State Child Health Plan Under Title XXI of the Social Security Act

State Children's Health Insurance Program
State of Minnesota

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

State: **MINNESOTA**
(Name of State/Territory)

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

(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.

Section 1. General Description and Purpose of the State Child Heath 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 **X** Providing expanded benefits under the State's Medicaid plan and the State's 1115 waiver, Minnesota Health Care Reform Waiver ; **OR**

1.3 A combination of both of the above.

INTRODUCTION

Minnesota's Medicaid State plan in effect on April 1, 1997 provides for coverage of infants up to age one with family income equal to or less than 275% of the federal poverty level; and Minnesota received approval under an 1115 waiver on April 27, 1995 to cover children up to age two with income equal to or less than 275% of poverty. Minnesota proposes a Medicaid expansion to provide Medicaid to children under age two in families with income above 275%, but no more than 280% of the federal poverty level.

This small expansion for infants under age two in families with income over 275% up to 280% of federal poverty will not result in "crowd-out," meaning erosion of the rate of private insurance for Minnesota residents, for a number of reasons.

1990 Census data indicate that Minnesota had approximately 1,500 children residing in the state with income in that narrow 5% range. This is approximately 0.03% of Minnesota's total population. Even if all 1,500 children lost or dropped insurance coverage due to the proposed Medicaid expansion, the effect on the private market of such a small population exiting is inconsequential.

It is virtually impossible for insurers to "carve out" this group of children, for both legal and practical reasons. There are a number of state statutes prohibiting this type of discrimination in the insurance industry, and one law that specifically prohibits insurers from using eligibility for Medicaid as an underwriting factor or reason to deny coverage.[1]

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[1] Minn. Stat. §62A.045 prohibits discrimination based on eligibility for public assistance. Minn. Stat. §72A.20, subd. 9 would make this type of carve out illegal as a prohibited trade practice. Minn. Stat.

It would not be practical for employers or insurers would want to exclude these children, since they would have to somehow means test applicants/employees, and completely alter their premium structure. Given that there are only 1,500 children total, this type of exclusion would more likely produce additional expense for employers/insurers.

While it is theoretically possible for families within that 5% range to drop coverage for their children under age two in order to qualify for Medicaid, we view that as unlikely. For many families, there would be no financial advantage in doing so, since premiums for dependents tend to be fixed after the second or third child. Families that dropped coverage would then be faced with attempting to obtain private coverage after the child reaches age two. Fear of being unable to find affordable coverage is a significant deterrent to dropping coverage in the first place.

Finally, the MinnesotaCare Program has been in existence for five years, and has been shown not to have any significant negative effect on the rate of insurance in Minnesota.

The Title XIX State plan amendments for the Medicaid expansion are included as Attachment I.

As directed by our Legislature, Minnesota will shortly submit a request for 1115 waivers to allow the State to incorporate its MinnesotaCare program as a Child Health Insurance initiative under Title XXI.

Minnesota will also submit separately a Child Health Insurance plan amendment outlining a program to provide a subsidy enabling families to utilize employer-sponsored insurance for currently uninsured children. Children with access to health insurance which is subsidized by a parent's employer are not eligible for the MinnesotaCare program. Health insurance from the employer is considered subsidized if the employer contributes at least 50% of the cost of coverage. Despite the contribution by the employer, the employee share of dependent coverage is not affordable to many low-income families. Minnesota will propose a Child Health Insurance Program that subsidizes health insurance available from an employer for children not eligible for MinnesotaCare.

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§62A.65 prohibits the use of exclusionary riders, with certain exceptions which are not applicable to this example.

Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2102(a)(1)-(3)) and (Section 2103(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.

OVERVIEW OF HEALTH COVERAGE IN MINNESOTA

Historically, Minnesota has had one of the lowest rates of uninsurance in the country. Of the 4,649,596 individuals in Minnesota in 1996[2], approximately 6 percent to 9 percent, or between 280,000 and 420,000, lacked health coverage at any point in time during the year.[3] While estimates of uninsurance in Minnesota vary by source, all surveys indicate that Minnesota's rate of uninsurance has remained stable over the course of the 1990s, in contrast to the experience nationally, where the numbers of uninsured have continued to climb.[4]

Sources of Health Insurance Coverage for Minnesotans

Data from the Minnesota Department of Health shows the distribution of Minnesota's population by primary source of health insurance coverage.[5] In 1996, two-thirds (67%) of Minnesotans received their primary health insurance coverage through a private sector source, either from an employer or individually purchased. Public program enrollment, including Medicare, accounted for approximately 25 percent of Minnesotans, and estimates of the uninsured ranged from 6 percent to 9 percent.

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[2] U.S. Bureau of the Census, Estimates of the Population of State: Annual Time Series, July 1, 1990 to July 1, 1997, press release of December 31, 1997.

[3] Estimates of the uninsured in Minnesota differ by the source of the estimates. Surveys conducted by the University of Minnesota in 1990 and 1995 show the rate of point-in-time uninsurance to be 6.0 percent, while the Current Population Survey (using three-year average data) shows the rate to be approximately 9.2 percent.

[4] The Current Population Survey (CPS) indicates that rates of uninsurance nationally have risen from 13.6 percent in 1990 (three-year average rate) to 15.4 percent in 1996. CPS data shows Minnesota's rate of uninsurance to be stable over this same time period at approximately 9.2 percent.

