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

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

State/Territory: Colorado
(Name of State/Territory)

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

_____
Suzanne Brennan, Medical and CHP+ Program Administration Office Director / Date Signed

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

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

Name:	Susan E. Birch	Position/Title:	Executive Director, Colorado Department of Health Care Policy and Financing
Name:	John Bartholomew	Position/Title:	Director of the Office of Financial and Administrative Services
Name:	William Heller	Position/Title:	Director, Children's Basic Health Plan d/b/a Child Health Plan *Plus* (CHP+)

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Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program

(CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

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

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

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

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

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

state plan.

The template includes the following sections:

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

and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

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

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

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

Medicaid Expansion- CHIP SPA Requirements

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

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

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

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

Medicaid Expansion- Medicaid SPA Requirements

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

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

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create

a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

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

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

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

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

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

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

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

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

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

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

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

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

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

Guidance: The effective date as specified below is defined as the date on which the State begins to

incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

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

Original Plan

Date Plan Submitted:	**October 14, 1997**
Date Plan Approved:	**February 18, 1998**
State Plan Effective Date:	**April 22, 1998**

On October 14, 1997, Colorado submitted a Title XXI State Plan to expand children's access to health coverage by building on the experience and infrastructure of the Colorado Child Health Plan (CCHP), an existing State-only program providing basic medical services to low-income children, and established Child Health Plan + (CHP+), a separate child health program. Coverage was initially provided to children through age 17 with family incomes at or below 185 percent of the Federal Poverty Level (FPL).

Date Amendment # 1 Submitted:	**January 19, 1999**
Date Amendment # 1 Approved:	**September 21, 1999**
Date Amendment # 1 Effective:	**April 22, 1998**

Effective April 22, 1998, Colorado amended its Title XXI State Plan to expand coverage to children through age 18 with family incomes at or below to 185 percent of the FPL.

Date Amendment #2 Submitted:	**December 20, 2000**
Date Amendment #2 Approved:	**March 28, 2001**
Date Amendment #2 Effective:	**October 1, 2000**

Colorado submitted its second amendment on December 20, 2000, to eliminate premiums and implement an annual enrollment fee for families with incomes between 151 and 185 percent of the FPL.

Date Amendment #3 Submitted:	**December 27, 2000**
Date Amendment #3 Approved:	**March 28, 2001**

Date Amendment #3 Effective: **October 1 2000**

On December 27, 2000, Colorado submitted an amendment to its Title XXI State Plan to make changes in its application and enrollment process and in its service delivery system.

Date Amendment #4 Submitted: **June 28, 2002**
Date Amendment #4 Approved: **April 24, 2003**
Date Amendment #4 Effective: **February 1, 2002**

Colorado submitted its fourth amendment on June 28, 2002, to update and amend the SCHIP State Plan to indicate compliance with the final SCHIP regulations and to add dental benefits for children. The addition of the dental benefit was effective February 1, 2002.

Date Amendment #5 Submitted: **December 17, 2003**
Date Amendment #5 Approved: **March 9, 2004**
Date Amendment #5 Effective: **November 1, 2003**

On December 10, 2003, Colorado submitted its fifth amendment to provide Colorado with the authority to implement and to subsequently revoke an enrollment freeze, as the State budget allows. A freeze on enrollment became effective on November 1, 2003, and will remain in place until either additional funds become available, or the number of enrolled children no longer obligates all appropriated funds.

Date Amendment #6 Submitted: **September 27, 2005**
Date Amendment #6 Approved: **December 23, 2005**
Date Amendment #6 Effective: **July 1, 2005**

On September 27, 2005, Colorado submitted its sixth amendment to raise the upper eligibility limit for children covered under the State plan from 185 percent of the Federal Poverty Level (FPL) up to 200 percent of the FPL.

Date Amendment # 7 Submitted: **May 30, 2007**
Date Amendment # 7 Withdrawn: **May 23, 2008**

On May 30, 2007, Colorado submitted its seventh amendment to require individuals to establish residency before applying for the SCHIP program. The amendment was

withdrawn on May 23, 2008.

Date Amendment # 8 Submitted: **June 25, 2008**
Date Amendment # 8 Approved: **May 6, 2009**
Date Amendment # 8 Effective: **March 1, 2008**

On June 25, 2008, Colorado submitted its eighth amendment to add a new income disregard of 2.5 percent of FPL only for families above 200 percent of FPL after allowable deductions (e.g. child support payments) are applied. If the family is above 200 percent of the FPL, the child qualifies for CHIP. IF the family remains above 200 percent of the FPL after allowable deductions, and the 2.5 percent disregard, the child is denied coverage under CHIP. The State requested a retroactive date of March 1, 2008.

Date Amendment #9 Submitted: **April 30, 2010**
Date Amendment # 9 Approved: **July 28, 2010**
Date Amendment #9 Effective: **May 1, 2010**

On April 30, 2010, Colorado submitted its ninth amendment to increase the upper income level to 250 percent of the FPL. The SPA adds the following out-of-pocket cost changes. For all families above 151 percent of the FPL there will be a $25 enrollment fee for one child, a $35 enrollment fee for two or more children. In addition, while copayments of $5 per office visit will be charged to families with incomes that fall between 151 and 200 percent FPL, families with incomes from 201 to 250 percent of FPL will be asked to pay $10 per office visit. The State requested a retroactive effective date of May 1, 2010.

Date Amendment # 10 Submitted: **April 16, 2012**
Date Amendment # 10 Approved: **September 17, 2012**
Date Amendment # 10 Effective: **April 1, 2012**

This State Plan Amendment includes the following changes:
- Puts the State Plan into the revised CHIP State Plan template that was issued in 2011.
- Adds Express Lane Eligibility.
- Adds the Tribal Consultation policy and procedure.
- Clarifies the State's presumptive eligibility and 12-month continuous eligibility policies for CHIP.
- Adds the Income and Eligibility Verification System as a method for verifying income.
- Clarifies the State's CHIP Dental Services, as required in the revised State Plan template.
- Increases the annual enrollment fee for families with income greater than 205% and

up to 250% of the FPL, to $75 for one child and $105 for two or more children.

SPA # 11
Date SPA # 11 Submitted: August 30, 2012
Date SPA # 11 Approved: December 10, 2012
Date SPA # 11 Effective: July 1, 2012

SPA # 11 Description: This State Plan Amendment increases the copayments for some services and adds copayments for services that previously had none.

SPA # 12
Date SPA # 12 Submitted: January 18, 2013
Date SPA # 12 Approved: April 25, 2013
Date SPA # 12 Effective: January 1, 2013

SPA # 12 Description: This State Plan Amendment includes the following changes:

- Changes Colorado's CHIP program from a Separate Program to a Combination Program. Under or uninsured children 6 through 18 years of age with family income above 100% FPL and at or below 133% FPL are covered through a Medicaid Expansion. Under or uninsured pregnant women with family income above 133% FPL and at or below 185% FPL are also covered through a Medicaid Expansion. Uninsured pregnant women with family income at or below 250% FPL that are ineligible for Medicaid are moved from the Section 1115 Waiver to coverage through the CHIP State Plan. No changes are made to the income eligibility requirements of populations already covered though the CHIP SPA.
- Adds eligibility for children of State employees as long as they meet all other eligibility requirements.
- Revises language surrounding the ten day noticing procedure.
- Modifies Express Lane Eligibility to comply with instructions from the Centers for Medicare and Medicaid Services.
- Adds passive enrollment to the MCO assignment and selection process for children.
- Updates eligibility screening process and methods used to coordinate with other health coverage programs.

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

The State included consultation on this SPA in the tribal consultation log dated 8/01/2012. A copy of the relevant page of the consultation log is attached.

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

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

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

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

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

See Attachment 1 for a description of children's insurance status by income and race and ethnicity.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.1005.

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

2.3-TC Tribal Consultation Requirements- (Sections 1902(a)(73) and 2107(e)(1)(C)) ; (ARRA #2, CHIPRA #3, issued May 28, 2009)

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health

Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

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

The Colorado CHP+ program meets the requirements described above through execution of a formal consultation agreement with American Indian health programs in Colorado. Together with the Department of Health Care Policy and Financing (the Department), the parties to the consultation agreement include the Southern Ute Indian Tribe, the Ute Mountain Ute Tribe, Denver Indian Health and Family Services, the Colorado Department of Public Health and Environment, and the Office of the Lieutenant Governor of Colorado.

The Department intends to use the following process, as described in the consultation agreement, to seek advice on a regular ongoing basis from the parties:

Programmatic Action Log Update

On a bi-monthly basis (approximately every sixty days) each state agency (the Department of Public Health and Environment and the Department of Health Care Policy and Financing) shall distribute to the Tribes and the UIHO Urban Indian Health Organization a Programmatic Action Log Update. The Update shall contain a continuous list of Programmatic Actions that each state agency is developing or initiating. The Update has a short description of each Programmatic Action, any clearly foreseeable Tribal implications, important dates, or implementation timeframes, and if the Programmatic Action is considered an Actionable Item. The Update shall indicate a date by which additional consultation must be requested by a Tribe or the UIHO (thirty days from receipt of the Update). The Update shall also contain an area to track whether additional consultation was requested, and by whom, and to update current status or resolution of Programmatic Actions.

