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State/Territory Name: Maryland

State Plan Amendment (SPA) #: MD-I7-0001-LEAD

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

JUN 15 2017

Shannon M. McMahon
Deputy Secretary of Health Care Financing
Maryland Department of Health and Mental Hygiene
201 W. Preston St.
Baltimore, MD 21201

Dear Ms. McMahon:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) MD-17-0001-LEAD, submitted to the Centers for Medicare & Medicaid Services (CMS) on January 12, 2017, with additional information submitted on June 5, 2017, has been approved. This SPA has an effective date of July 1, 2017.

Maryland's SPA MD-17-0001-LEAD implements a CHIP health services initiative (HSI) to improve the health of low-income children by conducting lead hazard home assessments to identify lead hazards in the homes of low-income children with elevated blood lead levels above 5µg/dL reside in the state and abating any identified lead hazards in the children's homes. This program expands on current lead hazard control work conducted by the state.

In addition, Maryland's SPA MD-17-0001-LEAD implements a CHIP HSI to improve the health of low-income children by providing home assessments that identify asthma triggers and conditions could contribute to lead poisoning in homes of low-income children with asthma and/or an elevated blood lead level above 5µg/dL and conducting educational home visits to help the family address medication adherence, nutrition, and safe cleaning techniques in the children's homes.

CMS agrees to continue to provide CHIP administrative federal financial participation for the lead hazard home assessments for Medicaid-covered children with an elevated blood lead level above 5µg/dL through the state's next legislative session, while the state pursues a state law change to expand the types of individuals that may conduct the home assessments. If the state law is changed, the state will need to submit a Medicaid state plan amendment to reflect this change.

Section 2105(a)(l)(D)(ii) of the Social Security Act (the Act) and 42 CFR 457.10 authorize use of title XXI administrative funding for expenditures for HSIs under the plan for improving the health of children, including targeted low-income children and other low-income children. Consistent with section 2105(c)(6)(B) of the Act and 42 CFR 457.626, title XXI funds used to support an HSI cannot supplant Medicaid or other sources of federal funding.

The state shall ensure that the remaining title XXI administrative funding, within the state's 10 percent limit, is sufficient to continue the proper administration of the CHIP program. If such funds become less than sufficient, the state agrees to redirect title XXI funds from the support of this HSI to the administration of the CHIP program. The state shall report annually to CMS the expenditures funded by the HSI for each federal fiscal year.

Your title XXI project officer is Ms. Ticia Jones. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Jones' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-8145
Facsimile: (410) 786-5882
E-mail: Ticia.Jones@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Jones and to Mr. Francis McCullough, Associate Regional Administrator (ARA) in our Philadelphia Regional Office. Mr. McCullough's address is:

Centers for Medicare & Medicaid Services
Philadelphia Regional Office
Division of Medicaid and Children's Health Operations
The Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, PA 19106

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

We look forward to continuing to work with you and your staff.

Sincerely,

/ Anne Marie Costello /

Anne Marie Costello
Director

cc: Mr. Francis McCullough, ARA, CMS Region III

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: Maryland
(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))

/ S /

_____ 6/13/17
Deputy Secretary for Health Care Financing
(Signature of Governor, or designee, of State/Territory, 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: Debbie Ruppert Position/Title: Executive Director, Ofc of Eligibility Services
Name: Lorie Mayorga Position/Title: Deputy Director for Eligibility Policy, Ofc of Eligibility Services
Name: Cornelia Ellis Position/Title: Division Chief, Maryland Children's Health Program

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

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
Effective Date:

Implementation Date:

SPA #MD-17-0001-LEAD___, Purpose of SPA:_____

Maryland will use the health services initiative (HSI) option under Section 2105(a)(2) of the Social Security Act and 42 CFR 457.10 to advance a two-pronged initiative to combat lead:

1) Program #1: Healthy Homes for Healthy Kids: Expansion of lead identification and abatement programs for low-income children through programs delivered by the Maryland Department of Housing and Community Development (DHCD); and

2) Program #2: Childhood Lead Poisoning Prevention & Environmental Case Management: Expansion of county level programs to provide environmental assessment and in-home education programs with the aim of reducing the impact of lead and other environmental toxins on vulnerable low-income children. The program will be conducted by environmental case managers and community health workers seated in Local Health Departments (LHDs) and conducted in counties with the greatest need.

Proposed effective date: July 1, 2017

Proposed implementation date: July 1, 2017

Maryland's Modified Adjusted Gross Income (MAGI) SPA Roster

Transmittal Number	SPA Group	PDF Number	Description	Superseded Plan Section(s)
MD-14-0010 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	MAGI-equivalent standards, by age group; Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0

MD-14-0011 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1

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.