[5] Some individuals are enrolled in more than one type of health insurance coverage. For example, many Medicare enrollees also are enrolled in Minnesota's Medical Assistance program. The information presented in Table 1 counts individuals only once, however, and assigns them to coverage based on the primary payer for coverage.

Table 1: Primary Source of Health Insurance Coverage for Minnesotans, 1996

Source	Percent Covered
Employer-Based	62%-65%
Individual	5%
Medical Assistance	8%
MinnesotaCare	2%
Medicare	14%
Other Public	1%
Uninsured	6%-9%

Note: Numbers may not total to 100% due to rounding.
Source: Minnesota Department of Health.

Excluding Minnesota's elderly, nearly all of whom have Medicare as their primary source of insurance coverage, shows that approximately three-quarters (76%-79%) of non-elderly Minnesotans receive health coverage through a private sector source, with 15% receiving coverage through a public program (either Medical Assistance, MinnesotaCare, Medicare, or another public program). Between 7 percent and 10 percent of non-elderly Minnesotans are uninsured at any point in time.

Trends in Uninsured Minnesotans

Minnesota has traditionally had one of the nation's lowest rates of uninsurance. While estimates of the rate of uninsurance for Minnesota vary based on the source of the estimate, all sources agree that Minnesota's rate of uninsurance has remained stable while the nation's overall rate has increased. Table 2 shows three-year average uninsurance rates for Minnesota and the U.S.

Table 2
Three Year Average Rates
Percent of Population Lacking Health Insurance Coverage
Minnesota and U.S.

Average Ending	Minnesota	U.S.
1990	8.7%	13.6%
1991	8.9	13.9
1992	8.8	14.2
1993	9.2	14.7
1994	9.2	15.1
1995	9.2	15.3
1996	9.2	15.4

Source: U.S. Bureau of the Census, Current Population Survey.

In aggregate, depending on the estimate used, 280,000 to 420,000 Minnesotans lack health insurance coverage at any given time, a rate that has been stable over the 1990s. Table 3 (on the following page) shows additional detail on how the uninsured in Minnesota are distributed among various demographic and income groups.

There have been several notable shifts in the uninsured population between 1990 and 1995. In particular, the representation of lower income populations and children among the uninsured has fallen considerably since 1990. In 1990, nearly two-thirds of the state's uninsured had incomes below 200% of the federal poverty guidelines and one-quarter of the state's uninsured were children. As a result, the MinnesotaCare program was designed to focus on these populations: children and the working poor who may not have access to Medical Assistance. Therefore, while eligibility for MinnesotaCare extends up to 275 percent of the federal poverty level, 91 percent of the enrollment in the program is for individuals with incomes of 200 percent or lower of the federal poverty level. The effect of MinnesotaCare's focus on lower-income individuals is evident. By 1995, the percentage of the uninsured who had incomes below 200 percent of poverty had declined to approximately 40 percent. It is likely that the focus of the MinnesotaCare program on lower income individuals had a significant impact on reducing uninsurance among this group.

TABLE 3: Who are the uninsured in Minnesota? 1990 and 1995

	1990	1995
Gender		
Male	50.0%	55.0%
Female	50.0%	45.0%

Employment Status (adults)		
Self-employed	22.5%	23.9%
Employed by someone else	46.7%	58.1%
Homemaker	N/A	4.4%
Unemployed	18.8%	11.7%
Retired	2.9%	2.1%
Marital Status (adults)		
Single	42.0%	43.4%
Married	42.2%	37.1%
Living with partner	N/A	12.0%
Divorced/widowed/separated	15.9%	7.9%
Race/Ethnicity		
White	94.0%	86.6%
African American	3.2%	2.9%
American Indian/Alaskan	0.2%	2.2%
Asian/Hmong/Pacific Islander	0.7%	1.4%
Hispanic/Latino	1.4%	3.6%
Other	0.6%	3.4%
Education Level (adults)		
Less than high school	9.1%	10.5%
High school degree	38.9%	36.6%
Some college/tech school	40.3%	37.1%
College graduate/Grad School/Beyond	11.6%	17.0%
Region of state (by Regional Coordinating Board region)		
RCB 1 (Northwest MN)	8.2%	5.4%
RCB 2 (Northeast MN)	12.3%	8.8%
RCB 3 (Central MN)	14.5%	13.3%
RCB 4 (seven-county metro)	46.5%	53.4%
RCB 5 (Southwest MN)	10.4%	9.6%
RCB 6 (Southeast MN)	8.1%	9.5%
Income (as % of federal poverty guidelines)		
0%-100%	16.8%	12.6%
101%-200%	41.7%	33.1%
201%-300%	24.1%	25.7%
301%-400%	9.2%	13.6%
401% +	8.2%	14.9%

Source: Minnesota Health Care Access Commission Household Survey, 1990 and University of Minnesota Health Insurance and Access Survey, 1995. Uninsured defined as point-in-time.