Additional Consultation

A Tribe or UIHO may request additional consultation on any Actionable Item on the Update or on any question, concern, policy, practice, or issue within the scope of the state agencies' responsibilities relating to the health of American Indians or Alaska Natives living in Colorado. Actionable Items on the Update shall indicate a date by which a Tribe or the UIHO must request additional consultation thirty days from receipt of the Update Additional consultation shall be

initiated by written notice may be in the form of an email from a designated Tribal or UIHO Liaison(s) and directed to a designated Indian Health Liaison(s). Consultation may include but shall not be limited to meetings (face-to-face or via teleconference), written correspondence, including emails, presentations, and discussions at the Colorado Commission of Indian Affairs Health and Wellness Committee meetings. When consultation is completed, a written response from one or both state agencies to the party that requested the consultation shall be sent describing the final determination or outcome regarding the topic of consultation. This information shall also be included on the Programmatic Action Log Update.

Meetings:
Face-to-Face and Remotely
The state agencies, Tribes, and UIHO all together or individually, shall meet face-to-face no less than once per fiscal year and as resources allow. As necessary, the state agencies, Tribes, and UIHO, all together or individually, shall meet remotely via teleconference or videoconference to discuss outstanding issues or hold consultations as described above.

Section 3. Methods of Delivery and Utilization Controls

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

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.
Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

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

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

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

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

☒ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS' Regional Office for review and approval. (Section 2103(f)(3))

The program uses MCOs for health care delivery services. The statewide provider network established by the former Colorado Child Health Plan has been expanded to care for children who are eligible for CHP+ but who have not yet been enrolled in a HMO (HMOs generally initiate coverage on the first of the month only) and those children who live in areas where no service is available.

Health Maintenance Organizations

State legislation (House Bill 97-1304) requires that only plans willing to contract with Medicaid

are eligible to serve CHP+ clients. This will ensure that clients are not forced to change providers each time their financial situation changes the program for which they are eligible (Medicaid or CHP+). The CHP+ program contracts with managed care organizations serving a significant number of commercial and Medicaid clients statewide. These plans vary in structure, service area and membership.

Contract standards are based on a review of standards from the following sources: National Association of Insurance Commissioners (NAIC) Model Acts, National Committee for Quality Assurance (NCQA) Accreditation Standards, and Quality Improvement System for Managed Care (QISMC) standards.

CHP+ HMO contractors have to pass the examination of three entities: the Colorado Division of Insurance (DOI), the Department of Public Health and Environment (CDPHE) and the Colorado Department of Health Care Policy and Financing (HCPF). The DOI grants HMO licenses based on a review of financial stability, adequate provider subcontracts, access to care and quality of care. The DOI subcontracts the quality and access review to the CDPHE. When a licensed plan applies for a Medicaid contract, HCPF reviews several aspects of the plans operation including provider network, utilization, management, access to care, quality improvement and grievance procedures. HCPF reviews the Medicaid plans that apply to serve CHP+ clients. Where CHP+ contract standards vary from those of DOI and HCPF, the Department conducts additional reviews in coordination with the Medicaid, DOI, CDPHE, or other purchaser reviews.

Essential Community Providers: As required by state legislation (House Bill 97-1304), CHP+ only contracts with HMOs that are willing to contract with the Colorado Medicaid program. To retain their Medicaid contracts, these HMOs must fulfill the statutory requirements of SB 97-75 with regard to use of ECPs. Therefore, the CHP+ managed care network includes these providers. ECPs include community health centers, community mental health centers, public health agencies, school-based clinics, family planning clinics, and other indigent care providers.

Self-Insured Managed Care Network

The Department contracts with a single entity to manage all aspects of the self-insured managed care network. These physicians, hospitals and ancillary service providers provide services covered by the CHP+ comprehensive benefit package in areas where HMO services are not available, mainly rural areas. The self-insured managed care network provides the same benefit package through a managed care system that is provided through the HMOs in a managed care system.

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

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

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

The self-insured managed care network and the HMOs use managed care utilization standards to assure that enrollees only receive appropriate and medically necessary care.

Section 4. Eligibility Standards and Methodology

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

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

4.0. ☒ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group : The Medicaid expansion will increase eligibility to under or uninsured children 6 through 18 years of age with family income above 100% FPL and at or below 133% FPL and to under or uninsured pregnant women with family income above 133% FPL and at or

below 185% FPL.

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

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option. SSA verification is used to verify citizenship and identity. An automated response from SSA confirms that the self-reported data is consistent with SSA data and meets citizenship and identity verification requirements. No further action is required for the applicant.

4.1.1 ☑ Geographic area served by the Plan if less than Statewide: The plan is available statewide, in all 64 Colorado counties.

4.1.2 ☑ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group: CHP+ is available to children 0 through 18 years of age with family income at or below 250% FPL.

4.1.2.1-PC ☐ Age: _____ through birth (SHO #02-004, issued November 12, 2002)

4.1.3 ☑ Income of each separate eligibility group (if applicable): To be eligible, a child must be from a family whose annual income is at or below 250% of the federal poverty level. Family size and income criteria are described in Attachment 2.

4.1.3.1-PC ☐ 0% of the FPL (and not eligible for Medicaid) through _____% of the FPL (SHO #02-004, issued November 12, 2002)

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

4.1.5 ☑ Residency (so long as residency requirement is not based on length of time in state): A resident is anyone who is: 1) a U.S. citizen; or 2) a documented legal immigrant who has had an Alien Registration Card for 5 years or more and 3) a resident of Colorado. The state accepts self-declaration of residency.

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child will be denied coverage because the child is eligible for Medicaid, not for reasons of disability status.

4.1.7 ☑ Access to or coverage under other health coverage: Both the application and the separate "Insurance Form" ask families questions about other insurance coverage. The plan administration seeks information about all other access to health care coverage, both public

and private, on the application form before the child is enrolled in the plan and from providers once the child is determined eligible for the plan. A child will be found ineligible if the child: 1) is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) is eligible for Medicaid; or 3) has had coverage under an employer plan with at least a 50% employer contribution during the three months prior to application. The Health Care Program for Children with Special Needs is not considered a private health plan and children covered under this plan may still be covered by CHP+. Children who are a members of a family that is eligible for health benefits coverage under a State health benefits plan based on a family member's employment with a public agency in the state may be covered under this plan (as described in Section 4.4.1) if they meet all other eligibility criteria.

If the State finds that a child enrolled in CHP+ is retroactively eligible for Medicaid, the State will notify the family that the child will be disenrolled from CHP+ and enrolled into Medicaid in 10 days. If there are fewer than 10 days remaining in the month in which the child is determined eligible for Medicaid, CHP+ eligibility is extended through the last day of the following month. The State may choose to enroll the child into Medicaid sooner than 10 days if the Medicaid benefit package offers necessary services that the CHP+ plan does not cover.

4.1.8 ☑ Duration of eligibility, not to exceed 12 months: Once a child has been accepted, he or she is continuously eligible for one year from the postmark date of the complete application unless the child moves from the state, turns 19 years old, or becomes eligible for or enrolled in Medicaid, or other private insurance.

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

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

4.1.9.1 ☐ States should specify whether Social Security Numbers (SSN) are required. Social Security Numbers are not required.

Guidance: States should describe their continuous eligibility process and populations

that can be continuously eligible.

4.1.9.2 ☒ Continuous eligibility. Children ages 0-18 may be continuously eligible. Once a child has been determined eligible, the child is continuously eligible for one year from the postmark date of the complete application unless the child moves from the state, turns 19 years old, or becomes eligible for or enrolled in Medicaid, or private health insurance.

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

4.1.0-P ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option. SSA verification is used to verify citizenship and identity. An automated response from SSA confirms that the self-reported data is consistent with SSA data and meets citizenship and identity verification requirements. No further action is required for the applicant.

4.1.1-P☑ Geographic area served by the Plan if less than Statewide: The plan is available statewide, in all 64 Colorado counties.

4.1.2-P☑ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group: Pregnant women of any age who meet the income requirements in section 4.1.3-P are eligible.

4.1.3-P☑ Income of each separate eligibility group (if applicable): To be eligible, a pregnant woman must be from a family whose annual income is at or below 250% of the federal poverty level. Family size and income criteria are described in Attachment 2.

4.1.5-P☑ Residency (so long as residency requirement is not based on length of time in state): A resident is anyone who is: 1) a U.S. citizen; or 2) a documented legal immigrant who has had an Alien Registration Card for 5 years or more and 3) a resident of Colorado. The state accepts self-declaration of residency.

