

**INDIANA'S APPLICATION 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.

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**INDIANA'S 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:        State of Indiana

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

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Frank O'Bannon, Governor, State of Indiana

*(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.

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## **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. Health Insurance Coverage

##### Low-Income Children:

The total number of Indiana children under 19 is estimated to be between 1,595,000 and 1,673,000. This number varies depending upon which Census Bureau CPS data is utilized. The reported average of 1995, 1996, and 1997 CPS data indicates that there are 1,595,000 children under 19 in Indiana. Whereas, the reported average of 1994, 1995, and 1996 CPS data indicates that there are 1,673,000 children under 19 in the State.

Eighty-six percent of the children in Indiana are estimated to be Caucasian; 10 % are estimated to be African-American; 3% are estimated to be Hispanic; less than 1% are estimated to be Asian; and less than 1% are estimated to be Native American.

Estimates of the number of children under 200% of the federal poverty level (FPL) range from 556,000 to 618,000. These estimates were calculated using data from two sources: 1) the 1990 Census data increased by the population growth; and 2) poverty data from the 1996 and 1997 CPS.

##### Health Coverage of Low-Income Children:

A March 1998 Employee Benefit Research Institute (EBRI) analysis of the March 1997 CPS data found that the uninsured rate for children in Indiana was 9.6%. Estimates of the number of total uninsured children in Indiana range from 173,000 to 179,000. Approximately 129,000 to 143,000 of these children are below 200 % FPL, including approximately 88,000 to 97,000 children who are under 150% FPL. These data include children who are eligible for Medicaid but who are not enrolled in the program. These estimates are based upon the Census data cited above; uninsured rates calculate from the 1996 CPS by the EBRI; a 1997 Kaiser Commission Report; and a 1997 American Academy of Pediatrics paper.

It is estimated that close to one-half of all uninsured children under 200% FPL reside in the five largest counties of the State. Certain other counties also have a high number of uninsured children.

Approximately 209,000 children in Indiana are currently enrolled in the Medicaid program. Sixty-four percent of these children are white, 31% black, 4% Hispanic and less than 1% each are Native American and Asian. Almost half of these children reside in the five largest counties in the state. There are also approximately 55,000 to 61,000 children who are currently eligible for Medicaid, but are not enrolled in the program.

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According to the EBRI July 1997 analysis of the March 1996 CPS data, 76.4% of children in Indiana are covered by private insurance. Sixty-eight percent of these children are covered under employer-based plans, while the remaining 8.4% are covered by other private insurance plans. There are no data regarding private coverage of low-income children available at the present time.

## 2.2 Current State Efforts to Provide or Obtain Creditable Coverage for Uncovered Children

### 2.2.1. Current Strategies for Enrollment of Children in Public Health Insurance Programs.

#### Medicaid:

The primary public health insurance available in Indiana is through the Medicaid program. As indicated previously, approximately 209,000 children are currently enrolled in Medicaid. Hoosier Healthwise, a mandatory managed care program under Medicaid has recently been phased-in. Hoosier Healthwise is comprised of a Primary Care Case Management system and a Risk-Based Managed Care system. Primary medical providers (PMPs) provide preventive and primary medical care, and furnish authorizations and referrals for most specialty services. Children eligible for Medicaid through the Title XXI expansion will be integrated into these managed care networks, thereby assuring that they each have a medical home.

Individuals currently apply for Medicaid at one of the 105 Division of Family and Children (DFC) offices located throughout the State. Over 1,500 Public Assistance caseworkers process Medicaid applications at these locations. Medicaid eligibility packets are currently available in every local DFC office and at the central DFC office. In addition, the local DFC offices make the packets available to various community service agencies in the individual counties. Many local offices have arrangements with the hospitals in their communities, whereby the hospitals inform the caseworkers of the babies born to Medicaid recipients. These children are enrolled in the program without the parent having to contact the DFC office.