Uninsured Children

Minnesota has traditionally had one of the nation's lowest rates of uninsured children. Estimates of the rate of uninsurance among children in Minnesota range from 4.3% to 7.2% (or 52,000 to 89,000

children).[6] For the purposes of the S-CHIP program, targeted low-income children are defined as those children (under age 19) below 200% of poverty. In 1996, Minnesota had approximately 1,377,190 children under the age of 19.[7] Of this group, 31.5%, or approximately 405,000 children were in families with incomes at or below 200% of the federal poverty level.[8] Of these low-income, uninsured children, an estimated 50,000 lack health insurance coverage.[9]

Minnesota has made great strides to reduce the rate of uninsurance among children. It is likely that the cumulative effect of a number of insurance reforms instituted in the early 1990s combined with a strong economy has had an impact on reducing uninsurance among children. Insurance market reforms included limitations on underwriting and rating differentials in the small group market (including guaranteed issue, guaranteed renewal, and rate bands) and individual health insurance markets (where guaranteed renewal and rate regulations were instituted), and the establishment of the MinnesotaCare Program.

Between 1990 and 1995, the percentage of children who lack health insurance coverage for 12 months or more (long-term uninsured children) fell dramatically, from 5.2% of the state's children to 3.1%.[10] The combination of the health insurance reforms and a strong business climate led to a dramatic increase in offering of health insurance by small employers in Minnesota, and a subsequent increase in the number of individuals enrolled in small group plans.[11] It is likely that some previously long-term uninsured children became insured through new small group plans. The establishment of the MinnesotaCare Program also likely had a large impact on reducing overall long-term uninsurance rates among Minnesota's children. Approximately 50,000 Minnesota children are currently enrolled in MinnesotaCare.

However, while long-term uninsurance has been reduced considerably, the percentage of children who are uninsured for part of the year has not been reduced but has remained stable at approximately 5.8% of the state's children.[12] So, although the MinnesotaCare

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[6] The 4.3% figure is the point-in-time estimate of uninsured children under the age of 19 from the University of Minnesota Health Insurance and Access Survey, 1995. The 7.2% estimate is derived using a three-year moving average of uninsurance rates from the Current Population Survey for 1994 through 1996 for children under age 18.

[7] U.S. Bureau of the Census, Current Population Survey, 1997.

[8] Based on a three-year moving average of CPS data.

[9] U.S. Census Bureau web site, table of Low Income Uninsured Children by State, 3-year average of the CPS for 1993-1995.

[10] Call, K.T., et al. "Who Is Still Uninsured in Minnesota? Lessons From State Reform Efforts," *Journal of the American Medical Association*, October 8, 1997, Vol. 278, No. 14.

[11] Enrollment in small group (2-50 employees) products in Minnesota's health insurance market increased from slightly less than 300,000 in 1994 to over 400,000 by 1996.

[12] Call, K.T., et al. "Who Is Still Uninsured in Minnesota? Lessons From State Reform Efforts," *Journal of the American Medical Association*, October 8, 1997, Vol. 278, No. 14.

program has been successful in reducing long-term rates of uninsurance, survey results show that up to 85% of those children who are uninsured are likely to be eligible to qualify for the MinnesotaCare program. Therefore, there appears

to be a substantial population yet to reach among Minnesota's children.[13]

Uninsured by Race/Ethnicity

The Robert Wood Johnson Foundation (RWJF) Survey, conducted in 1993, found a higher rate of uninsurance among minority groups, however the sample size was not large enough to be statistically significant. The 1995 Minnesota Health Insurance Access Survey conducted by the University of Minnesota, (which estimated an overall rate of uninsurance in Minnesota at 6%), substantiated the RWJF findings.

The portion of the uninsured population which is made up of minority groups in Minnesota has increased for every sub-group except African Americans. And the rate at which minority populations are represented in the uninsured ranks is in all cases higher than the overall portion
of the population they represent in the state.[14] Unfortunately, this information is not available specifically for minority children in Minnesota. Table 4 recaps the rate of uninsured by race in 1990 and 1995, compared to the State population by race in 1990:

Table 4: Minnesotans Uninsured by Race/Ethnicity, 1990 and 1995

Race	1990	1995	% of the Overall MN Population, 1990
White	94.0%	86.6%	92.28%
African American	3.2%	2.9%	2.8%
American Indian/Alaskan	0.2%	2.2%	1.2%
Asian/Hmong/Pacific Islander	0.7%	1.4%	2.3%
Hispanic/Latino	1.4%	3.6%	1.6%
Other	0.6%	3.4%	n/a

Source: Minnesota Health Care Access Commission Household Survey, 1990 and University of Minnesota Health Insurance and Access Survey, 1995 (Uninsured defined as point-in-time); U.S. Census Bureau and Minnesota State Demographer's Office.

STATE-SUBSIDIZED HEALTH COVERAGE

Health Care Programs of the Department of Human Services
Minnesota currently provides coverage of health care services for about 525,000 low-income, uninsured individuals, some with special health care needs. This population is served through three programs administered by the Minnesota Department of Human

[13] Estimate from the Minnesota Department of Human Services, based on information contained in the 1995 Minnesota Health Insurance and Access Survey, conducted by the University of Minnesota.

[14] Comparison of data from the Minnesota Health Care Access Commission Household Survey, 1990 and the University of Minnesota Health Insurance and Access Survey, 1995, for uninsured rates at a point in time.

Services: Medical Assistance, MinnesotaCare and the General Assistance Medical Care Program. Approximately 300,000 of all enrollees are children.