TN No: Approval Date Effective Date _____

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))

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)

Maryland Poison Control Center (MPCC)

The MPCC, a unit of the University of Maryland School of Pharmacy, responds to approximately 35,000 human exposure calls each year. These are calls to the MPCC where an individual has been exposed to potentially toxic substance and the caller is seeking medical advice/treatment from the MPCC. Each year, the majority of those calls involve exposures that occur in children. Below are the numbers of pediatric human exposure cases reported to the MPCC over the past two full calendar years, broken down by quarter.

Year	Quarter	Total Pediatric	Total Human	% Pediatric
2010	1	5,282	8,554	61.75
2010	2	5,572	9,218	60.45
2010	3	5,465	9,363	58.37
2010	4	5,323	8,761	60.76
2011	1	5,113	8,662	59.03
2011	2	5,310	8,962	59.25
2011	3	5,257	9,284	56.62
2011	4	5,145	8,836	58.23

NOTE: For this summary, pediatric calls are defined as those that occur in children age <19 years.

The percentage of pediatric cases reported to the MPCC changes a bit over time (range of 56.62% - 61.75%). In the schedule of projected costs and allocation method submitted with the amendment to the Cost Allocation Plan, the allocation of MPCC costs to the under-19 years (child) population uses an overall percentage of 59.31%, which is the simple average of the above 8 quarters of data. The percentage of quarterly allocations to CHIP, going forward, would be made based on the most recent call data, gathered for the quarter being claimed.

Cost. A revision of the Maryland CHIP Cost Allocation Plan has been submitted sperately. In brief, the projected costs of this program are approximately $4.1 million, of which roughly 59.31% or $2.4 million are attributable to pediatric services to individuals under 19 years old. At Maryland's CHIP rate of 65%, this would result in a federal expenditure of approximately $1.5 million. MPCC, a previously state-funded program, will continue to track total calls and calls respecting children in order to supply accurate statistics for cost allocation.

Conformity with 42 CFR 457.1005. The services of the MPCC conform to the requirements of CHIP regulations. Specifically, they are not prohibited by any provision of Subpart D. As a unit of the University of Maryland School of Pharmacy, the activities of the MPCC are subject to stringent controls for quality. MPCC services are offered at no cost to individuals who call to request them, so the provisions of Subpart E limiting enrollee financial responsibility are satisfied.

Section 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).

Background

The Centers for Disease Control considers a child to have an elevated blood lead level (BLL) if the lead in that child's blood is >5µg/dL.[1] Lead exposure, in the form of paint chips or lead-contaminated dust from deteriorated lead-painted surfaces, continues to be an environmental hazard for many children in Maryland. Out of an estimated 2,399,375 occupied residential units in Maryland, 437,441 (18.2%) were built before 1950 and 923,917 (38.5%) between 1950 and 1979. While a significant number of pre-1950 and 1950 to 1979 residential rental units have been made lead free, untreated pre-1950 and 1950 to 1979 units are highly likely to have lead-based paint.[2] As a result, Maryland's children, especially low-income children who live in older housing, are particularly vulnerable to lead exposure. Exposure to lead can result in major physical and neurological damage to children, leading to serious consequences for their educational attainment and health including: stunted brain development, reduced intelligence quotient (IQ), hearing and speech problems, learning disabilities, anemia, hypertension, renal impairment and immunotoxicity, among a range of other conditions. In addition, children who are lead poisoned are seven times more likely to drop out of school and six times more likely to become involved in the juvenile justice system. In 2015 there were an estimated 535,094 children under 6 years of age in the State of Maryland. Of these, 110,217 were tested for blood lead, and 2% of all children tested had a BLL ≥ 5µg/dL. Baltimore has the highest concentration of these children.[3]

HSI Assurances

1. Maryland provides assurances that the HSI program will only target children under the age of 19.
2. Maryland provides further assurances that funds under this HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.
3. Maryland provides further assurances that the State will report on agreed upon metrics at regular intervals to CMS on the progress of the HSI.

1 https://www.cdc.gov/nceh/lead/acclpp/blood_lead_levels.htm
2 http://mde.maryland.gov/programs/Land/Documents/LeadReports/LeadReportsAnnualChildhoodLeadRegistry/LeadReportCLR2015.pdf
3 Ibid.

Initiative Overview

Maryland will use the health services initiative (HSI) option under Section 2105(a)(2) of the Social Security Act and 42 CFR 457.10 to advance a two-pronged initiative to combat lead:

1) *Program #1: Healthy Homes for Healthy Kids*: Expansion of lead identification and abatement programs for low-income children through programs delivered by the Maryland Department of Housing and Community Development (DHCD); and
2) *Program #2: Childhood Lead Poisoning Prevention & Environmental Case Management*: Expansion of county level programs to provide environmental assessment and in-home education programs with the aim of reducing the impact of lead and other environmental toxins on vulnerable low-income children. The program will be conducted by environmental case managers and community health workers seated in Local Health Departments (LHDs) and conducted in counties with the greatest need.