#### Other Child-Related Programs:

There are a number of other public programs in Indiana that provide health related services to children. DFC caseworkers refer families for these services, where appropriate. As these child-related programs engage in outreach activities that target individuals eligible for the services they offer, they also strive to identify other programs for which the children may be eligible and to make the appropriate referrals.

The Healthy Families Indiana Program, a voluntary home visitation program, is designed to prevent child abuse and neglect by linking families to a variety of services, including child development, health care, and parent education. The goals of the Healthy Families Indiana program include every child having a medical home and every child having up to date immunizations. Referrals are also made to Medicaid and various other child-related programs in the State. Approximately 2,500 children are currently enrolled in the Healthy Families Indiana program. Each individual community develops its own Healthy Families outreach plan.

The Children's Special Health Care Services (CSHCS) program is an insurance program that provides medical assistance to approximately 8,000 children with certain chronic medical conditions who meet medical and financial eligibility requirements. Children are referred to the CSHCS program by providers and by other programs in the State. CSHCS requires children who apply for the program to also apply for Medicaid. Children with special medical needs and their siblings who are eligible for Medicaid are identified by the CSHCS care coordinator when the care coordinator first receives the case and during the annual re-evaluation. Applications for the CSHCS program will soon be taken by the newborn intensive care unit at Riley Hospital for Children, the only children's hospital in the State. The CSHCS program and the First Steps Early Intervention Program have combined intake systems. Each county has a single point of entry which can take a combined Medicaid, CSHCS, First Steps, and SSI application. This collaboration has resulted in a large increase in the number of children served by the CSHCS program.

The Indiana Maternal and Child Health (MCH) program requires direct service grantees to facilitate their clients into Medicaid if they meet the eligibility requirements. The MCH program, located within the Indiana State Department of Health (ISDH), provides information regarding financial eligibility for SOBRA expanded Medicaid. Provisional data shows the MCH program served approximately 39,000 individuals under age 20 in fiscal year 1997. Children under 100% of poverty are served free of charge. An additional 123,315 children were served through the MCH lead screening and Newborn Screening programs. MCH funds 19 child or adolescent health clinics and four school based health clinics. Services for children are also provided at other MCH sites. All 41 of the MCH grantees are Medicaid providers, and several of these act as PMPs under the Medicaid managed care program. Each individual MCH grantee does its own outreach and marketing. Grant applications include Memorandums of Understanding which are used to develop collaborations between various programs in the individual communities. Referrals to other programs are documented on the encounter forms and entered into the project data base, so that follow-up can be performed during the next visit.

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The MCH program also operates the Indiana Family Helpline which provides health care information and referrals through a toll free telephone number. The Family Helpline staff screen all clients for Medicaid eligibility and provide appropriate referrals. The Helpline is advertised through flyers distributed in numerous sites throughout the State. The number is also included in mailings which are sent to consumers by the Family and Social Services Administration (FSSA).

Local Health Departments (LHDs) provide immunizations, lead screenings and other direct services to individuals throughout Indiana. Many of these activities are funded with federal and state dollars channeled through the ISDH. Some LHDs have special staff dedicated specifically to outreach activities.

Indiana has a Step Ahead initiative which is designed to develop comprehensive seamless delivery systems at the local level for children from birth to age thirteen. The initiative is designed to support efforts in individual counties to reduce duplication and fragmentation of services. Local Planning Councils which are representative of the individual counties' demographic ethnic and service population work to address child issues in the community. At the state level, Step Ahead strives to coordinate funding streams and remove barriers that are problems for families and providers.

First Steps, Indiana's early intervention system for infants and toddlers who have developmental delays, brings together federal, state, local, and private funding sources to develop a coordinated, community-based system of services. Each community works to develop its own system to coordinate networks of traditional and non-traditional service providers. The networks include MCH programs; community mental health centers; Women, Infants and Children (WIC) programs; developmental disabilities agencies; MCH agencies; CSHCS programs; private health care providers; child care providers; United Way agencies; and numerous independent providers and service coordinators. First Steps has a "child find" system which provides a coordinated, community system for identifying, locating and evaluating children who are eligible for early intervention services. This system is implemented in different ways in each individual community.