Table 5

Minnesotas in Public Health Care Programs, September 1997			
	Medicaid	MinnesotaCare	GAMC
Total in Program	392,681	99,824	33,118
Children < 21	223,204	53,511	1,345
Children < 19, and under 200% of FPL	212,544	43,769	1,293

Medical Assistance

The Minnesota Medical Assistance program covered around 400,000 individuals at any point in time during 1997, and approximately 220,000 of these were children under the age of 21. Minnesota Medical Assistance provides coverage for acute, chronic and long-term care needs. Approximately 160,000 recipients receive services through a managed care delivery system. The program also provides medical services through a number of waiver projects which include home and community-based service waivers for persons with mental retardation and related conditions, and for the disabled, elderly and chronically ill individuals.

Table 6

Children in Medicaid Program by Age and Race, September 1997						
Race	0 - 1 years	2 - 5 years	6 - 18 years	19, 20 years	Total < Age 19	Total < Age 21
African American	6,473	11,953	25,711	1,892	44,137	46,029
Asian	2,819	5,241	14,064	674	22,124	27,298
Hispanic	3,817	4,202	7,052	678	13,303	15,749
American Indian	1,883	3,123	9,076	604	14,082	14,686
White	24,480	28,479	83,400	6,772	116,359	123,081
Unknown	269	114	388	90	771	861
All	39,741	53,112	119,691	10,660	212,544	223,204

Minnesota Medical Assistance covers pregnant women and infants from birth to age 2 with income at or below 275% of the federal poverty level of income; children age 2 through 5 at or below 133% of federal poverty, and children age 6 through 15 at or below 100% of federal poverty. The Program covers medically needy families and other families whose eligibility is related to AFDC with income no more than 133 and 1/3% of

the AFDC standard. Children above age 15 to age 21 are covered as medically needy. No asset test applies to children.[15]

MinnesotaCare

The MinnesotaCare program began in 1987 with the Children's Health Plan, a state-funded effort to address the rising numbers of uninsured children. In 1992, the program was expanded to include families and to provide coverage with premium cost-sharing on a sliding scale basis. At that time, children under age 18 and families with income up to 185% of the federal poverty level were eligible. The service package contained service limitations, most notably a limitation on hospitalization costs. No asset limit has been applied to eligibility. However, in 1997 the State Legislature adopted asset limits of $15,000 for one, and $30,000 for two or more, but exempting pregnant women from any asset requirement. This change has not been implemented in the MinnesotaCare Program.

Expansion under 1115 waiver

In 1995, Minnesota received approval under its Health Care Reform Waiver to obtain Medicaid matching funds through MinnesotaCare for pregnant women and children up to age 21 in families with income up to 275% of federal poverty. All children and pregnant women began receiving the full Medicaid benefit set of services under this waiver. Service delivery in MinnesotaCare was also converted to managed care by the end of 1996.

The MinnesotaCare Program is 100% state-funded for coverage of parents, legal guardians of minor children, dependent siblings up to age 25 in eligible families. Coverage is available to these other family members with household income up to 275% of federal poverty levels. Adults without children are eligible if household income at or below 175% of the federal poverty level.

The MinnesotaCare program has an approximate monthly enrollment of 100,000 individuals. More than half of the enrollees are children under age 21. A significant portion, or 71%, of the children enrolled are in families with income below 150% of the federal poverty level.

Table 7

Children in MinnesotaCare Program, by Age, Race and Income Level, September, 1997

[15] The asset test which became applicable to families and children on 7/1/97 was repealed by the 1998 Legislature, unless the state receives federal approval to maintain the asset test under an 1115 waiver.

Race	0 - 1 years	2 - 5 years	6 - 18 years	19, 20 years	Total < Age 19	Total < Age 21
African American	51	356	1,527	133	1,934	2,067
Asian	74	395	1,496	151	1,965	2,116
Hispanic	26	162	687	67	875	942
American Indian	4	42	291	20	337	357
White	696	6,713	28,394	2,738	35,803	38,541
Unknown	1,639	460	6,578	811	8,677	861
Total	2,490	8,128	38,973	3,920	49,591	53,511

	Income Level					
Children < Age 21	0 - 100%	101 - 150%	151 - 200%	201 - 250%	251 - 275%	275 + %
53,511	14, 495	21, 040	11,775	4,352	819	1,030

Private Insurance Protections

To deter employer shifting of health coverage to the public sector, insurance barriers were adopted in MinnesotaCare. Families were not eligible to enroll for 18 months after the loss of employer subsidized health coverage, and were required to wait 4 months after the loss of any other type of health coverage. Families with employer-subsidized insurance available to them are not eligible for MinnesotaCare.

To assure health care to children in families with incomes at or below 150% of the federal poverty level, two enrollment conditions are waived for this group of children: (i) The 4-month waiting period after termination of other health coverage does not apply to these children; and (ii) the four-month penalty period for nonpayment of the premium is not imposed on these children. In addition, children under age two are not disenrolled with other family members for nonpayment of premiums.

All MinnesotaCare applicants with income above 200% of federal poverty levels receive information regarding the availability of private insurance provided by the Department of Commerce.

