

**STATE CHILD HEALTH PLAN  
UNDER TITLE XXI  
OF THE SOCIAL SECURITY ACT**

**THE HUSKY PLAN**

**John Rowland, Governor  
STATE OF CONNECTICUT  
January 7, 1998**

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

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

State/Territory: **Connecticut**

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

\_\_\_\_\_ John G. Rowland, Governor, Connecticut, January 14, 1998 \_\_\_\_\_  
(Signature of Governor of State/Territory, Date Signed)

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

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.**

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**Section 1. General Description and Purpose of the State Child Health Plans** (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1. Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2. Providing expanded benefits under the State’s Medicaid plan (Title XIX); **OR**
- 1.3. A combination of both of the above. *The HUSKY Plan includes both Medicaid coverage for children and an insurance program. The Medicaid portion of the HUSKY Plan is referred to as Part A, and the insurance program is referred to as Part B. As of June 1, 1997 the state’s Medicaid program covered children age 0-13 in families with income up to 185% of the federal poverty level (FPL). As described in the state’s amendment to its Medicaid state plan, under the HUSKY Plan Part A (Medicaid), the state will expand Medicaid to include children age 14-18 in families with income up to 185% of the FPL. The expansion for children 14-16 was effective July 1, 1997, and the expansion for children 16-18 will be effective January 1, 1998. Based on the state plan in effect as of April, 1997, children born on or after September 30, 1983 will be claimed at the state’s Medicaid FMAP rate of 50%. Children born prior to September 30, 1983 retroactive to September 30, 1979 will be eligible for the Title XXI FMAP rate of 65% until such time as they age out of the accelerated coverage under Title XXI based on the Medicaid State Plan that was in existence prior to April, 1997 (see below).*

<u>Birthdate</u>	<u>Medicaid Coverage @ 185%</u>	
	<u>Start Date of 65% FMAP and Medicaid Eligibility</u>	<u>FPL under TXXI Start of 50% FMAP</u>
Sept. 30, 1983	N/A	July 1, 1997
Sept. 30, 1982	July 1, 1997	Oct. 1, 1998
Sept. 30, 1981	July 1, 1997	Oct. 1, 1999
Sept. 30, 1980	January 1, 1998	Oct. 1, 2000
Sept. 30, 1979	January 1, 1998	Oct. 1, 2001

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

### Coverage

(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

- 2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

*See Appendix 2.1.*

- 2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)

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

*The state currently conducts various Medicaid outreach activities, including contracts with FQHCs and disproportionate share hospitals to assist Medicaid applicants in filling-out the application. (See 2.2.2 for a description of a public health insurance program for children).*

- 2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

*The only health insurance program for children that involves a public-private partnership is called Healthy Steps. The state in partnership with Blue Cross/Blue Shield and the New Haven school system developed a limited program to assist non-Medicaid eligible, uninsured children age 0-17 in families with income up to 200% of the FPL who are enrolled through the New Haven school system.*

- 2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered: (Section 2102)(a)(3)

*The State Department of Public Health does offer coverage for a limited number of children with household income up to 200% of the federal poverty limit in New Haven County. All of these children will be eligible for the HUSKY Plan based on their family income and the fact that the Healthy Steps Program is 100% state funded and was in existence prior to the passage of the Balanced Budget Act.*

*See Section 4 for a description of coordination with Medicaid.*

**Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4)**

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

- 3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)

*As noted in Section 1.3 above and described in the state's Medicaid state plan amendment, under Part A of the HUSKY Plan the state will use Title XXI funds to expand Medicaid eligibility for children 14-18 with family income up to 185% of the FPL.*

*For children with family income over 185% FPL (Part B of the HUSKY Plan), the state will contract with managed care plans (MCPs). The state will select MCPs through a competitive bidding process. The state will issue an RFP that establishes operational and financial requirements, including access to care, provider network, member services, utilization management, claims processing, and quality assurance. The state will establish a method for evaluating each bidder's ability to provide cost-effective, accessible, quality services. This method will include evaluating the following factors: provider network for each service area, efficiency of operation, ability to provide the required services, quality management, ability to perform the necessary administrative tasks, financial viability, and price.*