The proposed HSI Program #1 and HSI Program #2 are two distinct programs. Program #1 will serve eligible residents in the entire state of Maryland. Program #2 will serve nine specific counties in Maryland.

Under both proposed programs, eligibility is limited to low-income children, who are (1) enrolled in Medicaid or CHIP *or* (2) Medicaid or CHIP eligible but not yet enrolled.

Program #1: Healthy Homes for Healthy Kids

Through an Interagency Agreement between the Maryland Department of Health and Mental Hygiene (DHMH) and DHCD, DHCD will administer a lead identification and abatement program—the "Healthy Homes for Healthy Kids" Program—building on DHCD's experience and expertise in this area. DHCD currently abates lead in an average of 110 homes in Maryland annually. Under the Healthy Homes for Healthy Kids Program (Program #1), DHCD will expand its existing lead identification and abatement activities to focus on identifying lead-contaminated residential properties across Maryland where low-income children under the age of 19 reside or visit for at least 10 hours per week. The proposed HSI programs will create an opportunity to abate 70-200 *additional* homes in Maryland. Pregnant women are not eligible for the services proposed under the HSI.
Under Program #1, eligible properties will include residential properties that are owner-occupied, occupied by a family member of the owner, or occupied by a tenant, as well as residential properties in the process of becoming licensed for, or currently maintaining a license for the provision of childcare services. HSI funds will not be used for commercial, non-residential properties.

To qualify for services through Program #1, children must meet two primary requirements.

First, they must be (1) enrolled in Medicaid or CHIP *or* (2) Medicaid or CHIP-eligible but not yet enrolled. Second, eligibility for Program #1 is limited to children with a BLL of ≥ 5µg/dL.

When lead is detected in the residential property occupied by the eligible child, DHCD will provide lead abatement services to eligible properties reducing the overall risk of lead poisoning among low-income children in Maryland. If the lead abatement work requires for the families to vacate the premises following HUD guidelines, DHCD will provide relocation support for families.

If approved, Program #1 will have a proposed effective date of July 1, 2016, and will not be time limited.

Income Assessment

To the extent a child is not currently enrolled in Medicaid or CHIP, their income must be assessed. To qualify for Medicaid or CHIP, a child's household income must be at or below the adjusted income threshold of 322% of the federal poverty level (FPL).

DHCD currently utilizes the Area Median Income (AMI), set by the Department of Housing and Urban Development (HUD), to assess eligibility for its programs. The AMI is established by the United States Department of Housing and Urban Development (HUD), and is updated on an annual basis. HUD computes AMIs based on available data for each metropolitan area, parts of some metropolitan areas, and each non-metropolitan county. DHCD's Research Department reviews and publishes the AMIs on a statewide basis, with adjustments for household sizes from 1 through 8 family members, organized by percent of the Median Income (i.e. 30%, 50%, 60% 80%, etc.). AMIs vary from location to location; for example, AMIs in Montgomery County, Maryland are higher than Somerset County, Maryland. Individual household income will be reviewed and verified by DHCD as part of the application process for DHCD financing to ensure compliance with the Income limits established for various financing programs.

Due to resource restrictions, DHCD is unable to perform a modified adjusted gross income (MAGI) income assessment of potential program recipients. For purposes of Program #1, the State intends to use a percentage of the AMI adjusted to the CHIP income threshold of 322% FPL as the ceiling for income eligibility. DHCD will collect household size information to ensure the family is within the income limits to determine if the child is eligible to participate—e.g., does the family's income fall below the AMI ceiling for that area.

Specifically, under the 2016 HUD income limits,[4] the median income for the rest of state for a family of four is $90,500 and Washington, D.C. Primary Metropolitan Statistical Area (PMSA) median income limit is $109,500. In general, the AMI is higher than the income cutoffs for CHIP or Medicaid services. Therefore, DHCD will verify a child's eligibility for Program 1 utilizing the percentage of AMI equivalent to 322% FPL specified in Table 1.

