive injections for pneumonia, influenza, and hepatitis B. The final proposal that came out of House did not include copays for mammographies. We are working to ensure that the final agreement includes all of these new benefits.
- **Giving states more flexibility to administer Medicaid.** The President's Medicaid proposal will eliminate the burdensome waiver process for both managed care and home- and community-based care alternatives to institutionalization. It will preserve the guarantee of Medicaid and also make it easier to extend health care coverage.

Improving Health Care for Our Children

#24 Billion

- **Extending health care coverage for millions of uninsured children.** The President has fought to make sure that extending health care coverage to millions of uninsured children is a top priority in any balanced budget deal. The President made sure that the Budget Agreement included \$24 billion to provide meaningful health care coverage to uninsured children. The President also supports allocating revenue from tobacco tax to allocate additional Federal support for children's health.
- **Outlining principles to use to evaluate children's health initiatives emerging from the Budget Agreement.** The President is committed to making sure that any investment in children's health care meets three principles: **(1) that coverage is meaningful:** from checkups to surgery -- children should get the care they need to grow up strong and healthy; **(2) that coverage is targeted:** through grant programs and Medicaid, this investment should cover as many uninsured children as possible; and **(3) that this investment supplements not supplants coverage:** this investment should cover children who do not currently have insurance -- rather than replace public or private money that already covers children.

CHALLENGES AHEAD

Making New Strides in Health Care, While Providing Americans With Adequate Protections

- **Protecting Americans from discrimination by health based on their genetic information.** The great strides that scientists are making in their understanding of genetic predispositions for diseases open the door for possible misuse. Specifically, insurance companies may attempt to use this information to raise premiums or deny coverage to Americans. Studies show that a leading reason many women are unwilling to be tested for the genetic predisposition for breast cancer is because they fear that their insurance will be dropped if they test positive. Last year, the President signed the Kennedy-Kassebaum law, which prevents health plans from excluding an individual from group coverage because of genetic information. This year the President is calling for further legislation that extends these protections to consumers in the individual market, prohibits raising premiums in individual and group markets because of genetic information, and prevents health plans from disclosing any genetic information.
- **Challenging the scientific community to find an AIDS vaccine in the next decade.** President Clinton challenged the nation to commit itself to the goal of developing an AIDS vaccine within the next ten years. To help fulfill this commitment, the President is bringing nations together to invest in this commitment (all of the nations at the G-8 agreed to increase their commitment), dedicating a research center for AIDS vaccine research at the National Institutes of Health (NIH), and reaching out to scientists, pharmaceutical companies, and patient advocates to maximize the involvement of both the private and public sectors in the development of an AIDS vaccine. The President has already taken steps to enhance the possibility of developing an AIDS vaccine by increasing funding for NIH vaccine research and development over 33 percent in the last two years.

DRAFT

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
IMPLEMENTATION UPDATE
September 30, 1997

FEDERAL GOVERNMENT UPDATE

Organization within the Administration. Since the Balanced Budget Act (BBA) was signed less than six weeks ago, almost all of the Administration's activity has focused on the interpreting the law and setting up the systems necessary to administer it. The children's program will be administered jointly by the Health Care Financing Administration (HCFA) and the Public Health Services' Health Resources and Services Administration. The lead organization with the Center for Medicaid and State Operations (CMSO, formerly the Medicaid Bureau) within HCFA.

Public Information. There have been several releases of information since the bill was passed. The first of these was a letter sent on August 27 to state officials. This letter from Sally Richardson, director of HCFA's CMSO, informed the states of the organization of the program at HHS, its basic parameters, and a summary of the statute. On September 10, the Federal Register contained a notice describing the states' preliminary allotments from the over \$4 billion appropriation for fiscal year 1998. A set of questions and answers on some of the most frequently asked questions was distributed on September 11 to a National Governors' Association meeting and to advocacy groups. A "state plan template" or guide on the minimum requirements for a state children's health insurance plan was sent out on September 15. And, on October 1 a second set of questions and answers will be distributed. All documents can be found on the Internet; www.hcfa.gov.