*In addition, the state will use Title XXI funds to establish two supplemental health insurance programs, to be known as the HUSKY Plus program, for those enrollees in the state subsidized portion of Part B whose medical needs cannot be accommodated within the basic benefit package offered by the MCPs under the HUSKY Plan, Part B. One program will supplement MCP coverage for enrollees with intensive physical health needs and the other will supplement coverage for enrollees with intensive behavioral health needs. The physical health services will be delivered through current Title V providers, and the behavioral health needs network will be organized by the Yale Child Study Center and will include most traditional community-based behavioral health providers. See Appendix 3.1 for a summary of HUSKY Plus.*

- 3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

*For both Parts A and B, the Medicaid definition of medical necessity will prevail. "Medical Necessity or Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.*

*Medically necessary behavioral health services for children in Medicaid Managed Care shall include:*

*The coordination of and linkage to those social and medical services which ensure the health and safety of the child;*

*Preventive health care services that are designed to avoid the need for future medically necessary services;*

*Services for chronic, long-term disorders which, if left untreated, will affect the physical or mental health of the child; and*

*The duration of treatment provided by a managed care health plan for these children shall be based on the individual needs of the child.*

*For children enrolled in Part A, the utilization controls will be the Medicaid controls. For children enrolled in Part B, the primary utilization control for the basic package of services in Part B will be the responsibility of the MCPs. In the RFP the state will include a definition of medical necessity and utilization management requirements. The MCPs will be required to have written utilization management policies and procedures that include appropriateness criteria for authorization and denial of payment and protocols for prior approval, hospital discharge planning, and retrospective review.*

*As discussed in Appendix 3.1 (summarizing HUSKY Plus), utilization will be managed through prior authorization based on individual care plans and medical necessity guidelines.*

**Section 4. Eligibility Standards and Methodology.** (Section 2102(b))

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

- 4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))
- 4.1.1. Geographic area served by the Plan: *Statewide*
- 4.1.2. Age: *Individuals must be under 19 years of age.*
- 4.1.3. Income: *In order to receive a state subsidy under Part B, family income may not exceed 300 percent of the federal poverty level. However, the state will apply the income disregards shown in Appendix 4.1.3. Families with income greater than 300 percent of the FPL may purchase coverage without state subsidy.*
- 4.1.4. Resources (including any standards relating to spend downs and disposition of resources): \_\_\_\_\_
- 4.1.5. Residency: *To be eligible for the HUSKY Plan, Part B, a child must be a resident of the State of Connecticut.*
- 4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility): *Measures of disability/acuity will apply in HUSKY Plus (see Appendix 3.1.).*
- 4.1.7. Access to or coverage under other health coverage: *Children who are eligible for Medicaid or covered under a group health plan or under health insurance coverage and children of any state, federal, or municipal employee eligible for employer-sponsored insurance are not eligible for the HUSKY Plan, Part B. For other children, an application may be disapproved if it is determined that the child was covered by employer-sponsored insurance within the last six months (this may be extended to 12 months if the commissioner determines that six months is insufficient to deter applicants or employers from discontinuing employer-sponsored dependent coverage). However, an application may be approved if the reason for loss of employer-sponsored insurance is unrelated to the availability of the HUSKY Plan or otherwise exempt under section 11 of Public Act 97-1 of the October 29 Special Session. The authorizing legislation (see Appendix 1.3) identifies ten reasons that are unrelated to the availability of the HUSKY Plan.*
- 4.1.8. Duration of eligibility: *In general, a child who has been determined eligible for the HUSKY Plan (either Part A or B) shall remain eligible for 12 months unless the child attains the age of 19 or is no longer a resident of the state. Applicants for Part B enrollees will be required to notify the enrollee's MCP of any change in circumstance that could affect the enrollee's continued eligibility for coverage under Part B (i.e., attaining age 19 or moving out of state) within 30 days of such change. In addition, DSS may*

*determine that an enrollee is no longer eligible if eligibility was a result of making a false statement, misrepresentation or concealment of or failure to disclose income or health insurance coverage, or if the enrollee's family fails to pay premiums. Any payment made by the state on behalf of an enrollee as a result of any false statement, misrepresentation or concealment of or failure to disclose income or health insurance coverage by an applicant responsible for maintaining insurance may be recovered by the state.*

*Eligibility shall be re-determined not more than 12 months after determination of eligibility and annually thereafter.*

4.1.9. Other standards (identify and describe):

*There will be no other standards.*

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))

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

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

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

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2))