Premiums

For families with income above 150% of the federal poverty level, premiums are established on a sliding scale from 1.8% to 8.8% of gross income, with premiums set at full cost when income is at or above 275% of the federal poverty level. For children in families with income at or less than 150% of the federal poverty level, the premium is fixed at $4 per month.

Benefit Limits

Pregnant women and children in MinnesotaCare receive the full set of benefits allowed under the Minnesota Medical Assistance program. However, benefit limits apply to

adults who are not eligible pregnant women. A ten percent co-payment applies to inpatient hospital costs of adults with gross family income above 175% of the federal poverty level. Adults receive preventive dental services only[16], and have limitations on mental health services[17].

General Assistance Medical Care (GAMC)

The GAMC program is a state-funded program which provides acute and primary health care

[16] Non-preventive dental services for adults (with the exception of orthodontia) will be added effective July 1, 1998.

[17] Covered outpatient mental health services are the following: diagnostic assessments, psychological testing, explanation of findings, medication management, day treatment, partial hospitalization, and psychotherapy.

coverage for persons who are not eligible for Medical Assistance. Individuals who may be covered include non-citizen children, and persons who are of advanced age or incapacitated, undocumented and nonimmigrant persons. The program serves approximately 33,000 residents, and about 1,300 are children. One third of this population are served through managed care plans. This program offers the same basic health services as Medical Assistance but does not include long term care, home care or personal care services. The program has provided health care coverage since 1973.

Table 8

Children in GAMC by Age, September, 1997						
Age	0 - 1	2 - 5	6 - 18	19, 20	Total < 19	Total < 21
Number	27	325	941	52	1,293	1,345

Table 9

Children in GAMC by Race, September 1997							
Race	African American	Asian	Hispanic	Native American	White	Unknown	Total < 21
Number	77	96	1,100	13	56	3	1,345

Health Services of the Department of Health

The Minnesota Department of Health's Division of Family Health administers, coordinates and supports many activities statewide addressing maternal and child health, including the Title V Block Grant funds for maternal and child health. The Department is also the designated lead agency for health care reform. The responsibilities of the Department of Health are carried out in conjunction with its many activities related to the public health. These include the statewide planning and coordination of maternal and child health services through the acquisition and analysis of population-based health data; the provision of technical support and training; the coordination of various public and private maternal and child health efforts; and support for targeted maternal and child health services in communities with significant populations of high risk, low income families through the grant process.

These program goals are accomplished through both state and local partnerships. The Minnesota Department of Health has interagency agreements with the Department of Human Services to carry out shared responsibilities related to EPSDT requirements, and partnerships with the Department of Children, Families and Learning, and local community health boards. In addition, maternal and child health program efforts involve an extensive system of community health agencies, schools, private non-profit and public agencies, volunteer organizations, hospitals and other health professionals.

Current five-year goals of the Title V Block Grant include reduction in the infant mortality rates of two minority populations - African Americans and American Indians; improvement in the initiation of prenatal care during the first trimester for these two

populations as well as the Asian/Pacific Islander women; and improvement in the adequacy of prenatal care in these groups.

Maternal and Child Health Special Projects: The Maternal and Child Health (MCH) section of the Division of Family Health is responsible for state-administered maternal and child health projects, and oversight of community-based programs. The Minnesota Maternal and Child Health law requires the state to target high-risk and low-income individuals with four specific statewide priorities: family planning, improved pregnancy outcomes, services to children with or at risk for developing a handicapping condition or chronic illness; and childhood injury prevention. Grants funded by Title V along with a state appropriation are distributed on a needs-based formula by Community Health Boards to non-profit organizations, public agencies and American Indian tribes to carry out these objectives. In addition, local programs which began before 1981 are continued through the Special Projects grant system: a comprehensive preventive and primary care service system for Minneapolis children and youth which includes off-site services, school-based services and after-hours emergency care; the Adolescent Health Program for health services and education at five St. Paul school-based sites, a project internationally known as a model for prevention of unplanned adolescent pregnancies and for interagency service integration; and finally a preventive dental health service project for rural elementary school children of the Goodhue-Wabasha Community Health Board.

MCSHN: A major project funded by the Title V Block Grant is the program for Minnesota Children with Special Health Needs (MCSHN) which promotes the development of integrated health services for children with special health needs through a network of agencies at the state, regional and local levels. The program is developing a statewide needs assessment system and enhanced data capacity for the purpose of providing population-based data regarding unmet need which is critical for establishing priorities, services designs and measuring program effectiveness.

Children with chronic illness or conditions which interfere with normal growth are eligible for services from professional staff who work to assure that the child has access to comprehensive and appropriate health services, and provide coverage of necessary services not reimbursable through any other source. Based on conservative estimates, 79,000 children[18] in the state potentially qualify as children with special health needs. MCSHN participates in a number of interagency projects which include the Early Childhood Intervention Project; the Family Support and Preservation Project; Family Services and Children's Mental Health collaborative; adolescent transition projects and grants; child find projects; and numerous health care reform activities. In 1996, approximately 5,600 children received direct services such as clinic assessments, treatment, evaluations and early intervention services. The program sponsors a service to track about 1,700 children from birth to age 4 considered "at risk".

[18] With a broader definition of this group, as children with chronic health conditions who require more than routine health care, this group would be approximately 431,000, or 30% of the child population.