4.1.7-P☑ Access to or coverage under other health coverage: Both the application and the separate "Insurance Form" ask families questions about other insurance coverage. The plan administration seeks information about all other access to health care coverage, both public and private, on the application form before the pregnant woman is

enrolled in the plan and from providers once she is determined eligible for the plan. A pregnant woman will be found ineligible if she: 1) is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) is eligible for Medicaid.

If the State finds that a client enrolled in CHP+ is retroactively eligible for Medicaid, the State will notify the client that she will be disenrolled from CHP+ and enrolled into Medicaid in 10 days. If there are fewer than 10 days remaining in the month in which the client is determined eligible for Medicaid, CHP+ eligibility is extended through the last day of the following month. The State may choose to enroll the client into Medicaid sooner than 10 days if the Medicaid benefit package offers necessary services that the CHP+ plan does not cover.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1)"lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In other words, a State that chooses to cover pregnant women under this option must otherwise cover pregnant women under their State plan as described in 4.1.11. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☐ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1993(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

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

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
(4) An alien who belongs to one of the following classes:
(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
(vi) Aliens currently in deferred action status; or
(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;
(6) An alien who has been granted withholding of removal under the Convention Against Torture;
(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.

☐ Elected for children under age _____.

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

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

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

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

4.2.2. ☑ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

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

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

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

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

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

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

Both initial eligibility and annual renewal eligibility for CHP+ are determined either at the main office or at a decentralized eligibility site.

Applications may be received by mail or by Fax at the central office or during face-to-face interviews at the decentralized sites. Applicants may also complete applications online, or drop off paper applications in person during central office business hours.

The State has developed and implemented an eligibility, enrollment and application tracking system for CHP+. The system uses a sophisticated business rules engine and state-of-the-art secure Internet technologies to reduce the overall cost of administration and increase the speed and accuracy of screening for Medicaid eligibility, determining eligibility for CHP+ and enrolling children and pregnant women into the program.

Current employment income, self-employment income and cash income from other sources reported are used to qualify families with employment or retirement income. Verification of earned income is verified through the Income and Eligibility Verification System (IEVS), which extracts wage information reported by employers to the Colorado Department of Labor and Employment.

ELIGIBILITY DETERMINATION AND RENEWAL

<u>Redetermination of Eligibility</u>

Persons enrolled in CHP+ are enrolled for a period of twelve months. Renewal letters and packets are mailed to families at least 45 days before the day their CHP+ coverage terminates. Reminder letters are mailed to the family 30 days before the end-of-coverage date. Families are encouraged to return their completed renewal application at least 30 days prior to termination to allow continuity of care through their managed care organization (MCO). If the family does not resubmit a complete application by the ending date of coverage, the person's eligibility may still be renewed. The only penalty is interrupted coverage.

At redetermination, renewal requires the same financial documentation as was required at the time of the family's original application. A family will be fully processed for eligibility at each

renewal period.

Once the State has re-determined eligibility, a letter is sent to the households above 150% and at or below 250% of the FPL which owe an enrollment fee to notify them that they have 30 days from the date of re-determination to submit the enrollment fee. Coverage begins when the State receives the enrollment fee. If the enrollment fee is not submitted by the end of the 30-day period, the client's coverage will end at the end of the redetermination period. Once the client pays the enrollment fee, coverage will resume.

Enrollment in Health Plans

All pregnant women are enrolled in the CHP+ managed care network for the entire enrollment period. Eligible children who live in areas served by MCOs, however, must enroll in an MCO. Once eligibility has been determined, the families of these children have the opportunity to select a participating MCO in their county of residence. If the family has notified the Department or its designee of its chosen MCO prior to the last business day of the month during which the child was determined eligible, the child shall be enrolled in that MCO. If the family has not chosen an MCO, the child shall be enrolled in an MCO by the Department or its designee. In areas of the state where there is only one participating MCO available, the Department or its designee select that MCO and enroll the child.

Families are notified of the MCO in which their children are enrolled and are offered a 1-800 number to answer any questions they may have or change their MCO. If the family wants to change MCOs, it will have 90 days from the effective date of the MCO enrollment to contact the Department or its designee in order to select a different MCO. Once an enrollee has selected an MCO or upon expiration of the 90 day period, the enrollee shall remain enrolled in that MCO for the remainder of the eligibility period. Families who live in areas of the state that are not served by an MCO continue to receive care through the CHP+ managed care network.

For renewal applications, the Department or its designee reassigns the eligible child to the participating MCO they were enrolled in during the previous enrollment period. Families of eligible children may notify the Department or its designee within their re-enrollment period, if they wish to change the MCO enrollment.

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

4.3.1 Limitation on Enrollment. Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(4)) (42CFR, 457.305(b))

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

The applicant must pay the annual enrollment fee in order for the child(ren) to enroll in CHP+. Once the State has determined eligibility (or automatic redetermination has occurred), a letter is sent to households that are above 150% and at or below 250% of the FPL to notify them that they owe an enrollment fee and have 30 days from the date of determination (or redetermination) to submit an enrollment fee. Coverage begins when the State receives the enrollment fee. If the enrollment fee is not submitted by the end of the 30-day period, the client will be denied for non-payment and will have to re-apply.

In the event the Department makes a determination to limit enrollment to ensure that the program maintains sufficient funds, enrollment in CHP+ shall be halted.

The Department accepts applications for enrollment at times when sufficient funding is available to justify enrolling more individuals. The Department may limit the number of children to be enrolled according to the funds available for the program. When the Department has established that all of the funds appropriated for this program are obligated, the Department, in accordance with 457.65(b), will notify CMS in writing that a freeze in enrollment has taken place, or will take place.

During an enrollment cap, applications will be screened for Medicaid in the same manner as currently described in the approved State Plan Amendment. If the applicant appears to be Medicaid eligible, the application will be referred to Medicaid. If the applicant does not appear to be Medicaid eligible, the application will be returned to the applicant with a letter explaining the cap. The letter will also encourage the applicant to apply again when the enrollment cap is lifted.

An enrollment cap will not affect current enrollees. Reenrollment applications will be screened for Medicaid and the CHP+ and enrolled in exactly the same way as prior to the cap. Siblings and newborns to existing enrollees will continue to be enrolled using currently approved procedures. Applicants will be enrolled in CHP+ if they are determined eligible after being screened for Medicaid.

As funds become available through the budget process, the cap will be lifted. Public notice will occur using the methods used as described for the implementation of the cap. Applicants will be screened and enrolled in the order of receipt. CMS will be notified any time the cap will be lifted based on the criteria listed above.

No waiting list will be maintained for CHP+.

The administration of an enrollment cap will be communicated prior to implementation by providing in writing; a posting on the Internet, a letter to the legislature, and policymakers throughout the state. It will also be presented to the Medical Services Board, members of which

are appointed according to political affiliation, geographic representation, and provider or recipient status. A news release will be provided to the media on how the new applications will be responded to. No waiting list will be maintained for interested CHP+ applicants. A notice of the removal of a cap will be provided to media, interested parties, and policy makers at the appropriate time.

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

4.3.2. ☒ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355). The State provides presumptive eligibility for children and pregnant women, and meets the requirement in 42 CFR 457.355. The State does not require verification of citizenship status for purposes of presumptive eligibility.

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

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

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

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies. Free/reduced lunch programs.

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

Express Lane option. Express Lane Eligibility is used to determine income only. The free/reduced lunch program uses the income levels specified for the program by the USDA. The income level for free lunch is 130% of the FPL, and the income level for reduced lunch is 185% FPL. Data from free/reduced lunch does not replace the Medicaid/CHP+ eligibility process; it only prompts the State to open a case. Children up to 133% FPL are eligible for Medicaid, and children at or below 250% FPL are eligible for CHP+.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI. Citizenship and identity are verified through the SSA interface.

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

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

4.4 Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

4.4.1. ☑ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102)(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply

a waiting period for pregnant women.

Families who apply for Medicaid are informed about CHP+ and families applying for CHP+ are informed about Medicaid. The joint Medicaid/ CHP+ application notifies the applicant that information will be shared with both Medicaid and CHP+ to determine eligibility for both programs.

The State uses an integrated system that determines eligibility for public assistance programs including Medicaid, CHP+, the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and many others. In determining eligibility for CHP+, the eligibility system will first run eligibility rules for Medicaid. If the applicant is determined to be eligible for Medicaid, the applicant is enrolled in Medicaid and CHP+ eligibility is denied. If the applicant is determined to be ineligible for Medicaid, the system will run eligibility rules for CHP+. If the applicant is determined to be eligible for CHP+, the applicant is enrolled in CHP+. Because the State uses an integrated system and a joint application, eligibility is run for both programs without applicants or eligibility technicians performing additional steps. At the end of the eligibility determination process, the system automatically generates and sends notices to the applicants informing them of which program(s) they are approved for and which are denied. The Department also contracts with an eligibility and enrollment vendor that processes most CHP+ applications, provides application assistance and customer service.