*The state will contract with an entity to be a single point of entry servicer (SPES) for applicants and enrollees under Parts A and B of the HUSKY Plan. The SPES will be responsible for making a preliminary determination of eligibility under Part A and a final determination of eligibility under Part B and enrolling eligible children under Part A and B into and MCP. Eligibility will be determined based on information collected on the application form, which will include name, address, date of birth, social security number, residency, family income, employment, and insurance (both current and in the previous six months). The SPES will verify address and income and whether the child is a Medicaid beneficiary. In addition, if an applicant is employed, the SPES will contact the employer for information about employer-sponsored insurance coverage. Income will be calculated in the same manner as for poverty level children under Medicaid with the income disregards provided in section 15 of Public Act 97-1 of the October 29 Special Session or as may be amended. As described in 4.4.1 (below), as part of the eligibility process the SPES will determine whether a child may be eligible for Medicaid and, if so, send the application and supporting documents to the Department of Social Services for final eligibility determination. Also, if a child has insurance coverage, he/she will not be enrolled in HUSKY Part B.*

*Individuals will be able to apply in-person or by mail. SPES will use a simplified mail-in application process. If information is incomplete, the SPES will contact the applicant (by mail or phone) to obtain missing information. If the SPES determines that a child is eligible for Part A or B (and does not appear eligible for Medicaid coverage through spenddown), the SPES will provide information about participating MCPs and help the family to select an MCP, and then refer the child to the MCP of their choice. If enrolled under HUSKY Part B, the SPES will also provide information about HUSKY Plus. The SPES will send daily rosters of enrollees to the MCPs. The role of the SPES in terms of choice counseling and enrollment will be very similar to the functions conducted by the enrollment broker for Connecticut Access (the state's Medicaid managed care program).*

*Not more than twelve months after determination and annually thereafter, the SPES shall make a preliminary determination under Part A and re-determine eligibility for Part B. The SPES shall mail a form to each enrollee to obtain information to make the eligibility determination. Also, as noted in 4.1.8, applicants will be required to notify their enrollee's MCP of any change in circumstance that could affect continued eligibility for coverage (i.e., attaining age 19 or moving out of state). If the child is no longer eligible, he/she will be disenrolled.*

*Enrollees will be able to change enrollment during an annual, open enrollment period, which will occur at the time of the redetermination of eligibility.*

4.4. Describe the procedures that assure:

4.4.1. Through intake and followup screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))

*As noted in section 4.3, the state will contract with a SPES for applicants and enrollees under Parts A and B of the HUSKY Plan. However, unlike for Part B, the SPES will make a preliminary determination of eligibility for Medicaid. Instead, the SPES's responsibility regarding Medicaid will be to verify whether an applicant is already a Medicaid beneficiary (through on-line access to the state's eligibility system) and, if the child is not a Medicaid beneficiary, to assess (based on the information collected as part of the application process) whether a child may be eligible for Medicaid. If the SPES makes a preliminary determination that the child is eligible for Medicaid, the SPES will send the application and supporting documents to the Department of Social Services for final determination of eligibility. The SPES will be required to contract with qualified entities in every region in the state.*

*The application will include information on insurance coverage. As noted above, if an applicant is employed but does not indicate insurance*

*coverage, the SPES will contact the employer. If a child has insurance coverage, he/she will not be enrolled in Part B. Also, if a child has had insurance coverage in the past six months and does not meet one of the exemptions, he/she will not be enrolled in Part B.*

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))

*As noted in 4.4.1, if the SPES makes a preliminary determination that the child is eligible for Medicaid the SPES will send the application and supporting documents to the Department of Social Services for final determination of eligibility*

4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))

*As noted in 4.3 and 4.4.1, the application process will include collecting information about current coverage and coverage in the past six months. Children currently covered will not be eligible for Part B. The SPES will review applications to determine whether applicants or employers of applicants have discontinued employer-sponsored dependent coverage for the purpose of participation in the HUSKY Plan, Part B. Children who had employer-sponsored coverage within the previous six months who lost*

*coverage for reasons related to the availability of the HUSKY Plan (e.g., no longer purchasing family coverage) will not be eligible. Children who lost coverage for reasons unrelated to the availability of the HUSKY Plan will be eligible for Part B. If DSS determines that six months is not a sufficient period of time to deter applicants and employers from discontinuing employer-sponsored dependent coverage for the purpose of participation in the HUSKY Plan Part B, the Commissioner may extend the period up to an additional six months.*

- 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). (Section 2102)(b)(3)(D))