4 See Appendix A, AMI Chart with 2016 Income Limits As of June 2016.

Table 1: Income Limits for Program #1

Size of family unit	322% of FPL*	AMI DC PMSA**	Percentage of AMI DC PMSA equivalent to 322% FPL	AMI Rest of State**	Percentage of AMI Rest of State equivalent to 322% FPL
1	$38,833.00	$76,500	50.76%	$63,333	61.32%
2	$52,293.00	$87,333	59.88%	$72,333	72.29%
3	$65,752.00	$98,250	66.92%	$81,500	80.68%
4	$79,212.00	$109,167	72.56%	$90,500	87.53%
5	$92,672.00	$118,000	78.54%	$97,667	94.89%
6	$106,131.00	$126,667	83.79%	$105,000	101.08%
7	$119,590.00	$135,500	88.26%	$112,167	106.62%
8	$133,050.00	$144,167	92.29%	$119,500	111.34%

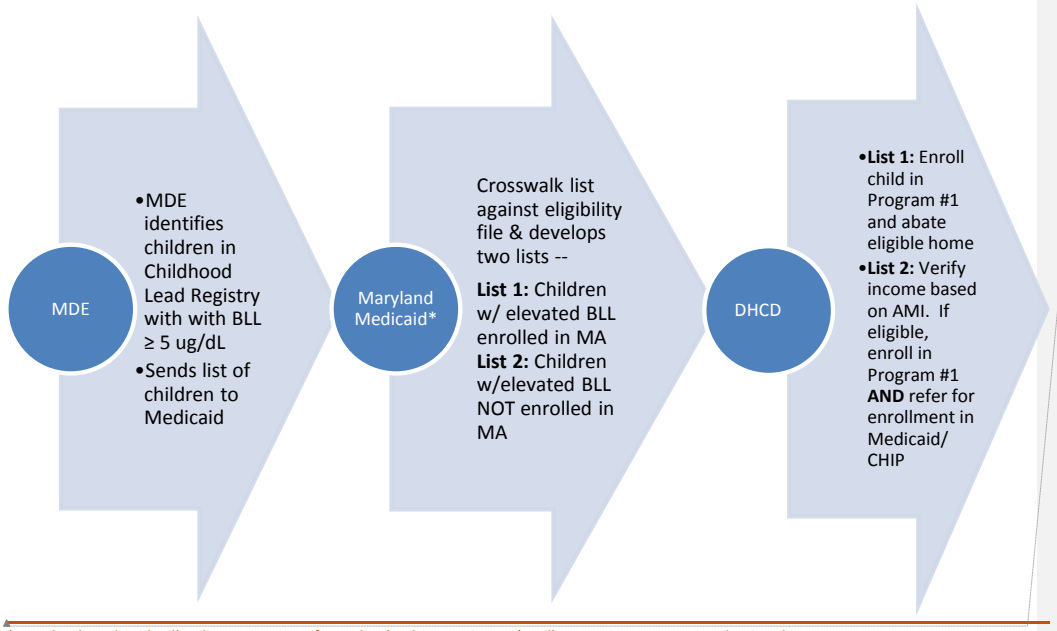
*FPL rates are based on 2017 levels.
**AMI DC PMSA and AMI Rest of State is based on 2016 levels. The AMI percent will be adjusted annually to reflect the equivalent of 322% FPL.

For example, consider a scenario where a family in Baltimore City applies for Program #1. Using 2017 FPL guidelines, a child in a family of 4 would qualify for CHIP in Maryland if the household income did not exceed $79,212. Using DHCD's AMI chart above, the child of a family of 4 would qualify for Program #1 if the household income did not exceed 72.56% of AMI for DC PMSA, which is approximately 322% FPL.

Program #1: Enrollment Strategies
Maryland will use two strategies for enrolling children in Program #1 .These two strategies are outlined below.

Program #1: Enrollment Strategy 1—Childhood Lead Registry
Maryland will leverage the Maryland Department of the Environment's (MDE) Childhood Lead Registry (CLR) to enroll children in Program #1. The Statewide CLR provides state-level surveillance on BLLs in children. Children with a BLL of ≥5 µg/dL will be referred to Program #1.

Figure 1: Program #1's Overview of Enrollment using MDE's CLR Data



*Maryland Medicaid will utilize University of Maryland Baltimore County's Hilltop Institute to receive the CLR data

MDE's Childhood Lead Registry (CLR) receives reports of all blood lead tests performed on Maryland children aged zero to six years. By law, a report is sent to MDE's CLR after a child receives a result from either an in-office (capillary) test or goes to a commercial laboratory for blood lead testing. If an elevated BLL5 exists, MDE contacts the corresponding Local Health Department (LHD) to inform the LHD that a child in their jurisdiction has an elevated BLL, the level of that BLL, as well as information for contacting the child's family.

There are currently 2,166 children with elevated BLLs in the CLR. These children are categorized by:

1) whether the child is a new case versus an on-going case of lead poisoning and;
2) the child's BLL.