Targeted Services: A number of Family Health Division projects target specific services or populations:

Fetal Alcohol Syndrome - a new initiative to prevent and reduce harm from FAS/FAE

Healthy Beginnings Program - a universally offered home visiting program responding to all live births in certain geographic areas, to promote positive parenting and healthy child development.

Minnesota Education Now and Babies Later - a multi-faceted, primary prevention, community health promotion approach to the reduction of adolescent pregnancies, targeting 12 to 14 year olds, their parents, schools and communities.

Tobacco-Free Communities for Children - a multi-faceted approach to reduce the number of children who use tobacco.
WIC Outreach - additional state funds will be used to inform potential recipients of the necessity of good nutrition and availability of the WIC program.
Newborn Metabolic Screening Intiative - provides testing, follow-up and support to families with a newborn testing positive for a metabolic disorder.
Targeted Home Visiting Programs - Nine grants are issued to provide for early intervention in the form of home visiting services to families at risk of child maltreatment.
Newborn Hearing Screening - a new initiative which will assist hospitals and other health care facilities to screen infants for hearing loss, and promote hearing loss screening of infants statewide.
SSI Safety Net - a project to reduce the gaps in medical service needs of children who lose SSI as a result of the more restrictive citizenship requirements or the child disability requirements (although Medicaid has now been restored to children losing SSI due to changes in the definition of child disability).

Nutrition Programs: The Supplemental Nutrition Program in the Division of Family Health, Department of Health is responsible for the federal nutrition programs, Women Infants and Children (WIC) and the Commodity Supplemental Food Program for Mothers (MAC). These programs are administered through various local agencies: public health agencies, community action agencies, tribal governments, and migrant health facilities. In addition, the Supplemental Nutrition Program has a cooperative agreement with the Minnesota Department of Agriculture for the issuance of food coupons to WIC recipients during the summer months for the purchase of fresh fruits and vegetables at farmer's markets. This program operates in 15 to 18 counties with members in the Minnesota Growers Association.

Community Health Services: Considerable responsibility for public health efforts, and maternal and child health efforts rests with the local public health infrastructure, a network of 50 Community Health Boards, established under the Community Health Services Act of 1976. Of these, 65 operate as cooperative, multi-county boards. The Community Health Board system was a strategic step toward establishing a partnership approach to meeting public health needs in the state. The roles of both state and local agencies was further refined by the Local Public Health Act of 1987.

Many public health service, agencies under the auspices of the Community Health Boards carry out functions important for the health of children. Local public health agencies are clinic providers of the EPSDT program. In addition, local public health agencies provide school health services through contracts or cooperative arrangements with school districts. In addition, the state and local partnership of public health agencies are engaged in a number of projects to redesign community-based services to better serve the needs of children. These initiatives include the Children's Mental Health Collaborative, the Family and Community Services Collaboratives, and Part H Collaboratives, all of which mandate interagency program planning, service coordination, and blended funding. Title V programs are also significantly involved in these initiatives.

PUBLIC-PRIVATE PARTNERSHIPS

Minnesota Comprehensive Health Act

The Minnesota Comprehensive Health Association (MCHA) health plan is a private-public partnership. MCHA is a non-profit, Minnesota corporation established by the Minnesota Legislature in 1976 to assure the availability of health care benefits to all qualified Minnesota residents who have been turned down by Minnesota's private market for individual health insurance. The program became operational in 1977, and is by far the largest high risk pool in the nation.

The costs of the program are funded by assessments against all health and accident insurance companies in the state, premiums charged to subscribers, and state appropriations. Because it costs more to provide health care to enrollees with poor health status, premiums are higher than those charged by commercial insurers, but are capped in an effort to contain the cost to the enrollee.

The total number of individuals enrolled during 1997 ranged from 27,000 to 30,000. There were 1,804 children served by this program in calendar year 1997. Most (1,278) were dependents of eligible parent subscribers, but 526 children covered as individual policy holders. The state's insurance reforms in 1992 have contributed to a decline in the enrollment of MCHA; these reforms included a guaranteed issue small group product, prohibiting riders in individual policies, and carving out high-risk groups, a mandatory ceiling on conversion policies, small-group reform measures, relaxing standards in commercial market underwriting, and an improved economy.

Migrant Health Service, Inc. (MHSI)

Migrant Health Services, Inc. is a non-profit organization which was formed to make health care accessible to farm workers who travel to work in the fields of Minnesota and North Dakota. The organization has provided and promoted comprehensive health care for farm worker families for 25 years. Ninety-eight percent of the population served is without health insurance. The program is funded with approximately 80% federal and state grants; and approximately 20% private foundation grants and patient fees. Currently, MHSI operates 10 health centers as well as a mobile health unit, providing extended service hours, for 10 to 20 weeks of the summer.

The health centers are staffed with nurses, bilingual outreach staff and clerks, and nutritionists. Services provided health education, care and education of pregnant and diabetic patients, limited vouchers for medical treatment, treatment referrals and home visits. Contracts are made with local providers to provide extended hours. Through a cooperative effort with the University of Minnesota Dental School, dental screening and dental services are provided to children who are enrolled in migrant school programs in the southern part of the State.