*The state will distribute informational materials about the HUSKY Plan through the tribal health departments on the reservations of the two federally recognized Indian tribes in the state (the Mashantucket Pequots and the Mohegans).*

- 4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

*As described in section 2.2.2, the state does offer a limited benefit package to children with household incomes between 185% and 200% of FPL in the New Haven area. The program is capped every year in the number of available slots. All of the children currently covered under Healthy Steps would be eligible under HUSKY Part B.*

*The Healthy Steps program will be phased out and all children will become eligible for coverage under HUSKY, Part B, subject to the legislative budget process. The appropriations for the Healthy Steps program were not intended to fund the HUSKY Plan. All of the costs of the HUSKY Plan for SFY98 were appropriated during the October 29, 1997 special session. In future state fiscal years the plan will continue to be funded through the appropriations process.*

*All children who are currently eligible under Healthy Steps will receive a special mailing from the Department informing them of the benefits available under the HUSKY plan, and they will be given directions on how to apply. In addition, all future applicants for the Healthy Steps program will be informed that they are eligible for coverage under HUSKY Part B and they will be directed to the SPES. Applicants for HUSKY Part B who identify their children as having been Healthy Steps clients within the past 6 months will be granted eligibility immediately assuming that all the other requirements are met.*

## **Section 5. Outreach and Coordination (Section 2102(c))**

Describe the procedures used by the state to accomplish:

- 5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))

*DSS, in consultation with the Children's Health Council, the Medicaid Managed Care Council, Infoline of Connecticut, and the local CAP agencies will develop mechanisms for outreach for the HUSKY Plan (Parts A and B), including the development of outreach materials. The state will use numerous methods to reach families of children likely to be eligible for the HUSKY Plan, including but not limited to radio and television ads, a direct mail campaign to all households with incomes below 300% FPL, brochures and flyers, a video, a toll free telephone number, web sites, and presentations by the state. Outreach materials will be distributed through the Department of Revenue Services, the Labor Department, DSS, the Department of Public Health, the Department of Children and Families, the Department of Motor Vehicles, the Office of Protection and Advocacy for Persons with Disabilities, consumer advocacy groups, providers, entities qualified to conduct presumptive eligibility, severe needs schools (schools in which 40 percent or more of the lunches served are served to students who are eligible for free or reduced price lunches), and community-based organizations (day care centers, schools, school-based health clinics, community-based diagnostic and treatment centers, and hospitals). The state is currently working with the Children's Health Council and the Commission on Children to develop the most effective means of reaching targeted children, including homeless children (DSS will distribute materials through homeless shelters). The Children's Health Council and other entities will be responsible for conducting part of the outreach activities. However, as part of its contract with the state, the SPES will provide some outreach activities, and MCPs will be permitted to market directly to prospective enrollees subject to approval by the Department with instructions to contact the SPES.*

*The outreach campaign will inform families of the availability of the HUSKY Plan, Parts A and B, provide basic information about Parts A and B, and provide information about how and where to apply. Applications and information regarding enrollment in the HUSKY Plan (both parts A and B) will be distributed by entities authorized to grant presumptive eligibility, severe needs schools (defined above), and community-based organizations. Applications and information will also be available by contacting the SPES, by calling the toll free number, mail, or in-person). Organizations distributing the applications and information will be trained to assist with completing the application form. Applicants may also receive assistance with completing the application form by calling the SPES toll free number. Applications may be mailed to the SPES or they may be filed in person.*

5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

*If an applicant applies for presumptive eligibility and is determined not eligible by the qualified entity or Department of Social Services but may be eligible for the HUSKY Plan, Part B, he/she will be referred to the SPES. Also, as noted in Sections 2.3 and 4.4.5, Healthy Steps will provide information and application materials for HUSKY Part B to all currently eligible children and to the parents of all children who subsequently contact the Healthy Steps program.*

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

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan, and continue on to Section 7.**

6.1. The state elects to provide the following forms of coverage to children:  
(Check all that apply.)

6.1.1. Benchmark coverage; (Section 2103(a)(1))

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

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

*Please note that the HUSKY Part B benefits combine the most generous benefits offered under the three state employee options (Blue Cross, MD Health Plan, and Kaiser Permanente). In addition, HUSKY benefits also include the HUSKY Plus benefit package which is not available to state employees. (See the HUSKY Plus Report to the Legislature which is included as Appendix 3.1 and a description of the benefits covered under HUSKY, Part B in Appendix 6.1.)*