Very important health care services for children are also provided by Community Health Centers (CHCs). These centers design their services around needs identified in their particular communities. Many of the CHCs engage in significant outreach activities. A more detailed discussion of the activities of the CHCs can be found in Section 2.2.2.

Special Populations:

The ISDH has developed a collaboration with the Indiana Minority Health Coalition (IMHC) to promote healthy lifestyles through disease prevention, health awareness, referral and information services, community outreach, and program services. In addition to funding the State and local coalitions, the agency relies upon these coalitions for outreach for the immunization program and other programs administered by the agency.

A Consolidated Outreach Project (COP), funded by the Department of Education, Department of Workforce Development, the Social Services Block Grant, and the Community Services Block Grant, provides intake assessment for migrant farmworkers who enter Indiana for seasonal employment. The families are referred to health care programs and other programs for services while they are in the state. Additional information regarding this project may be found in Section 2.2.2.

2.2.2. Public/Private Health Insurance Efforts

There are several current initiatives which provide health services to children through collaborative public and private efforts. These efforts include a collaboration between the ISDH and the Indiana Primary Health Care Association (IPHCA); managed care contracts between the Division of Mental Health (DMH) and managed care providers; and a health insurance high risk pool for medically challenged individuals that is financed through a partnership between the beneficiaries, the health insurance industry and the state. In addition, the Medicaid program and the CSHCS program may both be considered public-private initiatives due to the fact that they contract with private providers to provide services to the beneficiaries. A more detailed discussion of Medicaid and the CSHCS program may be found in Section 2.2.1.

Through a collaborative arrangement between the ISDH and the IPHCA, health care services are provided to children and other individuals in the State. This arrangement was designed to improve access to primary health care programs for the medically underserved; individuals at poverty level; working poor; migrant and seasonal farmworkers; the homeless; and individuals who lack health care due to geographic, financial and/or cultural barriers. The IPHCA also recently received a \$75,000 grant to promote outstationing in federally qualified health centers (FQHCs). This grant will be used to augment the state outstationing efforts.

The ISDH has also worked collaboratively with IPHCA to allocate the CHC start-up and planning funds allocated by the General Assembly in 1995, and the funds allocated by the General Assembly in 1997 for expanding existing services, start-up and planning. Applications for these funds were required to address community needs, special populations, and collaborative linkages. Overall, there are a total of twenty-two state and/or federally funded community health center sites in Indiana. In 1996, the federally funded sites alone served over 28,000 children. Over 4,000 of the individuals served by these FQHCs were migrant farmworkers. The 1996 data indicate that approximately 59% of the clients served at the FQHCs are Caucasian, 27% African-American, 14% Hispanic, and less than 1% combined are Native American or Asian. The CHCs that are not

federally funded also provide a variety of health services to the communities; however, such data are not currently available.

Many of the CHCs utilize outreach workers to market their services to potential clients in the individual communities. These outreach workers often go door to door to target potential clients. CHCs located in areas with high concentrations of Hispanics and migrant farm workers use Spanish speaking outreach workers and providers. As part of the COP partnership, the CHCs provide health services to migrant farmworkers.

The DMH has undertaken a collaborative effort with mental health providers throughout the state. The providers act as mini-HMOs in that they receive a payment up-front from the DMH, and have panel members who provide a full array of mental health services to seriously emotionally disturbed children who are at 200% of poverty or below. The DMH is also involved in the Dawn Project, a collaborative effort with the Department of Education Division of Special Education, the Marion County Office of Family and Children, the Marion County Superior Court Juvenile Division and the Marion County Mental Health Association. The goal of this pilot project is to provide community based services to children and youth in Marion County who are seriously emotionally disturbed and who are at imminent risk of long-term inpatient psychiatric hospitalization or residential care. Families are assigned a service coordinator who works with the family to design an array of services that meet the individual needs of the child and family. Referrals to the program come primarily from the Office of Family and Children, the Department of Education and the Juvenile Court.