County departments of social services provide support to low-income families in communities ranging from food stamps and Women, Infants, and Children programs to child care and Colorado Works. Many CHP+ referrals come from these programs. In addition, because federal law mandates linkage between CHP+ and Medicaid (for example, through a common application) some CHP+ applications are submitted through county departments of social services.

Other Creditable Coverage Screening

The joint Medicaid/CHP+ application, asks the applicant to report any health insurance coverage. If the family reports creditable coverage (most group health plans and health insurance coverage), the child or pregnant woman will be found ineligible. Providers contracting with the CHP+ are required contractually to notify the plan whenever they have reason to believe a member has coverage other than CHP+. CHP+ then verifies coverage with the insurance carrier and notifies the family that they will be disenrolled.

If a child has received health insurance in the last three months and the employer paid more than 50% of the premium, there is a three month lock out period for the applicant. There is no waiting period for pregnant women.

Children of state employees will be enrolled into CHP+ if they meet all other technical eligibility requirements including income limits and lack of health insurance. Per section 10203(b)(2)(D) of the Affordable Care Act, States are permitted to extend CHIP eligibility to children of State employees who are otherwise eligible under the Title XXI (CHIP) State Plan to the extent that one of two conditions is met. These conditions are described in a new section 2110(b)(6) of the Social Security Act (added by the Affordable Care Act and amended by Public Law 111-309) and are referred to as the hardship and the maintenance of agency contribution conditions.

Colorado is electing to cover children of state employees under the maintenance of agency contribution condition authorized in Section 2110(b)(6)(B) of the Social Security Act. Specifically, this section grants an exception to the exclusion of children of state employees if the State determines that public agency expenditures for health coverage for employees that have dependent coverage is not less than the amount of such expenditures in the 1997 State fiscal year, increased by the percentage increase of the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average).

Colorado will monitor whether it meets the maintenance of agency contribution criteria on an annual basis. The methodology outlined above will be used each year to ensure that Colorado's contribution towards the cost of employee dependent coverage remains no less than its contribution in 1997, adjusted for inflation.

4.4.2. ☑ children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102)(b)(3)(B)) (42CFR, 457.350(a)(2))

As explained in Section 4.4.1, Colorado uses an integrated system that determines eligibility for various public assistance programs, including Medicaid and CHP+. The joint Medicaid/CHP+ application notifies applicants that information will be shared with both Medicaid and CHP+ to determine eligibility for both programs. The eligibility system first runs eligibility rules for Medicaid prior to determining eligibility for CHP+. If the applicant is determined to be eligible for Medicaid, the applicant is enrolled in Medicaid and CHP+ eligibility is denied. The applicant then receives notice of this determination and their enrollment.

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR, 431.636(b)(4))

As explained in Section 4.4.1, Colorado uses an integrated system that determines eligibility for public assistance programs including Medicaid, CHP+, and many others. The joint Medicaid/CHP+ application notifies applicants that information will be shared with both Medicaid and CHP+ to determine eligibility for both programs. The eligibility system first runs eligibility rules for Medicaid prior to determining eligibility for CHP+. If the applicant is determined to be eligible for Medicaid, the applicant is enrolled in Medicaid and CHP+ eligibility is denied. If the applicant is determined to be ineligible for Medicaid, the system runs eligibility rules for CHP+. If the applicant is determined to be eligible for CHP+, the applicant is enrolled in CHP+ and receives notice of this determination and their enrollment.

4.4.4. ☑ the insurance provided under the State child health plan does not substitute for coverage under group health plans; states should check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR, 457.805) (42CFR 457.810(a)-(c))

4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined.

4.4.5 ☑ Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

CHP+ has contracts with Indian Health Services in all areas of the state to allow tribal clinics to deliver health care to Native Americans. Because the federal legislation governing the Indian Health Services has regulations against the use of managed care, CHP+ pays these facilities fee-for-service. These primary care contracts, continue to allow Native Americans full access to specialty providers through a managed care environment (though still paid fee-for-service.)

CHP+ works directly with the Indian Health Resource Center to reach out to Native Americans living in the Denver metro area, home to nearly half of Colorado's Native Americans. CHP+ conducts outreach to Native Americans living in the remainder of the state, much of which is rural, through local public health nurses and caseworkers. In Southwestern Colorado, case workers at the San Juan Basin Health Department in Durango will provide outreach at two Indian Health Centers at the Ute Mountain Ute Indian Reservation near Towaoc and Southern Ute Indian Reservation in Ignacio.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

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

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

☒ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

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

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

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

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

Colorado identifies and enrolls children eligible to participate in public health insurance programs through a broad outreach strategy through both public and private partners and through direct appeals to families in the media and in their communities. One of the most successful efforts after five years of operation has been and continues to be word of mouth that has been generated by the positive experiences of members and local partners.

One important method of enrollment that has simplified the process for families is the development of a simplified, joint application that partners and the agency can use to enroll children and families in both Medicaid or CHP+. This simplified application can be obtained through the standard Medicaid outreach and enrollment process, as well as through the standard CHP+ outreach and enrollment processes.

1. Medicaid, administered by the Colorado Department of Health Care Policy and Financing, provides health coverage to low-income children and families, elderly and disabled Coloradans. Colorado takes the following steps to enroll children in Medicaid:

    - County social services departments determine a person's eligibility for Medicaid. Presumptive eligibility sites (Federally Qualified Health Centers and Planned Parenthood clinics), county nurses offices, doctor's offices and Indian Health Centers determine presumptive Medicaid eligibility and enroll pregnant women. Infants up to twelve months old born to Medicaid-enrolled women are guaranteed Medicaid eligibility for twelve months.

    - Outstationed eligibility sites (FQHCs, Disproportionate Share Hospitals, and local county health departments) help people apply for Medicaid by collecting and sending their applications and paperwork to the county department of social services office for eligibility determination.

    - Posters, brochures, and a 1-800 number provide Medicaid information to potentially eligible families at several locations, including public assistance offices**.**

    - Colorado uses an integrated system that determines eligibility for public assistance programs including Medicaid, CHP+, and several others. Because the State uses an integrated system and a joint application, eligibility is run for both Medicaid and CHP+ without applicants or eligibility technicians performing additional steps. Through this system, any clients applying for CHP+ are automatically screened for Medicaid eligibility prior to being screened for CHP+ eligibility. (See section 4.4.1 for more details)

2. CHP+ is a public/private partnership providing subsidized health insurance for children in low-income families statewide who are not eligible for Medicaid. The Medical Services Board provided oversight and policy development. CHP+ is administered by the Department of Health Care Policy and Financing through private contractors who provide various services. These organizations manage the routine administrative matters associated with CHP+.

National data and three years of experience have shown that reaching out on a local level is the most effective way to reach eligible families. CHP+ has continued its efforts to partner with many community-based organizations throughout the year. CHP+ created partnerships with approximately 2000 community-based organizations including: schools; Head Start programs; family resource centers; community health centers; United Way agencies; public health departments; county departments of social services; Women, Infants, and Children programs; and many others. These extensive partnerships represent an extraordinary commitment statewide to enroll uninsured children as part of the CHP+ comprehensive marketing and outreach strategy. In addition, CHP+ program initiated a targeted television advertising campaign and began testing employer-based outreach activities. All of these activities represent Colorado's interest in reaching families in every way possible.

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

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

The Healthy Communities initiative does the marketing and outreach for CHP+. The Healthy Communities outreach and case management model takes into account that many families do not always understand the distinction between Medicaid and CHP+. Healthy Communities uses Family Health Coordinators who increase awareness of CHP+ and Medicaid programs, offer face-to-face application assistance, educate families on the value of preventative health services, link clients to providers that will serve as the client's Medical Home, and explain the reenrollment process.

CHP+ has created an extensive marketing and outreach program encompassing strategies that range from grass roots networking to mass market advertising campaigns. These efforts have been implemented to reach families many different ways with different messages.

To better evaluate the effectiveness of these strategies, CHP+ implemented a large-scale, application-source tracking system in March 2000. The system allows an application to be traced back to the initial source without relying on self-reported referral data. This tracking system will continue to be used to monitor trends and results from marketing and outreach campaigns.

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

1. The Health Care Program for Children with Special Needs (HCP) is a joint state/federal program administered by the Colorado Department of Public Health and Environment for children age 20 and under who have a physical disability that interferes with normal growth and development. HCP helps pay medical bills and provides follow-up for children diagnosed with a clinically qualifying handicapping condition. Children with conditions eligible for the program are identified through county nursing services, health care providers, Child Find coordinators in public schools, and local Early Childhood Connections staff.