As Maryland transitions to testing of all children in the State at ages 1 and 2 years (as opposed to the previous system which mandated testing only for Medicaid-enrolled children and children living in targeted "high-risk" areas of the State), MDE is providing more LHDs with information about children with BLLs of 5 - 9µg/dL, based on the 2012 CDC guidance, although

5 Code Of Maryland Regulations (COMAR) 10.11.04.02 (8) "Elevated blood lead level" means: (a) A blood lead level of 10 micrograms per deciliter or greater; or (b) A blood lead level of 5 micrograms per deciliter or greater for a blood test performed after March 28, 2016.

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the statutory definition of elevated blood lead at which MDE has authority to require landlord compliance is still 10 µg/dL.6 The aim of expanding mandatory testing for lead to encompass the whole State was to identify as many of the children affected by lead poisoning as possible. The State anticipates that the number of children and families who will be eligible to participate in Program #1 will increase in the short-term. However, based on historical trends in the areas where mandatory testing has been in place for two decades, we expect to see a reduction in the number of children with lead poisoning long-term as the housing stock is identified and abated.

Under Program #1, Maryland Medicaid will utilize CLR data from MDE. Then, Maryland Medicaid, with assistance from University of Maryland Baltimore County's Hilltop Institute, will cross match the names and other identifying information of children with a BLL >5µg/dL on the CLR with the Maryland Medicaid enrollment database. Medicaid will provide DHCD with two lists based on the CLR data—one identifying eligible children currently enrolled in Medicaid or CHIP with a BLL >5µg/dL and a second identifying a list of children with a BLL >5µg/dL who are not currently enrolled in Medicaid or CHIP.

Children who are identified as already enrolled in Medicaid or CHIP will not be subject to further income verification in order to qualify for Program #1. Based on the list provided by Medicaid, DHCD will contact the eligible children's families and seek to enroll them in Program #1 to determine whether abatement is appropriate in the child's home.

If a child with a BLL of >5µg/dL is not currently enrolled in Medicaid/CHIP, they will be referred to Program # 1 and their income eligibility will be assessed against the adjusted AMI standard. If they meet the income eligibility requirements, they will be enrolled in Program #1 and referred for assistance in applying for Medicaid/CHIP.

Program #1: Enrollment Strategy 2—Direct Referrals

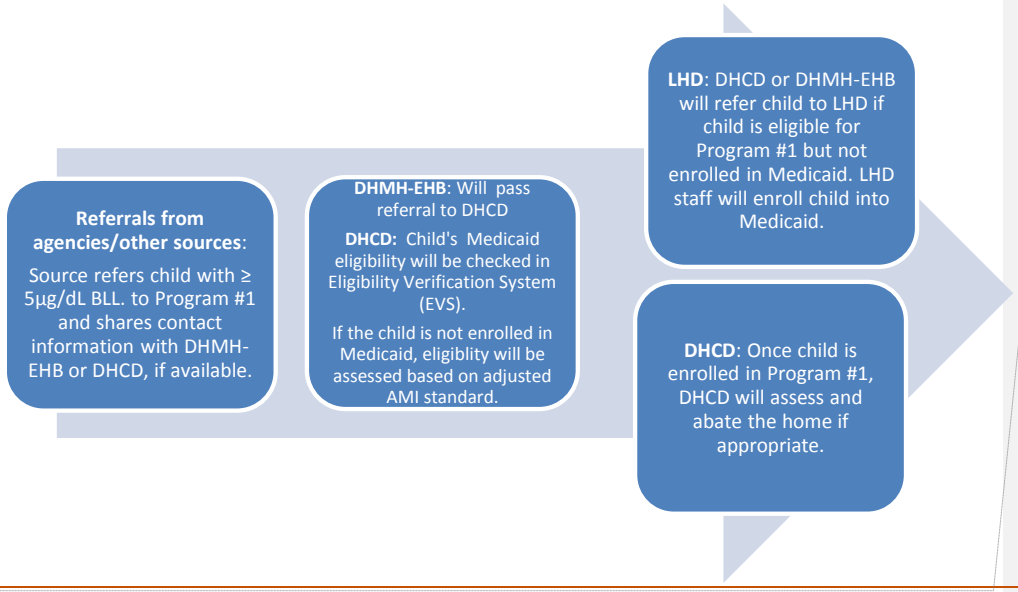
As a second strategy for enrollment, DHMH will inform stakeholders about Program #1's services and participation criteria as well as details on how to refer the child to the Program. Program #1 will accept referrals from a wide variety of sources including:

- Primary care providers, specialists and other health professionals involved in the child's care;
- State and county social services agencies;
- Local housing agencies;
- Public health agencies (based on either direct inquiries from the public, or from health care providers following up on lead tests of 5µg/dL or greater);

6 Maryland Code Annotated, Environment Article § 6-819(c)(1): "After February 23, 1996, an owner of an affected property shall satisfy the modified risk reduction standard: (i) Within 30 days after receipt of written notice that a person at risk who resides in the property has an elevated blood lead level documented by a test for EBL greater than or equal to 15 g/dl before February 24, 2006 or greater than or equal to 10 g/dl on or after February 24, 2006…"

- MDE, based on public inquiries, regulatory referrals from their enforcement unit, or notices of defect7 from renters; and
- Requests from homeowners or rental property owners.