A partnership between the health insurance industry and the State is the underlying principle behind the financing of an insurance risk pool for medically challenged individuals who are unable to obtain traditional health insurance. The Indiana Comprehensive Health Insurance Association (ICHIA), a private non-profit association created by the Indiana General Assembly, covers approximately 375 children. State programs make referrals to ICHIA where appropriate. ICHIA is funded through premiums, and an assessment on insurance companies licensed in the State. Since the insurance companies are able to obtain a state tax credit for these assessments, the State is an important partner in this initiative as well.

### 2.3. Coordination of Title XXI Program with Current Efforts

The Indiana Title XXI CHIP Medicaid expansion will include two parts:

Adding SOBRA children between the ages of 14 and 18 up to 100% of the FPL to the Medicaid program; and

Expanding Medicaid to all children ages 0-18 up to 150% of the federal poverty level.

This new program will build upon the current Medicaid program under Title XIX and the other child-related programs in the State. Enrollment in the Title XXI Children's Health Insurance Program (CHIP) will be conducted as part of the overall process for Medicaid enrollment. The Medicaid eligibility determination system known as "ICES" (Indiana Client Eligibility System) will reflect Title XXI as a separate eligibility category. ICES

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establishes an applicant's category of assistance based upon a hierarchy that prioritizes categories with full coverage and the least restrictive eligibility requirements over other categories. Since the Title XXI category will be lower in the hierarchy than the Title XIX poverty level categories, eligibility will first be explored under the Title XIX categories, and only children with higher incomes who do not qualify for Title XIX will be placed in the new Title XXI category. Reevaluations will be conducted on a quarterly basis for those receiving food stamps, and on an annual basis for those only eligible for Medicaid.

The DFC is currently evaluating different outstationing models, including a co-location model, and several alternative options. While local DFC directors will have considerable flexibility in fashioning outstation designs that are appropriate for the specific enrollment centers, they are required to consult with a myriad of entities in their community. These organizations include: Head Start, First Steps, community action programs, community health centers, childcare voucher agents, disproportionate share hospitals, public school system school lunch program, county hospitals, WIC clinics, MCH clinics, IV-D prosecutor staff, township trustees, and community multi-service centers. The current outstation model at Wishard Hospital, Indiana's largest public hospital, will be expanded so that hospital personnel will do the intake processing. A more detailed discussion of outstationing and information regarding new outreach activities can be found in Section 5.1.

In order to enhance coordination between child-related programs in the State, a state technical advisory group has been meeting weekly for several months. Representatives at these meetings include top executive staff of the Children's Health Insurance Program, the Office of Medicaid Policy and Planning, the Division of Family and Children, the Department of Health, the Division of Mental Health, the Budget Agency and the Department of Insurance. Further, the Governor's Advisory Panel on the Children's Health Insurance Program will be responsible for making recommendations for coordination between programs. The state is also in the process of reviewing consultants' proposals which will address, among other issues, coordination of programs. Additionally, Indiana will continue to strive to coordinate referrals between the Medicaid program and other child-related programs as discussed in Section 2.2.1. The Title XXI program will build upon these current referral and coordination efforts.

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

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**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)

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

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**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.**

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- 4.1.1. Geographic area served by the Plan: \_\_\_\_\_
- 4.1.2. Age: \_\_\_\_\_
- 4.1.3. Income: \_\_\_\_\_
- 4.1.4. Resources (including any standards relating to spend downs and disposition of resources): \_\_\_\_\_
- 4.1.5. Residency: \_\_\_\_\_
- 4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility):  
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- 4.1.7. Access to or coverage under other health coverage: \_\_\_\_\_
- 4.1.8. Duration of eligibility \_\_\_\_\_
- 4.1.9. Other standards (identify and describe):  
\_\_\_\_\_

- 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))

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4.4. Describe the procedures that assure:

4.4.1. Through intake and follow-up 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))

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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))

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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))

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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© of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)). (Section 2102)(b)(3)(D))

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

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

### **5.1. New Outreach Strategies**

Indiana is currently in the process of implementing expanded Medicaid outreach strategies which build upon the outreach efforts currently underway in the State. An action plan that encompasses short-term activities and long-range plans has been drafted. The goals of the plan include: encouraging simplicity, establishing processes that are convenient for families, and eliminating duplicative interviewing.