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

6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.**

6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If “existing comprehensive state-based coverage” is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for “existing comprehensive state-based coverage.”  
\_\_\_\_\_

6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4))

6.2. The state elects to provide the following forms of coverage to children:

(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))

- 6.2.1. Inpatient services (Section 2110(a)(1))
- 6.2.2. Outpatient services (Section 2110(a)(2))
- 6.2.3. Physician services (Section 2110(a)(3))
- 6.2.4. Surgical services (Section 2110(a)(4))
- 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. Prescription drugs (Section 2110(a)(6))
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. Inpatient mental health services, other than services described in 6.2.18., but not including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

*Inpatient hospital benefits will be available for conversion to outpatient services. Up to 35 days may be converted, 25 days will remain as a hospital reserve (they will not be available for conversion). The conversion will be available according to the following schedule:*

*1 inpatient hospital day = 1 sub-acute day  
1 inpatient hospital day = 2 partial hospitalization services  
1 inpatient hospital day = 2 intensive outpatient visits  
1 inpatient hospital day = 3 outpatient visits*

*Maximum of 60 days per year, with supplemental coverage available through HUSKY Plus for children who meet the criteria for the HUSKY Plus Behavioral Health Plan. See Appendix 3.1 for information on HUSKY Plus.*

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

*Maximum of 30 visits per year (in addition to allowable substitution of inpatient days) with supplemental coverage available through HUSKY Plus for children who meet the criteria for the HUSKY Plus Behavioral Health Plan. See Appendix 3.1 for information on HUSKY Plus.*

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

*Under HUSKY Part B, DME (other than powered wheelchairs, which are available under the HUSKY Plus Plan for Children with Intensive Physical Health Needs) is covered. See Appendix 3.1 for information on HUSKY Plus.*

- 6.2.13. Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))

*Home health services will be provided. See Appendix 3.1 for information on HUSKY Plus.*

- 6.2.15. Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. Dental services (Section 2110(a)(17))
- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

*Maximum of 60 days per calendar year for drug abuse and 45 days per year for alcohol abuse, with supplemental coverage available through HUSKY Plus for children who meet the criteria for the HUSKY Plus Behavioral Health Plan. See Appendix 3.1 for information on HUSKY Plus.*

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

*Maximum of 60 visits per calendar year, with supplemental coverage available through HUSKY Plus for children who meet the criteria for HUSKY Plus Behavioral Health Plan. See Appendix 3.1 for information on HUSKY Plus.*

- 6.2.20. Case management services (Section 2110(a)(20))
- Case management will be available through HUSKY Plus. See Appendix 3.1 for information on HUSKY Plus.*
- 6.2.21. Care coordination services (Section 2110(a)(21))
- Care coordination will be available through HUSKY Plus. See Appendix 3.1 for information on HUSKY Plus.*
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- Long term coverage will be available through HUSKY Plus. See Appendix 3.1 for information on HUSKY Plus.*
- 6.2.23. Hospice care (Section 2110(a)(23))
- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- Services of nurse midwives, nurse practitioners, podiatrists, chiropractors, and naturopaths will be covered.*
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
- Transportation by ambulance will be covered but non-emergency transportation will not.*
- 6.2.27. Enabling services (such as transportation, translation, and outreach services) (See instructions) (Section 2110(a)(27))
- Translation and outreach services will be available through both the MCPs and HUSKY Plus. All printed materials must be in English and Spanish, and both the MCPs and HUSKY Plus programs must provide translation services. See Appendix 3.1 for information on HUSKY Plus.*
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3. **Waivers - Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))

6.3.1. **Cost Effective Alternatives.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** (Section 2105(c)(2)(B)(i))

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii))

6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** (Section 2105(c)(2)(B)(iii))

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

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A))

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B))

## Section 7. Quality and Appropriateness of Care

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

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))

*The methods that will be used to assure quality and appropriateness of care will include contracting standards, licensing, reporting requirements, external reviews, and onsite reviews.*

*First, the RFP will include specific standards for quality of care, including the provision of well-baby care, well-child care, and immunizations. MCPs will be required to arrange for immunizations and comprehensive screens (and any needed interperiodic screens) in accordance with the schedules recommended by the American Academy of Pediatrics. As described below, MCPs will be required to submit annual reports on well-baby care, child care visits and immunizations. Please note that the state has a statewide immunization registry (Connecticut Immunization Registry and Tracking System), and the MCPs will be required to report to that registry and use that information to complete their immunization reports to DSS.*