Figure 2: Program 1's Enrollment Strategy Based on Referrals



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DHMH-EHB and DHCD will provide flyers and information for the listed sources to distribute to potential families. Both entities have budgeted for printing the necessary materials. DHCD will then accept the referrals and independently assess if the families are eligible for Program #1.

Medicaid is also working to grant specific DHCD staff access to Medicaid's Eligibility Verification System (EVS) to verify a child's enrollment in Medicaid. If the child is already enrolled in Medicaid/CHIP, DHCD will enroll them in Program #1 and commence the abatement work. If the family is found eligible for Program #1 based on income, but not enrolled in Medicaid/CHIP, DHCD or DHMH-EHB will enroll the child in Program #1 and refer the family to a LHD for assistance in applying for Medicaid. For any such referral, DHCD or DHMH-EHB will share the finder file and Medicaid will subsequently verify whether the referred family was enrolled into Medicaid/CHIP.

Under Program #1, DHCD will prioritize the work to ensure the most vulnerable children are addressed first. DHCD will use the methodology presented in Table 1 to prioritize eligible

7 A notice of defect is a legal notification instrument in Maryland law that renters in pre-1978 rental properties can submit to landlords and MDE which indicates there are defects in the rental property that could potentially pose a lead exposure risk to children.

properties for lead abatement under Program #1.

Table 2: Prioritization matrix to be utilized by DHCD

Priority measure	Category	Points	Category	Points
Level of elevated BLL of a child living in the property.*	5-9µg/dL	1 point per child	10µg/dL and above	2 points per child
Number of children living in the property who have an elevated BLL, or who have a history of elevated BLL, and who are under the age of 6.	history of blood lead	1 point per child	currently have elevated blood lead	2 points per child
Mother of child who currently has an elevated BLL, or a history of elevated BLL, is pregnant, and resides in the property with the child.	history of blood lead	1 point per child	currently have elevated blood lead	2 points per child

* If more than one child lives in the property and has elevated blood lead, award additional points accordingly.

This matrix will allow the State to ensure that the most vulnerable children are given the highest priority for lead abatement services. As an example, if two families were accepted into Program #1, DHCD would use this matrix to determine which family to serve first. Family #1 has three children, two of whom are under the age of 6, one of whom currently has an elevated blood lead of 10µg/dL, the second of whom has a history of elevated blood lead. Family #2 has three children, but only one child under the age of 6 with an elevated blood lead of 5µg/dL. The score for Family #1 is five points, whereas the score for Family #2 is three points; therefore, Family #1 would receive a higher priority for abatement services. *Program #1: Services*

Once a referral is received by Program #1 through one of the two enrollment strategies and the child is deemed eligible, DHCD will arrange for an environmental assessment of the child's residence (or other eligible property) to confirm lead contamination and determine the specific abatement work that is needed.

Under SPA 09-05 and as stated in the Maryland Code, Medicaid reimburses for environmental assessments that are performed by providers that are Lead Paint Risk Assessors accredited8 by MDE who also have enforcement authority. The only accredited Lead Paint Risk Assessors who have enforcement authority are those employed by health departments or MDE; other (private sector) accredited Risk Assessors do not have authority to enforce Maryland law, only authority to conduct assessments and issue lead-free certificates. Assessments are reimbursable as long

8 All persons performing lead paint inspections activities are trained and accredited by the MDE http://mde.maryland.gov/programs/Land/LeadPoisoningPrevention/Pages/inspectorscontractors.aspx

as they are performed by the aforementioned provider and the child has a BLL of ≥ 5µg/dL. Maryland will continue to reimburse for these assessments using existing Medicaid funds (procedure code T1029). With the exception of Baltimore City Health Department and Prince George's County Health Department, the remaining 22 local health departments do not have accredited Lead Paint Risk Assessors on their staff, and therefore have not been eligible for reimbursement for environmental assessments. It requires at least a year to train and accredit a new Lead Risk Assessor, so even if LHDs committed to developing this capacity, there would be a lag time before the capacity could be in place.
Funds from the HSI will be used to pay for environmental assessments that are conducted by Lead Paint Risk Assessors who do not have enforcement authority under Maryland law, such as those conducted by DHCD or private contractual environmental assessments.