Headstart programs for children of farm workers are operated at 14 sites in Minnesota each summer by the Tri-Valley Opportunity Council, Inc., a community action agency

(CAP). These programs offer EPSDT services to enrolled children, in coordination with the health programs of MHSI.

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):

Medical Assistance

In Minnesota, the Department of Human Services supervises, and counties administer the Medical Assistance program through the local offices of 87 county agencies which make available basic program information in written material, and respond to inquiries made by phone or in person. Metropolitan counties and counties with large geographic areas may have multiple office locations. In major metropolitan areas (Minneapolis., St. Paul, Duluth) staff are outstationed in hospitals and other community-based settings (these include public health offices, social service agencies, and medical providers).

Applicants have the option of mailing in application forms. One application form is used for all Minnesota health care programs.[19] A toll free phone line is available for health care program inquiries. In addition, callers on the toll-free lines to MinnesotaCare Minnesota Children with Special Health Needs are screened for potential Medical Assistance eligibility.

Eligibility for Medical Assistance is coordinated with MinnesotaCare, by screening MinnesotaCare applicants for potential Medical Assistance eligibility. Pregnant women and children who may be eligible for Medical Assistance (and thus be relieved of premium obligations) are advised of their potential eligibility and given the option of changing programs.

MinnesotaCare

Eligibility determinations in the MinnesotaCare Program are made by Minnesota Department of Human Services staff. Application procedures include mailing of application forms, and the use of more convenient methods of financial verification. A toll free number is available for program inquiries and eligibility questions. A period of 30 days applies to application processing; however, if the applicant is a pregnant women, the processing period is 10 days. Eligibility renewal is required annually and is also conducted by mail.

Application forms are made available at various community sites which forward them to the State agency: provider offices; school districts, public and private elementary schools, community health offices, WIC program sites, and local human services agencies. A

[19] However, applicants for cash assistance are not required to complete the separate Health Care Program Application, in order to have eligibility for health care programs determined. All necessary eligibility information is contained in the form used by the cash programs.

MinnesotaCare Benefits handbook outlines program coverage and eligibility requirements.

Outreach efforts in MinnesotaCare during the first 4 years were designed to reach a statewide population in the form of media campaigns, printed information placed in community-based agencies, and mass mailing campaigns with health associations and state tax forms. More recently, efforts have been designed to target specific populations which include ethnic and racial minority communities, employers not offering health care coverage, public health agencies, and school districts. Beginning with State fiscal year 1998, the Legislature established an annual fund of $750,000 for outreach grants. Grants have been awarded for a two-year period to 26 community-based organizations, public health and health organizations: 6 are to public agencies in the greater metropolitan area; 12 to public agencies and one to a private agency in rural areas of the state; six to agencies working with specific minority and ethnic communities in both metropolitan and outstate areas; one to the Minnesota News Network to develop a statewide media campaign; and one to the Minnesota Hospitals and Healthcare

Partnership to develop partnerships statewide between school districts and local hospitals.

The current targeted outreach efforts will include direct assistance in the application process to both English and non-English speaking populations; translation of program material (including application forms) for Asian and Pacific Islanders, Hmong, Somalis and Hispanics; media campaigns for minority populations; and will establish partnerships between community hospitals and schools to identify uninsured children.

Programs of the Minnesota Department of Health

Because of the importance of health care coverage for the populations they serve, both the Title V and WIC programs are aggressive in their attempts to identify children who are uninsured or underinsured; and to assist families in determining what public/private program best meets their needs, assist the family through the application process, and assist families in obtaining access to services once eligibility has been established. This is accomplished by:

Requiring MCH grantees to discuss health care coverage with all clients

1-800 telephone hotline for children with special health care needs that discusses financial constraints parents may have and assist families to identify appropriate public or private sources.

Use of the same application by MinnesotaCare and Minnesota Children with Special Health Care needs.

Making available MinnesotaCare applications at Title V/WIC clinic sites.

The 300 WIC clinics throughout the state routinely discuss health care coverage issues with the families they serve.

Provide information on available public resources to general public through fliers and brochures.

Formal training for professionals about available public resources via Title V- sponsored workshops or ad hoc meetings.

In addition, grantees of Maternal and Child Health Special Project funds have specific outreach plans for high risk pregnant women, and strategies to assure complete prenatal care with includes referral for Medicaid eligibility determinations._

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:

Program information is disseminated via all of the toll-free health care program phone lines (Medicaid, MinnesotaCare, Minnesota Children with Special Health Needs). The private insurance information sent to MinnesotaCare applicants who have income over 200% of poverty includes information on the MCHA program. Persons who apply for MCHA coverage within 90 days of the termination of benefits under a publicly funded health program (Medical Assistance, MinnesotaCare or General Assistance Medical Care) are not subject to the preexisting condition requirement, so long as the person remains a state resident.

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)

Coordination of the new group of eligible children will be accomplished through the use of the same application process and application form already in use in the Minnesota Health Care Programs. Information obtained in this process will establish whether the child is a targeted low-income child.

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

X **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)

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

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

X **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:

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):

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 finding 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 preexisting medical condition.

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

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))

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))

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))

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))

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

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))

Outreach for this group of infants will be incorporated into current outreach efforts in Minnesota Medical Assistance, MinnesotaCare, and public health programs (community public health agencies, Title V programs).

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

Section 6. Coverage Requirements for Children's Health Insurance (section 2103)

X **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."