Outreach to States and Groups. Three types of meetings have been happening. The first is a series of regular meetings with Congressional staff, state officials, advocacy groups, and beneficiary groups. These occur on a weekly or monthly basis (depending on the group) primarily with HHS staff.

Second, each of the public information releases to date have been accompanied by meetings with major groups in order to explain them and answer questions. White House staff have attended some of these meetings.

Third, there have been one-time meetings with certain groups like foundations and provider groups to explain our plans and discuss theirs.

STATES UPDATE

The following table summarizes the activities state-by-state. In addition, a preliminary draft survey by the National Academy for State Health Policy, found in 30 states responding to date:

(Not to be attributed)

- 9 states are only considering a Medicaid-only expansion;
- 10 states are only considering a new program (non-Medicaid); and
- 10 states are consider both.

And, 19 of the 30 states will require that children be uninsured for some time period prior to coverage in CHIP to limit "crowd out" (most others are undecided).

STATE	ACTIVITIES UPDATE
Alabama	After a contentious special legislative session, \$5 million was budgeted for health with a contingent \$10 million if revenues are sufficient. Despite Governor's original objections to funding it this year, F. James signed the budget on 9/23. Task force called the Children's Health Insurance Program Commission will submit a proposal to the state legislature in January. Initial plan suggests that the state may expand Medicaid to all children to poverty, beginning in 2/98.
Alaska	Informal working group has been meeting; expected to meet with the Governor on October 3 to discuss their proposal. Governor appears to want to expand to 200% of poverty by the end of 1998.
Arizona	New Governor has stated that getting a children's health program going soon is a priority but no immediate plans.
Arkansas	Debating whether to count 1115 Medicaid waiver, approved in August for children up to 200% of poverty, as a new program.
California	"Healthy Families" plan passed by state legislature on 9/13/97. Expands Medicaid to 100% of poverty for all children and creates a new program for children 100 to 200% of poverty that has fairly comprehensive benefits offers coverage through group purchasing coop or employers. Governor will likely sign this into law.
Colorado	State has funds to begin program; may build on an existing program that buys children up to 185% of poverty into family group coverage. Preliminary expansion may begin in January.
Connecticut	Republican Governor proposed plan 9/11; may call a special session in October or November with an expected start date of January 1 (more likely to be next summer) Combined Medicaid and new program. Democratic legislature has similar program. Builds on a Medicaid outreach effort funded earlier this year. State already covers up to 185% of poverty through Medicaid; may seek a waiver to go to 285% of poverty.
Delaware	Governor's office is looking at new program options; nothing definitive.
DC	

STATE	ACTIVITIES UPDATE
Florida	Probably will expand the Healthy Kids program; the state has an 1115 Medicaid and kids proposal in at HCFA. Although the Healthy Kids benefits are allowed in the statute, its cost sharing is not; the state wants an 1115 Medicaid to waive it. The state legislature meets in April to decide. Tobacco settlement money may be used as the state contribution.
Georgia	Health Policy Center at Georgia State University is planning. Looking at both new programs and Medicaid; if Medicaid. Legislature meets in January; expect implementation in July (sooner if Medicaid expansion).
Hawaii	Interested in expanding its 1115 Medicaid waiver.
Idaho	Governor wants a small expansion to 140/150% of poverty since he does not need to go through the state legislature for this. Could start in 10/97.
Illinois	Looking at Medicaid options, but in a preliminary planning stage.
Indiana	
Iowa	Task Force to present options to governor by 12/1/97; expect to introduce a bill by January and implement by 10/1/98. Nine public forums are planned in October to get input. Earlier in the year, the state had another task force and created a children's health trust fund.
Kansas	Two planning groups (Insurance Department and Department of Social and Rehabilitation Services) to report to Governor and state legislature in 1/98.
Kentucky	Set up work group; considering a range of options, including implementing / expanding their 1115 Medicaid waiver; however, may not begin in 1998.
Louisiana	Governor-appointed task force hoping to implement in 1998.
Maine	Governor & state legislature-appointed Maine Commission on Children's Health Care. In 3 months, will make recommendations on how to cover children. The state already has sufficient state share funding reserved.
Maryland	Looking at both new program and Medicaid options; preliminary stage.
Massachusetts	Has a 1115 Medicaid waiver that it wants to expand to 200% of poverty, possibly beginning this fall.
Michigan	
Minnesota	State already covers children up to 275% of poverty; wants a waiver to cover children at current levels (e.g., outreach) or create a new program.
Mississippi	
Missouri	Submitted an amended Medicaid 1115 waiver in August that combines kids with adults. Would essentially expand Medicaid to 200% of poverty. Amended the 1115 Medicaid waiver on 9/26. Have not submitted an official state plan. Expect to implement in 7/98.
Montana	Child Health Insurance Group set up to give recommendations. Looking at combination of a new program and Medicaid. New program could be implemented in 4/98.
Nebraska	State working group will give recommendations to Governor.