*MCPs will be required to meet all standards for quality of care in the RFP in order to contract with the state. In addition, each MCP must be licensed by the state as a Health Maintenance Organization (HMO) or operate as a Managed Care Organization based on Federally Qualified Health Centers and certified by the Department to participate in the Medicaid managed care program. As an HMO, the MCPs must comply with the managed care bill passed last year, which contains various quality/consumer protection requirements (See Appendix 7.1 for a summary of this bill). Once the state has signed contracts with MCPs, it will*

*continuously monitor quality through various mechanisms, including reporting, external reviews, and onsite reviews.*

*Reporting will include a report on the MCP's quality assurance plan (QAP), as required by the managed care bill (See Appendix 7.1), which includes information on complaints, prior authorization denials, utilization review (UR) denials, and all data required for HEDIS (or equivalent data for non-NCQA accredited plans). Information required by the managed care bill will be sent to both the insurance commissioner and DSS for review. (Under the managed care bill, if a plan is NCQA accredited for at least one year, it only needs to submit proof of accreditation and HEDIS. However, DSS will require NCQA accredited plans to submit a report on their QAPs, which must comply with Section 7.1.4.) In addition, DSS will require quarterly reports on compliance with the EPSDT periodicity schedule and on immunizations, similar to the reports currently prepared by Medicaid MCOs, and quarterly provider network reports. The functions of the external quality review organization are described in 7.1.1. In addition, the state will conduct periodic onsite reviews to determine ongoing compliance with contract requirements.*

Will the state utilize any of the following tools to assure quality?

(Check all that apply and describe the activities for any categories utilized.)

7.1.1. Quality standards

*The state will contract for an external quality review of the HUSKY Plan, Part B. Such review shall include, but not be limited to, an evaluation of access to care, a satisfaction survey, medical record standards, provider credentialing, individual case review, and the development of a consumer MCO report card (see 7.1.3).*

7.1.2. Performance measurement

*The state will require MCPs to submit HEDIS 3.0 reporting measures or equivalent data (which is likely to be HEDIS 3.0 or a modified version of HEDIS 3.0) (the insurance commissioner plans to issue regulations on this requirement in March of 1998) and quarterly reports on immunizations and compliance with the EPSDT periodicity schedule. In addition, as noted in Section 9.7, the state will comply with any national quality measures.*

7.1.3. Information strategies

*Both the SPES and the MCPs will be required to educate enrollees about their benefits, rights and responsibilities under the HUSKY Plan, Parts A and B, including HUSKY Plus. The MCPs will also educate enrollees about the importance of preventive services, health promotion activities, and visiting their primary care provider instead of an emergency room. In addition, no later than March 15, 1999, and annually thereafter, the state will develop and distribute a consumer report card on all MCOs.*

7.1.4. Quality improvement strategies

*The state will include specific standards for quality of care in the RFP, and MCPs will have to meet those standards in order to contract with the state. These standards will be monitored by the state through reporting requirements, onsite reviews, and external reviews.*

*In particular, MCPs will be required to establish an internal QAP, which will be in writing and available to the public. The written description shall include detailed goals and annually developed objectives; address the quality of clinical care and non-clinical aspects*

*of services for the entire range of care provided by the MCP; specify quality of care studies and related activities; provide for continuous performance of activities, including tracking of issues over time; and provide for review and feedback by physicians and other health professionals.*

- 7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. **(2102(a)(7)(B))**

*The state will require each MCP to include sufficient numbers of appropriately trained and certified clinicians of pediatric care, including primary, medical subspecialty and surgical specialty physicians, as well as providers of necessary related services such as dental, mental health, social work, developmental evaluation, therapy, school-linked clinic, and other public health services. The state will monitor network capacity through quarterly provider network reports and will suspend new enrollment if capacity is exceeded.*

*MCPs will be required to ensure that their provider networks provide access to primary care providers (PCPs) within 30 minutes and access to emergency services on a 24-hour, seven-day-a-week basis. Emergency cases must be seen immediately, urgent cases within 48 hours, and routine cases within 10 days. An emergency medical condition will be defined as a condition such that a prudent lay person, acting reasonably, would have believed that emergency medical treatment is needed. The state will monitor access requirements through reporting and member satisfaction surveys.*