While the new policy directive has been developed by the central DFC office, much of the responsibility for developing and implementing specific outreach efforts is being given to the DFC directors in the individual counties. Each individual DFC director was furnished a list of numerous individuals and entities that they are required to contact to discuss outreach and outstationing. The local DFC director will be responsible for working with these and other potential partners in the individual communities, and for fashioning outstationing models that meet the needs of the individual communities and the particular partners. This local design responsibility will be especially important in rural areas where different outreach strategies may have to be utilized. The directors also will develop local outreach plans geared to the specific communities. These plans are to be developed with input from the local office staff, local welfare planning councils, local health departments, local health care providers, Step Ahead Councils, and other community planning boards that address children's issues. In order to carry out their new responsibilities, each county director will be given a specific outreach appropriation for advertising and information distribution. A temporary executive position is being created at the central DFC office to coordinate the outreach and outstationing activities throughout the state.

#### *Short-Term Outreach Efforts:*

Indiana has undertaken a number of recent efforts designed to increase outreach. These efforts have included: evaluating the viability of a toll free telephone number, analyzing the number of uninsured children per county, reviewing equipment specifications and technical needs so that local providers and agencies who want to partner with the State can purchase compatible equipment, developing a simplified shortened Medicaid application form for those applying for Medicaid only, undertaking a media campaign that is designed to inform the public about the availability of the Medicaid program, and creating a new training curriculum for caseworkers and other individuals.

Over recent months, the DFC has also met with individuals representing hospitals, schools, health centers and social service agencies to discuss collaborative outreach and outstationing opportunities that may exist in the varying communities throughout the state. These discussions have led to the development of a number of outstationing models that could be utilized in different communities and in different types of settings. These models range from a co-location, to a partnership where a facility hires a full-time employee to collect the necessary application information. The goal is for the information to be obtained, verified and collected by a person at the outstation location. This

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information will then be forwarded to the local DFC office for evaluation and authorization. If all of the necessary documents are submitted by the outstation worker, the caseworker will authorize the case within twenty-four hours.

Long-Term Outreach Efforts:

In addition to establishing continuous coverage and presumptive eligibility one year pilot projects, as provided for by legislation passed by the General Assembly, the State has outlined a number of other outreach efforts that will also be implemented in the coming months. These efforts will include: coordinating the heightened outreach campaign among the various state agencies, promoting the new outreach efforts at a myriad of community service and health service meetings, analyzing a business study that addresses the feasibility of instituting a telephone interviewing process, delinking Medicaid from TANF and Food Stamps in the computer system, and establishing a significant presence at Indiana Black Expo and the state and county fairs. The presence at the county fairs will be especially helpful in providing outreach in rural areas of the State.

As the county directors become more involved in community networks, they will have an increased ability to connect children with other child-related programs in Indiana. Further, the DFC directors' new outreach responsibilities will provide an increased opportunity to engage in coordinated efforts that link Medicaid outreach and outreach for other child-related programs.

The state is also working with seven community coalitions to draft an application for a Robert Wood Johnson (RWJ) outreach grant. Some of these communities are also seeking to raise other funds to augment potential RWJ funding.

Special Populations:

Discussions will be held with the IMHC and Indiana Black Expo regarding potential Title XIX and Title XXI outreach collaborations. The COP will continue to be utilized to provide outreach for children in families of migrant farmworkers. The state has contacted the Indiana American Indian Manpower Council, the only entity in the State that specifically serves the Native American population in Indiana, and will continue discussions regarding joint outreach activities that can be utilized to enroll eligible Native American children. In addition, the State will continue its discussions with the Hispanic Health Access Initiative to identify special needs of the Hispanic population.