2. Colorado Indigent Care Program (CICP), administered by the Colorado Department of Health Care Policy and Financing, is a state and federally funded provider reimbursement program that discounts the cost of medical care at its participating health facilities for adults as well as children. If a person is eligible for Medicaid or CHP+, he or she is ineligible for CICP. Covered services vary by participating hospitals or clinics, but generally include hospital costs such as inpatient stays, surgery, and prescription drugs. All children deemed eligible for the above mentioned programs are directed toward them at CICP-participating providers. Colorado takes the following steps to enroll children in CICP:

   - CICP-contracted providers (primarily FQHCs, DSH hospitals, and participating clinics) screen children for CICP eligibility during their visit, assist with completing the application, and determine eligibility for the program.

   - The non-CICP community health centers and other safety net providers who determine Medicaid eligibility refer clients to a CICP provider if they determine that a client is not eligible for Medicaid, but may be eligible for CICP. Children are referred to CHP+ first if the safety net providers determine that a client is not eligible for Medicaid.

3. Cover Colorado, established in 1990 by the Colorado General Assembly as a quasi-governmental entity, provides health insurance to individuals, including children, who are

denied commercial health insurance by private carriers because of a pre-existing medical condition. Cover Colorado and CHP+ often compare enrollment and disenrollment information to discern trending that may be relevant to both programs.

4. Community Health Centers offer a wide range of health care to people who may need some financial assistance with their medical bills. Colorado has 15 community health centers with more than 50 clinic sites in medically under-served areas of the state. Community health centers provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, emergency care, diagnostic services and prescriptions.

   Community Health Centers, many of who are Federally Qualified Health Centers, take the following steps to enroll children in Medicaid, CHP+, the Colorado Indigent Care Program (CICP), or the health center's sliding fee scale plan:

   - Provide a financial screen for each new patient or family.
   - Provide information on and explanation of the program(s) that the family members are eligible for.
   - Assist with completing applications and collecting necessary documentation for eligibility determination.
   - Determine eligibility on-site or forward applications to the determining agency and communicate with family about eligibility status.
   - Assist families when their financial situation and eligibility changes to transition to the appropriate program.

   If a patient/family is not eligible for any program, the health center uses its sliding fee scale to determine the fee according to family size and income.

5. County public health departments identify low income, uninsured children through referrals from a variety of sources including: Women, Infant and Children (WIC), child health and immunization clinics, other community health providers (including private physicians), community health and social services agencies and schools, Headstart centers, Early Childhood Connections (Part C), homeless shelters, and self-referrals. Public health staff refers families to any available health care insurance source for which they appear to be eligible, including Medicaid and CHP+ and work with local physicians to try and secure services on a reduced-fee basis. Many public health agency staff members assist families in completing application forms for Medicaid and the CHP+. In Colorado, Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) outreach workers and administrative case managers are a part of local public health agency staff who facilitate access to Medicaid and to CHP+ services for eligible children.

6. Maternal and Child Health Block Grant (Title V of the Social Security Act) funds in Colorado are "passed through" to local public health agencies and other qualified non-profit

agencies where they are used to support a number of activities on behalf of women and children, particularly those of low income. State Title V staff provides oversight, consultation and standards to assure appropriate utilization of these funds. When families are ineligible for any insurance plan, or when there is not another provider of free or reduced price health care (i.e. community or rural health centers) available or accessible, these public health agencies provide direct services to low- income children. Services provided in local public health agencies are almost always provided by public health nurses. Services include comprehensive well child clinic services, including developmental and physical assessments, immunizations, and parent education. Families under 100% FPL pay nothing for these services. Others pay on a sliding fee scale.

7. School-based health centers (SBHC) provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, some diagnostics services and prescriptions. SBHCs provide services at no charge. However, patients are asked whether or not they have health care coverage. The amount of reimbursement for which SBHCs bill depends on the administrative capabilities of the center and whether a CHP+ participating managed care organization contracts with them. SBHCs facilitate application to Medicaid, CHP+ or CICP when documentation of family income and assets is obtainable without jeopardizing students' confidentiality.

8. The Special Nutritional Program for Women, Infants and Children (WIC) provides nutritious food to supplement the regular diet of pregnant women, breast-feeding women, infants, and children under age five who meet state income standards. Women and children under five years old qualify if the combined family income is at or below 185% of the federal poverty level. WIC staff encourage pregnant women and parents and guardians of infants under 12 months of age to apply for Medicaid and CHP+.

9. The Commodity Supplemental Food Program (CSFP) provides infant formula and nutritious foods to supplement the diet of pregnant and postpartum women and children under age 6. Women who live in Conejos, Costillo, Denver, Mesa, Rio Grande or Weld counties and who have a combined family income at or below 185% of the federal poverty level qualify for the program. Staff encourage pregnant women and parents and guardians of infants under 12 months of age to apply for Medicaid and CHP+.

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP. Express lane eligibility streamlines the eligibility process and reduces administrative burden to eligibility sites and clients. If the school determines the child is eligible for Free or Reduced Lunch using the Free/Reduced Lunch application, the school will provide the application information to an eligibility site if the family opts-in to this service, and a Family Medicaid/ CHP+ application will be initiated. Currently, on the Free/Reduced Lunch application, families must opt in to share their information with Medicaid/CHP+.

5.3 Strategies (formerly Section 5 "Outreach")

Guidance: Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90) The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

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

The primary outreach strategy for the CHP+ program is Healthy Communities outreach. Healthy Communities uses Family Health Coordinators who increase awareness of CHP+ and Medicaid/EPSDT programs, offer face-to-face application assistance, educate families on the value of preventative health services, link clients to providers that will serve as the client's Medical Home, and explain the reenrollment process.

In addition, the State uses the following strategies to reach people who may be eligible for the program:

1. Community Partnerships: A cornerstone of the CHP+ outreach strategy is to maintain and build on community partnerships. To reach all eligible families through as many avenues as possible, CHP+ works with more than 2000 partners. These include: schools; Head Start programs; family resource centers; community health centers; United Way agencies; public health departments; county departments of social services; Women, Infants, and Children nutrition programs; faith-based organizations and a myriad of others. So far, the most effective efforts in actually enrolling families are through schools, doctors' offices, health departments, community health centers, and departments of social services.

2. Managed Care Organizations: Managed care organizations have increased their CHP+ outreach. One method of partnering has been the implementation of joint media campaigns in which a majority of managed care partners have participated. These purchased advertisements were structured so that each partner received air time when marketing would be most effective.

   All of CHP+'s managed care partners have participated in various community events

throughout the state.

3. Advertising and Earned Media: Television ranks as the highest source of referral for individual applications. CHP+ and managed care organizations team together to purchase targeted television advertisements.

4. County Departments of Social Services: County departments of social services provide support to low-income families in communities ranging from food stamps and Women, Infants, and Children programs to child-care and Colorado Works. Many CHP+ referrals come from these programs. About 20% of CHP+ applications are submitted through the Medicaid application process managed by county departments of social services. CHP+ continues to focus on ways to minimize delays in referrals so that eligible children can be enrolled in an expeditious manner.

5. Satellite Eligibility Determination Sites: CHP+ has a network of 73 satellite eligibility determination sites (SED sites) statewide, including multiple locations for some sites. These sites comprise community health centers, county nursing services, school-based health centers, Indian Health Centers and other community providers, and have been an essential component of the programs outreach and enrollment activities. As part of their contract with CHP+, they are required to provide outreach to their community for CHP+ and have access to an on-line eligibility program to accelerate program enrollment. SED sites account for more than 30% of submitted applications.

6. Schools: Schools are consistently one of the most frequently cited sources of referral by applicants. Increasing numbers of school districts are partnering with CHP+ to assure the children they serve know about CHP+. In 2001, more than 60% of all school districts in the state participated in CHP+ outreach activities including coordination with National School Lunch Program information, disseminating materials about CHP+ to families or allowing CHP+ partners and staff to present to family-related functions.

7. Community Health Centers: The Colorado Community Health Network has made involving its members in Medicaid and CHP+ outreach a priority. Community health centers are the largest group of primary care providers throughout the state serving low-income children. Some serve as satellite eligibility determination sites. Others participate in community coalitions that enroll children in Medicaid and CHP+.

8. Colorado Covering Kids and Families: A significant partner in developing community-based outreach has been Colorado Covering Kids and Families, which is a Robert Wood Johnson Foundation funded grant program administered by the Department of Public Health and Environment. Colorado received a Covering Kids and Families Grant from the Robert Wood Johnson Foundation in 2002. This grant is administered by a coalition of community groups including the Colorado Community Health Network, the Colorado Children's Campaign and Catholic Charities. The program is active across the state.