DHCD will contract with licensed9 sub-contractors who are accredited10 to conduct the necessary lead abatement activities. The State will provide coordinated and targeted lead abatement services to eligible properties to mitigate all lead risks and ensure the long-term effectiveness of abatement activities. Abatement services are defined as the removal of lead hazards, including:

- The permanent removal, or enclosure, or encapsulation of lead based paint and lead dust hazards from an eligible residence;
- The removal and replacement of surfaces or fixtures within the eligible residence;
- The removal or covering of soil lead hazards up to the eligible residence property line; and
- All preparation, lab sampling analysis, clean up, disposal, and pre and post-abatement paint, dust, soil and clearance testing activities associated with such measures.
- Clearance testing will meet the stands of HUD's Lead-Based Paint Hazard control and/or Health Homes Grants.

Once work has started on an eligible property, DHCD will ensure all eligible surfaces and fixtures are abated. Eligible surfaces for abatement services include all structural components identified as hazards during the environmental investigation or the lead inspection/risk assessment including but not limited to: all window components, door and door frames, stairs, interior walls and ceilings, painted cabinets, interior railings, painted floors, exterior porches, exterior painted siding, exterior windows and trim, exterior trim boards, exterior painted siding, trim and doors on garages and other structures, and soil. A home shall not be deemed to have been abated until it passes a lead dust clearance test (see specifications below). A range of

9 Contractors in the State of Maryland must maintain a license with the Maryland Home Improvement Commission: https://www.dllr.state.md.us/license/mhic/
10 Any contractor performing lead abatement in Maryland must be trained and accredited by MDE: http://mde.maryland.gov/programs/Land/LeadPoisoningPrevention/Pages/inspectorscontractors.aspx

costs associated with lead abatement activities based on DHCD's experience in the field including, current materials, labor and other costs is provided below (see Table 3).

Table 3: Projected cost of lead abatement and encapsulation

Average Cost per home	Range of Costs	
Estimated Cost:	Low	High
Lead Abatement / Encapsulation*	$15,000	$25,000

*Lead Abatement/Encapsulation cost includes costs associated with surveys and assessments. All costs are inclusive of contractor profit and overhead. DHCD's administrative overhead (15%) not included in cost estimate.

Maryland's HSI Program #1 will not involve the replacement of water service lines to homes. The State will not utilize the HSI SPA to assess lead hazards in drinking water in most cases. In Maryland, when investigating the source of lead, the assessment typically finds that lead paint is the source of the exposure. The assessor will typically ask about other potential sources, such as: time spent in other countries; pottery; cosmetics; foods, spices, and candies; soil; and drinking water. Generally, testing of other potential sources is rare unless there is a strong indication that they may be contributing to lead exposure.

If it is determined that the source of lead exposure in the homes is from the water, and not from lead in the paint or soils, DHCD will look to funding sources other than this HSI to abate this problem. The State will not utilize the HSI SPA to replace service lines. However, it should be noted that the vast majority of pediatric blood lead poisoning cases in Maryland continue to be related to exposure to lead in paint. In the event that the source of lead exposure is related to water, the State will utilize HSI SPA funds to install water filters in the home.

In cases where a contractor determines that abatement is likely to fail without additional repairs[11] and certifies that the repairs are essential to maintain encapsulation integrity, these repairs will also be covered. HSI funds will only cover repairs essential to prevent encapsulation failure due to moisture and will include repairs to: vapor barriers, roofs, ventilation systems, electrical systems, plumbing and foundations. All services necessary for encapsulation integrity will follow the minimum standards as established by HUD for lead-based paint hazard control and/or health homes grants.

Cost estimates for additional repairs that may be deemed essential to prevent encapsulation failure are included in Table 4. In DHCD's experience only a subset of these additional repairs is typically required for a given property.

11 See HUD Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (2012 Edition), Chapter 13, Section IV.C.3 Durability, p. 13-12.

Table 4: Projected costs of additional repairs to prevent encapsulation failure

Essential Repairs	Range of Costs*	
	Low	High
Roof Repair/Replacement	$7,000	$13,000
Foundation Repair	$5,000	$10,000
Exterior Siding / Vapor Barrier	$7,000	$11,000
Electrical System Repair/Upgrade	$2,500	$5,000
Window Repair	$1,000	$2,000
Indoor Plumbing Repair	$3,500	$6,000
Ventilation Repair	$5,000	$5,000
Heating System Repair	$1,500	$3,500

*Lead Abatement/Encapsulation cost includes costs associated with surveys and assessments. All costs are inclusive of contractor profit and overhead. DHCD's administrative overhead (15%) not included in cost estimate.

For the purposes of this request, abatement does not include any of the following:

- Work that does not reduce a lead hazard, or prevent the reoccurrence of lead-hazards in the home;
- Work not performed by an accredited lead abatement professional;
- Lead abatement as it pertains to sources of potable water in the home; or
- Work on properties that do not have a program eligible child, under the age of 19, residing or frequently visiting the structure.