5.2. Coordination of the administration of this program with other public and private health insurance programs:

Crowd Out:

Indiana's Title XXI Medicaid expansion limits family income to 150% of poverty. This will serve as an indirect measure to address crowd-out as many of the lower income families do not have the option of employer-based health insurance. Further, in order to minimize substitution of Title XXI funded coverage for a child's current employer-provided health insurance coverage, Indiana will require that Title XXI funded enrollees not have other current health insurance. Upon application and at points of recertification, parents will be asked to attest to the lack of current coverage and to provide information regarding when the child last had coverage.

All children who apply for CHIP will be screened for Medicaid eligibility under Title XIX, and, if found eligible, will be enrolled under the Title XIX program. The Title XXI CHIP program will be a new category in the Medicaid eligibility determination system, ICES. As discussed in Section 2.3, the ICES system establishes an applicant's category of assistance based upon a hierarchy of eligibility categories. The CHIP category will be lower in the hierarchy than the Title XIX categories, thus ensuring that eligibility will first be explored under the Title XIX categories, and only those children with higher incomes who do not qualify under Title XIX will be considered for the Title XXI program. Since the Title XXI CHIP program will be a new Medicaid category, children who are found not eligible for Medicaid under Title XIX, will automatically be enrolled in the Title XXI program if they are up to 150% FPL and do not have other insurance.

Administration of the Federal Allocation:

The FSSA will modify ICES, IndianaAIM (Indiana's Medicaid management information system), FSSA's cost allocation plan, and any other related systems to correctly reflect expenditures eligible for reimbursement from Indiana's federal CHIP allocation.

Coordination of Outstationing Efforts:

By utilizing a Medicaid expansion approach for the CHIP program, all current and future outstationing collaborations, including those at disproportionate share hospitals and FQHCs, will also be utilized for Title XXI outreach. A more detailed discussion of outstationing can be found in Section 5.1.

**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.) \_\_\_\_\_
  - 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.”  

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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 including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 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))
- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. Hospice care (Section 2110(a)(23))
- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
- 6.2.27. Enabling services (such as transportation, translation, and outreach services) (See instructions) (Section 2110(a)(27))
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3. **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))
- 

Will the state utilize any of the following tools to assure quality?  
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

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

**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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8.2.2. Deductibles: \_\_\_\_\_

8.2.3. Coinsurance: \_\_\_\_\_

8.2.4. Other: \_\_\_\_\_

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

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))
- 
- 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:
-

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

The chart below documents Indiana’s strategic objectives, and the corresponding performance goals and performance measures. The material has been combined into one chart for the sake of simplification.

9.1 Strategic Objective	9.2 Performance Goal	9.3 Objective Means of Measuring Performance
9.1.1 Uninsured, targeted low-income children will have health insurance through Indiana’s Title XXI Program.	<p>I. By January 1, 1999, 40,000 previously uninsured, targeted low-income children will have health insurance through Medicaid CHIP.</p> <p>I. The CPS conducted in 3/99 will show a 10% reduction in the percentage of targeted low-income children who do not have health insurance coverage over the findings of the 3/98 results.</p>	<p>I. Annual Medicaid recipient survey will reveal that at least 40,000 new enrollees under age 19 did not have health insurance when they enrolled in Title XXI.</p> <p>II. The percentage of uninsured children under 150% FPG in the 1999 CPS will be lower than in the 1998 CPS.</p>
9.1.2 Children currently eligible but not enrolled in Medicaid will be identified and enrolled in that program.	<p>II. By January 1, 1999, there will be at least a 10% increase in non-CHIP Medicaid enrollment by children under age 19.</p>	<p>III. Medicaid enrollment information captured in the IndianaAIM system will reveal the percentage of new enrollees, by age, race, and sex.</p>
9.1.3 Children enrolled in Indiana’s Title XXI Program will have a consistent source of care medical and dental.	<p>III. By January 1, 1999, 100% of the children enrolled in Title XXI will select or be assigned a primary medical provider.</p> <p>IV. By January 1, 1999, 95% of children enrolled in Title XXI will self-select their primary medical provider.</p>	<p>IV. Hoosier Healthwise enrollment data in the Indiana AIM system will verify PMP selection or assignment.</p> <p>V. Hoosier Healthwise enrollment data in the Indiana AIM system will verify PMP selection.</p>
9.1.4 Parents/children enrolled in Title XXI will be satisfied with the program.	<p>V. At least 75% of parents surveyed during the first year of their child’s participation will express overall satisfaction with the Title XXI program.</p>	<p>VI. Annual Hoosier Healthwise recipient survey results will be used.</p>
9.1.5 Providers who participate in the Title XXI program will express satisfaction with the terms and conditions of their participation.	<p>I. At least 50% of providers surveyed will express overall satisfaction with the Title XXI program.</p>	<p>I. Annual Hoosier Healthwise provider survey results will be used.</p>
9.1.6 The child health programs and payment sources in Indiana	<p>I. Single, simplified application will be put</p>	<p>II. A majority of CHIP and Medicaid</p>