9. Community Voices: This is a joint Kellogg Foundation and Colorado Trust funded program, which has among its goals to improve the health of Denver's medically underserved through innovations in community outreach, enrollment in publicly funded health insurance programs like CHP+, as well as small employment health plans, and clinical case management. Community Voices efforts are designed to demonstrate that culturally sensitive community outreach to underserved populations improves enrollment of eligible individuals into plans, while engaging and empowering communities to assume greater responsibility for health. Staff at the Department met regularly with the Denver Health and Hospital Corporations Community Voices team to explore program successes, as well as, identify and resolve issues that might impede enrollment and access to care.

10. Toll Free Number and Website: CHP+ maintains a toll free telephone number so that community partners, members and potential members can obtain information about the program. In addition, CHP+ maintains a website (www.cchp.org) that can be used as a reference tool for community partners, members and potential members. CHP+ has observed a steady increase in web-based traffic regarding the program over the past two years. Both the toll free telephone number and website have Spanish options. For other languages, CHP+ relies on AT&T's language line. This is publicized on program materials.

Section 6. Coverage Requirements for Children's Health Insurance

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

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

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

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

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

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

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

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

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

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

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

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

- hearing services.

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

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

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

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

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide

an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

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

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

6.1.4.1. ☐ Coverage the same as Medicaid State plan
6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver
6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

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

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under ☐457.440

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

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit

comparison (Provide a sample of how the comparison will be done)

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

6.1.4.7. ☐ Other (Describe)

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

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

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

6.2.1. ☑ Inpatient services (Section 2110(a)(1))
6.2.2. ☑ Outpatient services (Section 2110(a)(2))
6.2.3. ☑ Physician services (Section 2110(a)(3))
6.2.4. ☑ Surgical services (Section 2110(a)(4))
6.2.5. ☑ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
6.2.6. ☑ Prescription drugs (Section 2110(a)(6))
6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))
6.2.8. ☑ Laboratory and radiological services (Section 2110(a)(8))
6.2.9. ☑ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
6.2.10. ☑ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
6.2.11. ☑ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

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

6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.14. ☑ Home and community-based health care services (See instructions) (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.15. ☐ Nursing care services (Section 2110(a)(15))

6.2.16. ☑ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)

6.2.17. ☑ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

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

6.2.20. ☑ Case management services (Section 2110(a)(20))

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

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

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

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

6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (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))

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

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (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))

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

6.2.1-DC ☒State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)**. The State does not cover this category of dental services.**
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999). **The State does not cover this category of dental services.**
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999). **The State does not cover this category of dental services.**
9. Emergency Dental Services

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

☐ State-developed Medicaid-specific
☐ American Academy of Pediatric Dentistry
☐ Other Nationally recognized periodicity schedule

☒ Other (description attached)

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

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

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)Page - 11 – State Health Official

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

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

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

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

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

6.3.1. ☑ The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Describe: Previously 8.6

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

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

6.4.1. ☐ **Cost Effective Coverage**- Payment may be made to a State in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10% limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a

community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

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

6.4.1.3. The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

Guidance: Check 6.6.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR, 457.1010)

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

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an

assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

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

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

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010)A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☐ Yes
☒ No.

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

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

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

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

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

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

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

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

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

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).
6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

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

☐ Yes
☒ No

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

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

6.4.3.6-PA Notice of Availability of Premium Assistance- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

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

Section 7. Quality and Appropriateness of Care

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

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

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

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

Quality improvement strategies should include the establishment of quantified quality

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

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

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

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

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

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

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

7.1.1. ☑ Quality standards

7.1.2. ☑ Performance measurement

7.1.2 (a) ☒ CHIPRA Quality Core Set

7.1.2 (b) ☐ Other

7.1.3. ☑ Information strategies

7.1.4. ☑ Quality improvement strategies

CHP+ will use quality standards, performance measures, information strategies, and quality improvement studies to assure high-quality care for CHP+ enrollees. The CHP+ program will use quality assurance methods and tools such as NCQA accreditation standards, National

Association of Insurance Commissioners (NAIC) standards, Quality Improvement System for Managed Care (QISMC), Healthplan Employer Data and Information Set (HEDIS), Consumer Assessment of Health Plans Survey (CAHPS) data, standard Division of Insurance reports and quality improvement study data. The CHP+ will use standards, performance measures, consumer information, and quality improvement methods for HMOs and for the CHP+ provider network.

The Department is in the process of negotiating a contract with a vendor to perform Quality Assurance activities. The Contractor will provide consulting services that incorporate Federal and State requirements that address ongoing quality assessment and improvement strategy for the CHP+ Program contracting program. The strategy, among other things, will include:

- Physician credentialing in the self-insured managed care network
- Performance based contracting standards
- Self-insured managed care network HEDIS calculation audit
- HEDIS analysis for all plans

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

The Department contracts with a quality assurance vendor to measure HEDIS indicators such as the following:

- Childhood Immunizations
- Adolescent Immunizations
- Children's access to primary care practitioners
- Appropriate medications for children with asthma
- Well child visits

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

Adequate access to emergency services is assured for all Colorado managed care enrollees by a Division of Insurance regulation that took effect on July 1, 1997. This

regulation (4-2-17) specifies that a managed care organization cannot deny an emergency claim if a "prudent lay person would have believed that an emergency medical condition or life or limb threatening emergency existed." The regulation also restricts the use of prior authorizations for emergency care and the denial of emergency care provided by non-network providers.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

Benefit procedures exist for members with chronic, complex, or serious medical conditions. All of the managed care organizations must comply with the Department of Insurance regulations regarding access to and adequacy of specialists.

The following are the benefits for persons with chronic conditions:

- Any combination of 30 treatment days for inpatient physical, occupational, and/or speech therapy per injury or illness. The services must be received within six months from the date on which the illness or injury occurred.
- Any combination of 30 treatments for outpatient physical, occupational, and/or speech therapy per illness or injury or diagnosed neurological, muscular, or structural abnormality per year.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

The CHP+ prior authorizations are consistent with commercial packages. The contracted managed care organizations and the statewide provider network are required to comply with the State regulations set forth by the Division of Insurance.

Section 8. <u>Cost-Sharing and Payment</u>

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

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

8.1.1. ☑ Yes

8.1.2. ☐ No, skip to question 8.8.

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

Guidance: It is important to note that for families below 150% of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50-.59). For families with incomes of 150% of poverty and above, cost sharing for all children in the family cannot exceed 5% of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

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

8.2.1. Premiums: The CHP+ Program uses an annual enrollment fee rather than a monthly premium. For families above 151% of the Federal Poverty level, an annual enrollment fee is $25 for one child and $35 for two or more. For families with income greater than 205% and at or below 250% of the Federal Poverty Level, the annual enrollment is $75 for one child and $105 for two or more children.

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments:

American Indian/Alaska Natives are exempt from co-payment and annual enrollment fees.

The following copayments shall be due for enrollees at the time of service:

A. For families with income, at the time of eligibility determination, less than 101% of the federal poverty level, all copayments shall be waived, except for emergency and urgent/after hours care, which shall be three dollars per use (co-pay is waived if client is admitted to the hospital).

B. For families with income, at the time of eligibility determination, between 101% and 150% of the federal poverty level, the copayment is:
   1. Two dollars per office visit;

2. Two dollars per outpatient mental health or substance abuse visit;
3. One dollar per prescription;
4. Two dollars per physical therapy, occupational therapy or speech therapy visit;
5. Two dollars per vision visit;
6. Three dollars per use of emergency care and urgent/after hours care.(Co-pay is waived if client is admitted to the hospital.)
7. Two dollars per trip for emergency transport/ambulance.
8. Two dollars per inpatient hospital visit.
9. Two dollars per inpatient hospital stay, for physician services in the hospital.
10. Two dollars per outpatient hospital or ambulatory surgery center visit.

C. For families with income, at the time of eligibility determination, between 151% and 200% of federal poverty level, the copayment is:
1. Five dollars per office visit;
2. Five dollars per outpatient mental health or substance abuse visit;
3. Three dollars per generic prescription;
4. Ten dollars per brand name prescription;
5. Five dollars per physical therapy, occupational therapy or speech therapy visit;
6. Five dollars per vision visit;
7. Twenty dollars per use of urgent/after hours care.
8. Thirty dollars per use of emergency care (co-pay is waived if client is admitted to the hospital).
9. Fifteen dollars per trip for emergency transport/ambulance.
10. Twenty dollars per inpatient hospital visit.
11. Five dollars per inpatient hospital stay for physician services in the hospital.
12. Five dollars per outpatient hospital or ambulatory surgery center visit.
13. Five dollars per date of service for laboratory and imaging services.

D. For families with income, at the time of eligibility determination, between 201% and 250% of federal poverty level, the copayment is:
1. Ten dollars per office visit;
2. Ten dollars per outpatient mental health or substance abuse visit;
3. Five dollars per generic prescription;
4. Fifteen dollars per brand name prescription;
5. Ten dollars per physical therapy, occupational therapy or speech therapy visit;
6. Ten dollars per vision visit;
7. Thirty dollars per use of urgent/after hours care.
8. Fifty dollars per use of emergency care (co-pay is waived if client is admitted to the hospital.)
9. Twenty-five dollars per trip for emergency transport/ambulance.
10. Fifty dollars per inpatient hospital visit.
11. Ten dollars per inpatient hospital stay for physician services in the hospital.
12. Ten dollars per outpatient hospital or ambulatory surgery center visit.