**Section 8. Cost Sharing and Payment** (Section 2103(e))

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

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. YES

8.1.2. NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income:  
(Section 2103(e)(1)(A))

8.2.1. Premiums: *Children with family income up to 235 percent of the FPL (before income disregards as provided for in section 15 of P.A. 97-1 of the October 29 Special Session, or as may be amended) will not be required to pay a premium. Children with family income that exceeds 235 percent of the FPL (before such income disregards) but does not exceed 300 percent of the FPL (before such income disregards) will be required to pay a premium of \$30 per child per month, up to a maximum of \$50 per family. Children with family income over 300 percent of FPL will be required to contribute the entire premium. Private organizations may subsidize premium payments.*

8.2.2. Deductibles: *Not applicable*

8.2.3. Coinsurance: *Not applicable*

8.2.4. Other: *For children in families with income over 185 percent of FPL, the state will establish a schedule of reasonable copayments for services other than the following: preventive care and services, inpatient physician and hospital, outpatient surgical, ambulance, skilled nursing, home health, hospice and short-term rehabilitation and physical therapy, occupational and speech therapies, lab and X-ray, preadmission testing, prosthetics, durable medical equipment, and dental exams. See Appendix 6.1.*

*The maximum annual aggregate cost sharing (premiums and copayments) for a family with income that exceeds 185 percent of poverty (before disregards) but does not exceed 235 percent will not be more than \$650. The maximum annual aggregate cost sharing for a family with income that exceeds 235 percent of FPL but does not exceed 300 percent will not be more than \$1,250. There will not be a limit on cost sharing for families with income that exceeds 300 percent of the FPL.*

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

*Information about cost sharing will be included in the outreach materials and both the SPES and the MCPs will provide information on cost sharing requirements.*

- 8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))
- 8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))
  - 8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))
  - 8.4.3. No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).
  - 8.4.4. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))
  - 8.4.5. No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))
  - 8.4.6. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A))
  - 8.4.7. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1))
  - 8.4.8. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105(c)(7)(B))
  - 8.4.9. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105(c)(7)(A))
- 8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: (Section 2103(e)(3)(B))

*MCPs will not be allowed to collect cost sharing that exceeds the maximums provided in section 8.2. Enrollees will be notified of this and of their right to complain to the state (e.g., through the toll free telephone number) if a provider/MCP attempts to collect cost sharing that exceeds such maximums. MCPs will be required to track cost sharing collections and notify enrollees and providers when the maximum has been reached. MCPs will also be required to report cost sharing collections to DSS and the SPES on a quarterly basis.*

- 8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:
- 8.6.1. The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**

8.6.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:

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**Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)**

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

9.1.1. *To increase the number of children in Connecticut with health insurance by expanding Medicaid (HUSKY Part A) coverage and creating a new health insurance program for previously uninsured children, to be known as HUSKY Part B.*

9.1.2. *To maximize participation in HUSKY, Parts A and B through outreach, a single point of entry, presumptive eligibility, a simplified application process and annual enrollment.*

9.1.3. *To promote the health of children through a health benefit package tailored to the health care needs of children, which includes comprehensive preventive services.*

9.1.4. *To assist those children enrolled in HUSKY, Part B, who have special physical and behavioral health care needs, to receive appropriate care through two supplemental plans (HUSKY Plus).*

9.1.5. *To design the HUSKY Plus program in a way that will maximize coordination between the HUSKY Part B and HUSKY Plus, by integrating basic health care needs into the care provided for intensive health care needs and, whenever possible, building upon existing therapeutic relationships with Title V providers.*

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

9.2.1 *To increase the number of children covered by health insurance.*

9.2.2 *To maximize participation in HUSKY Parts A & B.*

*Expand Medicaid (HUSKY Part A) enrollment of uninsured children 15-18 years old who are under 185% of the federal poverty level.*

*Expand Medicaid (HUSKY Part A) enrollment of uninsured children under 15 years old who are under 185% of the federal poverty level.*

*Increase the number of insured children 18 or under who are between 185% and 300% of the federal poverty level.*

9.2.3 *To promote the health of children through a comprehensive health benefits package.*

*Match or exceed the statewide average of the percentage of children in HUSKY Parts A and B who receive immunizations by age 2, meet or exceed state standards for well-child care, with a goal of at least 80% of children receiving all recommended well-child visits.*