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<p>will be coordinated to achieve family-friendly, seamless systems of care.</p>	<p>in place by August 1, 1998.</p> <p>II. Applications for Medicaid and CHIP by children and pregnant women will be taken by mail or in multiple locations in addition to DFC offices.</p> <p>III. The process of determining eligibility for and enrolling in Medicaid will be a one-step process.</p> <p>IV. The Hoosier Healthwise toll-free Helpline will track system responsiveness and priority issues for parents.</p>	<p>applications for children and pregnant women will originate from outside DFC offices.</p> <p>III.</p> <p>I. The face-to-face interview for children and pregnant women applying for Medicaid will be eliminated.</p> <p>II. Hoosier Healthwise Helpline and Indiana Family Helpline activity reports track calls answered and concerns or problems raised.</p>
<p>9.1.7 Children enrolled in Medicaid will enjoy improved health status.</p>	<p>V. By January 1, 1999, measures of health status in place for Hoosier Healthwise will show improvements in the following areas:</p> <p>A. immunization of 2-yr. olds</p> <p>B. preventive health services</p>	<p>III.</p> <p>HEDIS measures for 2-yr. old immunization as reported by Hoosier Healthwise providers</p> <p>IV. The percentage of children who receive age-appropriate EPSDT services will increase, with evidence drawn from a sample of chart reviews.</p>

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.

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- 9.3.4. \* The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
  - 9.3.7.1. Immunizations
  - 9.3.7.2. Well 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 assures that it will complete an annual assessment of the progress made in reducing the number of uncovered low-income children and report to the Secretary on the result of the assessment. The State also assures that it will submit the required evaluation by March 31, 2000.

Indiana presently has some of the data necessary to complete the chart of sample information needed for the annual report; however, efforts will have to be made to collect information that is not currently available. The state has estimates of the number of children under poverty, and the number of uninsured by level of poverty, and by county. Specific information broken down by race and ethnicity will be the most challenging to obtain.

The year 2000 evaluation will be based largely upon the strategic objectives set forth in Section 9. These performance measures are focused on enrolling children, establishing usual sources of care, measuring enrollee and provider satisfaction, coordinating child health and payment sources, and improving health status. The data used to measure performance will be compiled from existing databases. The Office of Medicaid Policy and Planning will be responsible for monitoring progress and conducting the annual assessment. The State has also issued a Broad Agency Announcement (BAA) for services of a consultant who will provide assistance with evaluation.

- 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. Public Input

Public Input on Plan Design:

In order to build upon the expertise and experience of a myriad of individuals and entities within the state, Indiana developed a public input plan that included four different levels of discussion.

A twenty-one member bi-partisan Governor's Advisory Panel representing a cross-section of Indiana experts was appointed to develop a blueprint on implementation of the CHIP Program and forward it to the Governor. Members on the panel include hospital representatives, physicians, insurance executives, parents, advocates, school officials, health clinic representatives, and members of the Indiana General Assembly. Numerous press releases have been utilized to publicize the work of the advisory committee. All advisory committee meetings have been publicized and have been covered by the news media. Further, there was significant news coverage of the General Assembly's deliberations on the legislation to authorize the Medicaid expansion recommended by the panel.