13. Ten dollars per date of service for laboratory and imaging services.

8.2.4. Other:

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

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

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

The Department worked closely with CHP+ stakeholders before putting forth this proposal to increase copayments. This change has been adopted into rule and was subject to the public rulemaking process. Stakeholders testified in favor of this change because it was a more acceptable alternative to the one put forth by the State Legislature, which would have increased cost sharing over 1000%. After rule adoption, the rules were published in the Colorado Register and posted to the Secretary of State website.

The Department gives CHP+ members and applicants a chart that describes plan options, annual enrollment fees, and copayments based on income and family size.

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

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

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

8.4.2. ☑ No cost-sharing applies to well-baby and well-child care, including age-

appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

The following procedures will be considered well-baby and well-child care: CPT-4 codes: Preventive medicine codes: 99381-New patient under one year; 99382-New Patient age 1-4 years; 99383-New patient ages 5-11 years; 99384-New patient ages 12 through 17 years; 99391-Established patient under one year; 99392-Established patient ages 1-4 years; 99393-Established patient ages 5 through 11 years; 99394 – Established patient aged 12-17; 99431- Newborn care (history and examination); 99432-Normal newborn care.

Evaluation and Management Codes: 99201-99205-New patient; 99211-99215-Established patient.

ICD-9-CM codes: V20-V20.2-Health supervision of infant and child; V70.0-General medical examination (routine); V70.3-V70.9-General medical examination.

All infants and children should be seen by a Primary Care Provider regularly for immunizations (shots) and check-ups. The CHP+ follows the well-child visits schedule recommended by the American Academy of Pediatrics. The American Academy of Pediatrics recommends that children receive well-child visits at the following ages: 1 week, 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months 18 months, 2 years, 3 years, 4 years, 5 years 6 years, 8 years, 10 years, 11 years, 12 years, and 13 years.

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

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

The 5% maximum allowable cost-sharing limit is calculated for each individual family. The annual amount is then recorded on the family's enrollment card with instructions in the member packet of the "shoe box" method and the process to be followed when the limit is reached.

State planners estimate that few families will reach their 5% limit. An analysis of the State's fee schedule suggests that cumulative cost sharing will rarely exceed 1% of the family's adjusted gross income. However, CHP+ administrative personnel make families aware of the aggregate limit on cost sharing through a number of information and educational sources.

Through direct communication with families, the CHP+ marketing and outreach efforts often discuss the aggregate limit on cost sharing. The first direct written communication with CHP+ families instructs parents that the expenditures on their child(ren)s health care through CHP+ should not exceed 5% of family income. Through contracts with Managed Care Organizations, the CHP+ administration ensure that the plans make their enrollees aware of the aggregate limit on cost sharing by including information regarding the cost-sharing limit in their member handbooks.

The State has adopted the "shoe box" approach to reimburse families who exceed the 5% limit. Families are required to track expenditures based on the calculation of family income provided by the state and to submit receipts for all expenditures in excess of the 5% limit. Since the eligibility process will determine an “eligibility income” for each family, that family will receive notification of the exact dollar figure that will represent 5% of the family’s adjusted gross income.

Once they submit evidence that they have exceeded the 5% cap, the state will issue them a "co-pay exempt" sticker to be placed on their membership card. Providers and plans will be informed that enrollees with this sticker are not being charged co-payment for any service. The 5% limit is calculated on the family’s income at the time of eligibility determination. This cap is cited on the enrollment card. The cap will be recalculated if a family applies for a redetermination before the year is complete.

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

The joint application includes a question asking the applicant to indicate their ethnicity. Alaskan Native and American Indian are two of the choices. When this information is entered into the computerized eligibility and tracking system, the rules engine recognizes ethnicity and determines a $0 co-payment. This $0 is printed out on the enrollees’ card. The provider uses this card to determine the co-payment to be charged to the patient.

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

If an enrollee does not pay the annual enrollment fee within the 30 days after the notice, they are denied for the program.

Guidance: Section 8.8.1is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

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

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (42CFR 457.570(a))

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

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

8.8.1. ☑ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☑ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☑ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☑ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☑ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☑ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as

described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

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

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

Strategic objectives are to:

1. Improve health status of children in Colorado with a focus on preventive, and early primary treatment.
2. Decrease the proportion of children in Colorado who are uninsured.
3. Encourage employer based coverage.
4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.
5. Improve access to dental care for children.

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

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

1. Improve health status of children in Colorado with a focus on preventive, and early primary treatment.
   Performance Goals:
   - Develop measurable performance goals with the Quality Improvement committee by January 2003.
   - Contract with a Quality Assurance vendor by September 2002.

2. Decrease the proportion of children in Colorado who are uninsured.
   Performance Goals:
   - By FY 04-05 the Department is to have an enrollment rate of 85% of the estimated eligible population every year.

3. Encourage employer based coverage.
   Performance Goals:
   - Maintain the three month lock out period for those applicants having had employer paid health insurance (employer paying at least 50%) within three months of application.

- Continue to ask if the applicant has other insurance on the joint application.

4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.
   Performance Goals:
   - Evaluate the transfer process of cases to State Medicaid Technicians at the administrative offices in FY 03-04.

5. Improve access to dental care for children.
   Performance Goals:
   - Conduct a quality assurance dental survey by June 2003.
   - Develop a plan for improved care based on the results of the Dental Survey.
   - Assure network adequacy.

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

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

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

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

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

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

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

9.3.8. ☐ Performance measures for special targeted populations.

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

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

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

The State works with a vendor to analyze survey results from the American Community Survey to estimate the percentage of children who are eligible for CHP+ but not enrolled.

The State uses HEDIS to measure changes in health outcomes and health care related goals.
The State's estimated baseline of uncovered, low-income children is 172,457, with a CHP+ eligibles baseline estimate of 69,157. This is a revision since the estimate submitted to HCFA in the 1998 annual report. More recent data, specific to Colorado, provided opportunity to derive an estimate that would more closely reflect the current status of children in the state.

Colorado began with year 2000 population projections for children under age 19 for each county in the state. The source of these projections was the Colorado Demography

Information Service within the Colorado Division of Local Government. Then, using individual county uninsured rates (published in the *1997 Colorado HealthSource Book: Insurance, Access, and Expenditures*, April 1998, and funded by the Rose Community Foundation and The Colorado Trust), each county's population projection was multiplied by its uninsured rate to get the number of uninsured under age 19 in that county. The Colorado Health Source Book derived the method for determining its uninsured rates from "Estimating County Percentages of Uninsured People," Inquiry, 28:413-419 (1991), and used a three-year average of 1995-1996-1997 CPS data from the March Supplements.

County uninsured rates ranged from 9.0% to 40.9% among the 63 counties in Colorado, varying widely from the overall state estimate of 15.2%. The computed county estimates of uninsured under age 19 were summed to get a total for the state. The following tables summarize this methodology:

Number of Children Who Are Uninsured

	Colorado 1997 County Uninsured rates (Colorado Demography Information Service)	**2000 Colorado Population under Age 19**	**# of Uninsured under Age 19 (Sum of County Estimates)**
Uninsured under age 19	Range = 9.0% - 40.9%	1,145,447	172,457

This represents all uninsured children in the state, at all income levels. To determine the number of children who would be CHIP-eligible, or at or below 185% of the federal poverty level (FPL), the Department used an estimate from the American Academy of Pediatrics (AAP) which says that CHIP-eligibles under 200% FPL in the state comprise 40.1% of the uninsured under age 19. The source for this estimate was AAP's analysis of 1994-1997 March Current Population Survey Supplements and a 1998 Census Bureau child population projection. Each county's under-19 uninsured estimate was multiplied by this percentage to get CHIP eligibles by county, which were then summed to get a state total. (If 40.1% is applied to the state total number of uninsured under age 19, instead of each county's total, a slightly different estimate is obtained, but the difference is negligible, attributable to the rounding of county estimates.)

Number of Uninsured Children Who Are S-CHIP-Eligible:

	AAP CHIP-Eligible Percentage (Using 1994-1997 CPS and Census 1998 projection)	**Number of Uninsured under Age 19**	**2000 Colorado Population under Age 19, Uninsured, and under 200% FPL**
Uninsured under age 19	40.1%	172,457	69,157

It is this final estimate — 69,157 — against which Colorado's S-CHIP measures its performance in reducing the proportion of uncovered, low-income children in the state,

for FFY 1998 and FFY 1999.