STATE	ACTIVITIES UPDATE
Nevada	New program being planned for implementation in 4/98.
New Hampshire	Still in a formative stage.
New Jersey	Governor introduced plan 9/24 to expand Medicaid to children up to 18 up to 133% of poverty, with a new state program for children up to 200% of poverty. Expected to begin Medicaid expansion in January or February. Outreach through schools, Scout groups, Head Start programs, child-care agencies, and other community organizations.
New Mexico	May expand 1115 Medicaid waiver to 235% of poverty for children up to age 5 and to 185% of poverty for children 5-17 years old. Planning to implement in 3/98.
New York	Likely to expand its Child Health Plus program; no immediate plans.
North Carolina	Task force staffed by UNC expects to have a proposal by late October. Debate over Medicaid versus new program. Expect decisions, new program by the Spring.
North Dakota	
Ohio	State already planning on Medicaid expansion to 150% of poverty on 1/1/98. May expand more through a new program in 4/98.
Oklahoma	Planning a Medicaid expansion to 150% of poverty, new program to 200% of poverty, for Spring, 1998.
Oregon	Likely to build on existing 1115 Medicaid program and a recently passed state subsidy program for low-income families. Its Medicaid expansion will begin in 1/98; its state program requires a waiver since they want to use children's health subsidies to purchase family policies. Its first public hearing is scheduled for 10/21/97.
Pennsylvania	Budget issues: the Governor is reluctant to increase state spending since they recently increased their cigarette tax to expand their Children's Health Insurance Program.
Rhode Island	
South Carolina	State passed Medicaid expansion over the summer, will cover children up to 19 to 150% of poverty through Medicaid on October 1. Simple mail-in applications distributed through schools, doctors' offices, neighborhood pharmacies, and hospitals.
South Dakota	
Tennessee	Wants to receive enhanced match for children covered in its 1115 Medicaid waiver as of April 1 (prior to the date allowed under law).
Texas	Considering 1115 Medicaid waiver and / or new program.
Utah	Planning on building on State insurance program. Benefits actuarially equivalent to Public Employees Health Plan for state workers. Expecting a bill by 12/1/97 and implement in April. State share is expected to be Medicaid savings from managed care pending 1115 approval; causing some controversy in Utah.
Vermont	Wants to expand 1115 Medicaid waiver to 275 / 300% of poverty.
Virginia	Preliminary discussions suggest a combined Medicaid and new state program. May have plan by January, implement by July.

STATE	ACTIVITIES UPDATE
Washington	State already covers children up to 200% of poverty. They want to be able to access the allotment for newly covered children below 200% of poverty because the state legislature does not want to expand higher. Senators Gorton and Murray tried to allow through an amendment to the HHS-Labor appropriations bill but withdrew it due to strong opposition. May look for an 1115 to do this.
West Virginia	State is concerned about state share. Would consider Medicaid if it could get an 1115 Medicaid waiver for benefits (preliminary).
Wisconsin	Want 1115 Medicaid waiver to implement Badger Care to cover adults as well as kids. Expected implementation in 7/98. However, not approved by state Senate which wants Medicaid expansion.
Wyoming	Work group to plan for legislative session in February. Looking at new program with implementation in 7 to 10 / 98.