9.2.4 *To assist children with special physical and behavioral needs through HUSKY Plus.*

*The goal is for 100% of referrals to HUSKY Plus to have eligibility determinations within 21 days.*

*Track the percentage of referrals to HUSKY Plus accepted or denied.*

*100% of children with the following conditions will receive care according to individual needs and professional guidelines:*

*Children with intensive physical needs with a diagnosis of cystic fibrosis under ICD 9 CM 277.0.*

*Children with intensive physical needs with a diagnosis of cerebral palsy under ICD 9 CM 343.*

*Children with intensive behavioral needs with a diagnosis of major depression under DSM IV 296.30 through 296.36.*

9.2.5 *To maximize coordination between HUSKY Part B and HUSKY Plus*

*100% of children in HUSKY Plus who receive case management.*

*100% of children in HUSKY Plus, who were formerly covered by Title V, who will continue to have the same specialty provider.*

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

*The state, through a contract with an external quality review entity, will conduct an annual evaluation based on an analysis of the program measurer, a sampling of patient charts, encounter data, and a patient satisfaction survey.*

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

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used. *Well child periodicity compliance.*
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
  - 9.3.7.1. Immunizations
  - 9.3.7.2. Well child care
  - 9.3.7.3. Adolescent well visits
  - 9.3.7.4. Satisfaction with care
  - 9.3.7.5. Mental health
  - 9.3.7.6. Dental care
  - 9.3.7.7. Other, please list: \_\_\_\_\_
- 9.3.8. Performance measures for special targeted populations.
- 9.4. The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1))
- 9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))
 

*The state, through a contract with an external quality review entity, will conduct an annual evaluation based on an analysis of the program measurer, a sampling of patient charts, encounter data, and a patient satisfaction survey.*
- 9.6. The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))
- 9.7. The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.
- 9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e))
  - 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)

- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
  - 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
  - 9.8.4. Section 1115 (relating to waiver authority)
  - 9.8.5. Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
  - 9.8.6. Section 1124 (relating to disclosure of ownership and related information)
  - 9.8.7. Section 1126 (relating to disclosure of information about certain convicted individuals)
  - 9.8.8. Section 1128A (relating to civil monetary penalties)
  - 9.8.9. Section 1128B(d) (relating to criminal penalties for certain additional charges)
  - 9.8.10. Section 1132 (relating to periods within which claims must be filed)
- 9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c))

*The legislature passed legislation authorizing the HUSKY Plan, including requirements regarding eligibility, enrollment, benefits, HUSKY Plus, cost-sharing, quality, and legislative oversight (See Appendix 1.3). In addition, the state developed a program for public involvement (See Appendix 9.9). This program was divided into five tracks: the overall distribution of information, the opportunity to submit written comments, a schedule of public hearings to distribute information and receive comments, ongoing involvement with the Children's Health Council, and a forum for prospective MCPs.*

*Five regional hearings and a forum for prospective provider health plans have already been held and a written response to comments will be distributed.*

- 9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

A financial form for the budget is being developed, with input from all interested parties, for states to utilize.

*See Appendix 9.10 for information on the state budget for the HUSKY Plan for SFY 1998. The program will be funded through state appropriations.*

## **Section 10. Annual Reports and Evaluations (Section 2108)**

- 10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))
  - 10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and
  - 10.1.2. Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.
- 10.2. State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: **(Section 2108(b)(A)-(H))**
  - 10.2.1. An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
  - 10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:
    - 10.2.2.1. The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
    - 10.2.2.2. The quality of health coverage provided including the types of benefits provided;
    - 10.2.2.3. The amount and level (including payment of part or all of any premium) of assistance provided by the state;
    - 10.2.2.4. The service area of the state plan;
    - 10.2.2.5. The time limits for coverage of a child under the state plan;
    - 10.2.2.6. The state's choice of health benefits coverage and other methods used for providing child health assistance, and
    - 10.2.2.7. The sources of non-Federal funding used in the state plan.
  - 10.2.3. An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
  - 10.2.4. A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
  - 10.2.5. An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
  - 10.2.6. A description of any plans the state has for improving the availability of health insurance and health care for children.
  - 10.2.7. Recommendations for improving the program under this Title.

- 10.2.8. Any other matters the state and the Secretary consider appropriate.
- 10.3. The state assures it will comply with future reporting requirements as they are developed.
- 10.4. The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.