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 prepregnancy 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 rehabilitate 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))

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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

X **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 eternal and internal monitoring) used to assure the quality ad appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 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. (Section 2102(a)(7)(B))

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

X **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 scare 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(c)(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)

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))

Expand access to health care insurance for uninsured infants.

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

Reduce the number of uninsured children in Minnesota by enrolling low income children under age two in the Medicaid program with income above 275% but equal to or less than 280% of the federal poverty level.

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))

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

9.3.1. X The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. The reduction in the percentage of uninsured children.

9.3.3. The increase in the percentage of children with a usual source of care.

9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. Other child appropriate measurement set. List or describe the set used.

9.3.7. X If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. X Immunization

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. X Other, please list:_____

From the HEDIS measures being reported to the Department of Health in 1998, the following measures relevant to children under age two:

Use of Service Measures: Inpatient utilization, acute care and non-acute care; ambulatory care; births and average length of stay for newborns; percent receiving inpatient and ambulatory mental health services; inpatient discharges and average length of stay of mental health admissions; readmission for selected mental health disorders; and

Effectiveness of care measures: Prenatal care in the first trimester (in addition to childhood immunization).

9.3.8. X Performance measures for special targeted populations.

1. Improve the health of infants from birth to age two whose family income is greater than 275% of the federal poverty level, but is equal to or less than 280% of federal poverty, as measured by an increase in Medicaid enrollment of this age group.

2. Improve the health of children from birth to age 2 as measured by participation in EPSDT.

9.4 **X** 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 **X** 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))

9.6 **X** 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 **X** 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(c))

9.8.1. **X** Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. **X** Paragraphs (2), (16) and (17) of Section 1903(I) (relating to limitations on payment)

9.8.3. **X** Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. **X** Section 1115 (relating to waiver authority)

9.8.5. **X** Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI

9.8.6. **X** Section 1124 (relating to disclosure of ownership and related information)

9.8.7. **X** Section 1126 (relating to disclosure of information about certain convicted individuals)

9.8.8. **X** Section 1128A (relating to civil monetary penalties)

9.8.9. **X** Section 1128B(d) (relating to criminal penalties for certain additional charges)

9.8.10. **X** 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 public has been involved in the process of designing a Child Health Insurance Program through an advisory committee to the Department of Human Services and the legislative process.

In September, 1997, the Department of Human Services initiated dialogue with a committee of thirty-five stakeholders and other advocates for children to identify barriers to children's access to health care and to explore strategies for addressing those barriers under the Child Health legislation. The committee convened several times between September and December of 1997. The committee consists of representatives from advocacy organizations for children, including disability advocacy, ethnic community organizations, and legal advocacy; the Minnesota Department of Health; community health facilities, medical provider associations and managed care organizations. Attachment 2 is a list of committee participants.

The following were identified by the committee as common barriers to children obtaining health care coverage:

Families at lowest income levels have difficulty paying the monthly MinnesotaCare premiums

Lack of transportation to application sites

Difficulties in completing application forms and understanding the process

Asset limit in Medical Assistance

Insurance barriers in MinnesotaCare

Language barriers

The Committee received a copy of the Governor's Supplement Budget Recommendation on health care for children prior to the 1998 State legislative session. The Department continues to involve the committee in ongoing child health planning activity. Most recently, the committee was included in an April 1, 1998 session to address strategies on outreach.

The Minnesota Legislature convened on January 19, 1998 for the second half of its biennial session, and adjourned on April 9, 1998. During the session, bills for Child Health Insurance programs were introduced in both houses, considered in public committee hearings, and passed both houses. A conference committee agreement on Child Health Insurance initiatives was adopted by the Legislature. The legislation was signed by the Governor on April 21,1998. The expansion of Medicaid for children under two was specifically considered by numerous committees in both the House and Senate, and is contained in the law as enacted.

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

	FY 1999	FY 2000	FY 2001
Number of Eligibles	5	12	12
Avg. Monthly payment	$ 490.75	$ 513.32	$ 538.48
Total Payments With Enhanced FMAP under Title XXI:	$26,584.00	$74,153.00	$77,541.00
State share	$ 8,015.00	$22,357.00	$23,541.00
County share	$ 891.00	$ 2,484.00	$ 2,598.00
Federal share	$17,679.00	$49,312.00	$51,565.00

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. X 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. X Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

10.2 X 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. X An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2. X A description and analysis of the effectiveness of elements of the state plan, including:

10.2.2.1. X The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted chid'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. X The quality of health coverage provided including the types of benefits provided;

10.2.2.3. X The amount and level (including payment of part or all of any premium) of assistance provided by the state;

10.2.2.4. X The service area of the state plan;

10.2.2.5. X The time limits for coverage of a child under the state plan;

10.2.2.6. X The state's choice of health benefits coverage and other methods used for providing child health assistance, and

10.2.2.7. X The sources of non-Federal funding used in the state plan.

10.2.3. X 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. X 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. X 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. X A description of any plans the state has for improving the availability of health insurance and health care for children.

10.2.7. X Recommendations for improving the program under this Title.

10.2.8. X Any other matters the state and the Secretary consider appropriate.

10.3 X The state assures it will comply with future reporting requirements as they are developed.

10.4 X 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.