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)) (42CFR 457.720)

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

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

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

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

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

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

Six working teams were created to design the core elements of the CHP+ and to promote ongoing public input into the plan. The CHP+ teams recommended benefits and cost sharing were applied to the CHP+ proposed in this Title XXI State Plan. The six teams were: 1) benefits design and pricing; 2) eligibility, enrollment, and management information system design; 3) financing; 4) marketing and outreach; 5) employer advisory group; and 6) contracting and quality assurance. A Policy Board reviewed team recommendations and gave strategic direction to the Department of Health Care Policy and Financing. The individuals who were members of these working teams had the opportunity to provide input into the development of CHP+, from the early stages of the decision-making process up to and beyond implementation. These

working teams were staffed and led by individuals representing the Department, the business community, the insurance industry, providers, children's advocates, schools, employers, and other public and private programs providing services to children.

Benefits Design and Pricing. This team was responsible for designing the benefit package and developing cost-sharing and subsidy structures. This team developed price estimates for the benefit package under different cost sharing and subsidy structures scenarios. Members of this team represented advocates for low-income families, the Colorado Division of Insurance, mental health providers, EPSDT outreach workers, providers of care to handicapped children, pediatricians, community health centers, and managed care organizations.

Marketing and Outreach. This team was responsible for developing a marketing plan and outreach strategy for partnering with schools, doctors offices, employers, social service providers, and public health entities throughout the state. This team recommended to the Department the most effective outreach plan, materials design, and marketing strategy to ensure that eligible families are notified that this product was available and how they could apply. The team developed a long term, phased plan for outreach and marketing CHP+. Not only school systems were tapped, but team members, through their varied work in the community were natural advocates and enlisted volunteers who could advocate for CHP+, throughout the state. Members of this team represented schools, day care centers, managed care organizations, providers, children's advocacy groups, and CHP+.

Eligibility, Enrollment, and Management Information Systems Design. This team was responsible for developing an eligibility and enrollment system that would be flexible, simple to administer, and meet the long-term needs of CHP+. This team was also responsible for developing recommendations for the rules by which a child would be deemed eligible for the program. Members of this team included representatives from managed care organizations, the Medicaid program in the Department of Health Care Policy and Financing, the Program for Children with Special Health Care Needs, Indian tribes, community health centers, CHP+ philanthropic provider clinics, and other providers.

Financing. This team was responsible for identifying funding streams available to finance the program, preparing budget projections, developing estimates of the number of children that would be enrolled, and creating mechanisms to ensure that CHP+ would be fiscally sound. Members of this team included representatives from community health centers, the Colorado Indigent Care Program, the Office of State Planning and Budgeting, the CHP+, and the Department of Health Care Policy and Financings budget and accounting offices.

Employer Advisory Group. This team presented recommendations to the Department regarding mechanisms to ensure that CHP+ did not become a substitute for employer-based coverage. This group established a means for the Department and employers to coordinate coverage for children eligible for the program, create incentives for employers to assist the Department with outreach and eligibility determination, and presented recommendations as to how the subsidy can be

structured to ensure that employees did not drop employer-based coverage. Membership of this team represented a broad base of employers and business organizations such as US West, Kodak, and Mile Hi Child Care Centers.

Contracting and Quality Assurance. This team was responsible for developing purchasing strategies and contract standards for the CHP+ program. The team reviewed options for purchasing, pricing and quality assurance from Medicaid and commercial models.

Policy Board. The initial Department-appointed Policy Board reviewed key team recommendations and gave strategic guidance to the Department of Health Care Policy and Financing in the design and implementation of CHP+. This group was comprised of high-level private sector business managers, hospitals, providers, children's advocates, the insurance industry, the General Assembly, the Colorado Department of Public Health and Environment, and the Colorado Division of Insurance.

The Department-appointed Policy Board disbanded after the passage of House Bill 98-1325, which became law on April 21, 1998. A provision of that legislation created an 11-member Policy Board charged with promulgating rules for the as CHP+.

Upon dissolution of the Policy Board in August 2001, public input is received through a variety of methods:

- Rule Making: At the time of any presentation of a rule to be approved by the Board, interested advocates are notified of the rule and public testimony is encouraged at the Board meeting;
- Department staff meet regularly with patient advocacy groups;
- Drafts of items requesting public input are placed on the CHP+ Website;
- Any member of the public has the right to correspond directly with Board members.

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

CHP+ contracts with Indian Health Services providers as SED sites and looks for ways to reach the tribal populations. In addition, CHP+ follows the tribal consultation process described in Section 2.3-TC Tribal Consultation Requirements.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR457.65(b) through (d).

a. Changing CHIP from a Separate Program to a Combination Program by expanding Medicaid: Public rule-making notice was published in the Colorado Register and the

Department's website on October 10, 2012.

b. Eligibility for children of state employees: Public rule-making notice was published in the Colorado Register and the Department's website on November 10, 2012.

c. Coverage of uninsured pregnant women at or below 250% FPL through the CHIP State Plan: Public rule-making notice was published in the Colorado Register and the Department's website on October 10, 2012.

d. Passive Enrollment: Public rule-making notice was published in the Colorado Register and the Department's website on September 10, 2012.

9.9.3 Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option. Indian tribes and organizations were consulted about Express Lane eligibility using the approved consultation agreement process. This consultation was sent to the tribes and organizations on December 20, 2011.

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

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

under the state plan using the attached form. Additionally, provide the following:

- Total 1-year cost of adding prenatal coverage
- Estimate of unborn children covered in year 1

CHIP Budget

STATE: Colorado	**FFY 2012-13**	**FFY 2013-14**
Federal Fiscal Year		
State's enhanced FMAP rate	**65%**	**65%**
Benefit Costs (Children 134-250% FPL)		
Insurance payments		
Managed care	$123,610,596	$115,565,287
per member/per year cost	$2,198.92	$2,399.44
Fee for Service		
Benefit Costs (Prenatal 186-250% FPL)		
Insurance payments		
Managed care	$19,864,698	$17,101,734
per member/per year cost	$11,542.53	$13,435.08
Fee for Service		
Total Benefit Costs	$143,475,294	$132,667,021
(Offsetting beneficiary cost sharing payments)	($1,112,877)	($1,235,362)
Net Benefit Costs	$142,362,417	$131,431,659
Administration Costs		
Personnel	$729,263	$729,263
General administration	$2,076,892	$2,076,892
Contractors/Brokers	$686,349	$686,349
Claims Processing	$0	$0
Outreach/marketing costs	$500,000	$500,000
Other	$0	$0
Total Administration Costs	$3,992,504	$3,992,504
10% Administrative Cap	$15,818,046	$14,603,518
Federal Share	$95,130,699	$88,025,706
State Share	$51,224,222	$47,398,457
Total Costs of Approved CHIP Plan	$146,354,921	$135,424,163

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: State appropriations, Tobacco Settlement funds, enrollment fees for families with income 150% FPL and above, and Hospital Provider Fee funds.

Section 10. Annual Reports and Evaluations

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

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

10.1.1. ☑ The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☑ The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☑ The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC ☒ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

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

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. ☑ The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8.

(Previously items 9.8.6. - 9.8.9)

11.2.1. ☑ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☑ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☑ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☑ Section 1128A (relating to civil monetary penalties)

11.2.5. ☑ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☑ Section 1128E (relating to the National health care fraud and abuse data collection program)

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

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

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

If an applicant does not agree with the eligibility determination assessed by the contractor, the applicant may appeal the decision. This appeal must be in writing and within 30 days of the eligibility determination letter. If the appeal cannot be favorably resolved with the contractor, the appeal is taken to the Grievance Committee. The Grievance Committee consists of the appeal staff person from the contractor, an eligibility technician, and three staff persons from the Department of Health Care Policy and Financing. The three staff persons have never seen the case before and are well versed in the rules of the program. Applicants may attend the committee meeting by telephone, in person, or may send a representative and may have access to all documents that were used to determine their eligibility. All communication needs are taken care of for the applicant during a committee meeting; i.e. translation. A final decision is made during the Grievance Committee meeting and the applicant is notified of the decision within 10 days. All decisions made in the Grievance Committee are final.

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

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

Within the MCO contracts are provisions regarding health services matters. The Contractor is to agree to adequately staff and maintain a Member services and Complaint response function to explain operations, assist in the selection of a PCP, assist in how to make appointments and recording and responding to member complaints, or oral expressions of dissatisfaction with the

Contractors plan.

The Contractor shall process prospective, concurrent and retrospective reviews, and have in place procedures for complaints and appeals of Adverse Determinations that comply with the requirements concerning these activities contained in Title 10, C.R.S., and Colorado Division of Insurance regulations. All determinations of Medical Necessity of Covered Services are subject to these appeal processes.

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

Key for Newly Incorporated Templates

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

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

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GLOSSARY

Adapted directly from SEC. 2110. DEFINITIONS.

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

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

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

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

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

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

ADDITIONAL DEFINITIONS- For purposes of this title:

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