GROUPS UPDATE

Currently, many of the Children's Health Agencies primary focus is on distributing information to members. Following is a summary of the most active children's health groups and their activities.

American Academy of Pediatrics (AAP)

- Developed summary materials for distribution to Chapter leadership and relevant AAP Committees. Chapter leadership has been requested to contact their Governor's Office so that they may be involved in decision making.
- Presented information on SCHIP at a meeting of all AAP Chapter leaders.
- Continued meetings of the Children's Health Groups so that members can discuss and share information on implementation issues.
- Plan to develop a presentation for AAP Fellows at the AAP Annual Meeting November 1-5, 1997, in New Orleans.

American Hospital Association (AHA)

- Developed website which discusses Children Health Implementation Legislation as well as information provided by the Health Care Financing Administration.
- Hosted a series of conference calls with state and metropolitan associations sharing information and encourage involvement.
- Plan to host a November 19, 1997, educational conference in Washington, D.C. which will include representatives from all fifty states.
- Plan to work with AHA's budget to include more outreach materials concerning Medicaid.

Families USA

- Organized conference call with HCFA and National Association of Children's Hospitals which attracted roughly 130 callers who shared information.
- Plan to develop materials and mailing lists to share with other groups what others are doing on Children's Health Implementation.
- Plan to host speakers to educate members about Children's Health Implementation ideas.

American Medical Association (AMA)

- Plan to work with state medical societies to distribute information to the physicians.

March of Dimes

- Co-sponsored a forum in Columbus, Ohio, with the Healthcare Leadership Council for policy makers (business leaders, governors, etc.) and hope to continue more of these forums which emphasize Children's Health Implementation.
- Plan to host a volunteer leadership conference with over 800 people in attendance in which members are being encouraged to get appointed to task forces.
- Work with HHS to host regional meetings on Children's Health Implementation.

National Association of Children's Hospitals

- Co-sponsored a series of conference calls with Families USA in which the HFCA staff was able to brief members about Children's Health Implementation.
- Produced question and answer summaries for members, paying particular attention to the issue of children's health insurance.
- Preparing for their annual conference in two weeks where multiple sessions which will address Children's Health Implementation.

Washington Business Group on Health

- Interested in distributing information to employers to encourage them to continue coverage.

UPCOMING MEETINGS

October

- 1 Effective date of new program
Congressional tobacco meeting (President)
HHS meets with Coalition on Healthy Communities / Healthy Cities
- 6 Children's health day: First Lady will speak to a breakfast with children's groups; will address the topic at the climate change conference
- 6-7 NGA executive committee meeting in Columbus, OH; to focus on children's health
- 7 National Education Association meeting (DC)
- 9 National Commission on Partnerships for Children's Health (Shalala)

Mid-October

- Letter to states describing state child health plan approval process
- Letter to states about payment process
- Letter to states about filing a Medicaid plan amendment if choosing Medicaid option
- HHS report on ways that states have limited "crowd out" or substitution of public for private coverage
- 20 Center on Budget and Policy Priorities meeting (DC)
- 26-29 APWA: Nat'l Association of State Medicaid Directors' annual meeting (Alexandria, VA)
- 31 American Association of Medical Colleges annual meeting (DC)

November

- 1-5 American Academy of Pediatrics annual meeting (New Orleans)
- 4 Washington Business Group on Health Board of Directors (DC) (possible Shalala, DeParle)
- 5-7 National Council of State Legislators meeting (DC); (possible First Lady)
- 9-13 American Public Health Association meeting (Indianapolis) (possible VP)

December

- 4-7 National League of Cities annual meeting (Philadelphia)
- 6 AMA annual meeting (Dallas)

January

- 22-24 Families USA annual meeting (DC), want President or Vice President
- 31-4 AHA annual meeting (DC)

June

- HHS to release payment issues guidance
- HHS to release guidance on states' annual reports
- 14-17 AAHP annual meeting (Boston)
- 26-30 American Nurses Association annual meeting