Five subcommittees were established to provide for a broader range of input and to allow for focused discussion on several areas of importance. Membership on the subcommittees includes nurses, pharmacists, local health department representatives, optometrists, mental health providers, numerous community and social services programs, migrant farmworkers and homeless parents, and various other experts.

A series of eight public forums were held across the state in order to allow for a wide range of input from a myriad of individuals and entities within the individual communities. The forums provided an opportunity for all citizens to share their concerns regarding methods for improving and for building upon the state's current health care system, and mechanisms for encouraging parents to access health services available for their children. The forums were held at a number of different sites and at different times in order to maximize awareness and participation. The local social service and health promotion agencies helped select the most appropriate time and location for each hearing. The organizers worked closely with numerous individuals and entities to promote the forums. Assistance was provided by the local WIC sites, local MCH agencies, local immunization sites, local Medicaid providers, local community health centers, local DFC offices, the LHDs, and the Indiana Coalition on Housing and Homeless Issues. In order to make it easier for parents to attend, child care was provided during the forums. Individuals who were not able to be present were encouraged to submit written comments. State and local news media were notified through a myriad of sources in advance of all public forums. News releases, media advisories and telephone calls were all utilized in an effort to maximize press coverage.

A number of focus groups were established to draw upon the expertise, experience, and perspectives of homogeneous groups of individuals. The focus groups consisted of individual groups of providers, advocates, parents and adolescents. The groups met in various locations throughout the State and discussed key issues from their own individual perspectives.

Promotion of Plan Implementation:

The Chair of the advisory panel is scheduled to appear before various editorial boards as a means of increasing awareness of the CHIP program. The state's web site operator, Access Indiana, is being contacted regarding the appropriate links that can be made between existing state sites. It is anticipated that substantial publicity will be utilized to promote the program once the State Plan receives federal approval. The State will perform an ongoing evaluation of the program with targeted public input.

9.10. Budget: Estimates and Cost Projections under CHIP (FFY 1998)

Two budget estimates are provided below. The SOBRA expansion includes a full year of costs, since it was effective before October 1, 1997. However, the 150% expansion will only be in effect for three months of FFY 1998, beginning July 1, 1998 (per state statute). The first estimate is based upon the enrollment of all targeted children. Due to the fact that enrollment may be slower at first due to ramp-up, a second estimate which takes this factor into account has been provided also.

Estimate 1: Expenditures for FFY 98 if all Targeted Children Enroll:

	Total Cost: (Federal and State)	State Cost:
<i>Cost of Benefits:</i>		
SOBRA Expansion (14 to 18 year olds) (65,515 children)	\$28,428,201	\$7,678,457
150% of Poverty Expansion: (36,236 children)	\$ 7,411,711	\$2,001,903
Total Cost for Benefits:	\$35,839,912	\$9,680,360
<i>Administrative Cost:</i> (Planning purposes and public input)	\$ 3,982,212	\$1,075,596
<i>Total Program Cost:</i>	\$39,822,124	\$10,755,956

Estimate 2: Expenditures FFY 98 -- Estimate based on Ramp-Up \*:

	Total Cost: (Federal and State)	State Cost:
<i>Cost of Benefits:</i>		
SOBRA Expansion (14 to 18 year olds): (12,937 children)	\$1,033,102	\$279,041
150% of Poverty Expansion: (12,352 children)	\$ 892,078	\$240,950
Total Cost for Benefits:	\$1,925,180	\$519,991
<i>Administrative Costs:</i> (Planning purposes and public input)	\$ 213,909	\$ 57,777
<i>Total Program Cost:</i>	\$2,139,089	\$577,768

Funding Source:

The state portion of the expenditures will be generated from the Medicaid appropriations line item provided by the Indiana General Assembly.

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**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.

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

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

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.

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- 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.

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- 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.