The number of eligible properties that could potentially be served by Program #1 will depend on the per-unit costs. These costs are expected to vary on average between $18,000 and $60,000 per eligible property. These are estimates of the complete costs, which include the lead abatement activities identified in Program #1, as well as DHCD administrative costs; there will be no absolute cap placed on per unit costs.

As mentioned under the assurances, the State will increase, not supplant, the number of homes being abated under DCHD's existing work. DHCD currently abates approximately 110 homes annually. Program #1 is projected to serve between 70 - 200 *additional* eligible properties annually. Given these considerations, using existing funds and HSI funds, DHCD will abate an estimated total of 180 – 310 homes annually.

To date, a waiting list has not been necessary to address all eligible families that present to

DHCD for service since DHCD staff balance availability of funds with eligible applicants for the various programs it runs. However, for Program #1, the initial properties will likely be drawn from a list of properties that was deferred by DHCD's Energy team due to the presence of lead and other hazardous materials. Currently, 1008 homes built before 1978 are on the deferred list. The deferred homes are listed over a six-year span. Program #1 will allow DHCD to begin revisiting the deferred properties so long as they meet the other eligibility criteria of Program #1.

DHCD will ensure that abatement work is successful utilizing the following three pronged strategy:

1) Only licensed and appropriately accredited professionals will be allowed to perform the work;
2) Abated homes will have to pass a visual lead dust clearance test, and obtain a limited-lead free certification in order to be considered abated; and
3) Quarterly reporting on quality metrics.

Specifically, when conducting the Scope of Work for Program #1, the following detailed requirements will be utilized for ensuring the work is professional and complete.

1) Licensed / accredited Professionals

Only licensed contractors and accredited professionals will perform the work. Individuals performing abatement services must be properly accredited by MDE.12 Only a person accredited by MDE as a lead abatement supervisor or lead abatement worker may perform lead abatement activities in accordance with state law.

A lead abatement supervisor is defined as an individual who has been trained by an accredited training program and accredited by MDE to supervise and conduct lead abatement services and to prepare occupant protection plans and abatement reports. A lead abatement supervisor is required for each lead abatement job, and must be present at the job site while all abatement work is being done. This requirement includes setup and cleanup time. The lead abatement supervisor must ensure that all abatement work is done within the limits of federal, state, and local laws.

A lead abatement worker is an individual who has been trained to perform abatement by an accredited training program and who is accredited by MDE to perform lead abatement.13 Professionals accredited by MDE are issued a card containing the person's picture, name, certification number, and expiration date. All accredited professionals must work for a MDE accredited lead abatement company. The abatement company and its employees must use abatement methods approved by HUD and/or the U.S. Environmental Protection Agency (EPA) and in accordance with state laws and regulations.

12Maryland's training and Accreditation requirements, Maryland Department of the Environment (2017). http://www.mde.state.md.us/programs/Land/LeadPoisoningPrevention/InspectorsandContractors/Pages/Programs/LandPrograms/LeadCoordination/inspectorscontractors/inspectors_abatementservices.aspx

13 Ibid.

DHCD has assured that there is a sufficient workforce available in Maryland that is licensed according to the aforementioned specifications in order to perform this work.

2) Post-Abatement Lead Dust Clearance

The State recognizes that abatement activities would only be eligible for federal assistance when performance of these activities can be demonstrated to be effective in abating all identified lead hazards (excluding water). State and federal law dictate that a clearance test must be performed after any lead abatement work is finished to verify the work area is safe enough for the eligible resident(s) to return. On the inside of a house or apartment, the dust is tested to confirm that abatement work has not created lead dust hazards that can poison young children, other occupants, or pets living in the building as defined in state law.

Only an accredited Lead Paint Inspector Technician, Lead Paint Visual Inspector or Lead Paint Risk Assessor,14 who is independent of the abatement company, may perform clearance testing after abatement work is completed. An accredited inspector is defined as an individual who has been trained by an accredited training program and accredited by MDE to conduct inspections and take samples for the presence of lead in paint, dust and soil for the purpose of abatement clearance testing. DHCD has assured that there is a sufficient workforce available in Maryland that is accredited according to the aforementioned specifications in order to perform this work.

During clearance testing, an interior visual inspection is done to see if the identified lead hazards have been abated. These professionals also inspect for the presence of any visible dust or paint chips. If any problems are found, the abatement supervisor must resolve all of them before the clearance testing may continue. After the visual inspection passes, the Lead Paint Visual Inspector or Lead Paint Risk Assessor must take dust wipe samples that are sent to a laboratory for analysis. Clearance dust samples must be taken from the floors, windowsills, and window troughs in the rooms where work was done. At least one sample must be taken from outside the work area if containment was used and from each unique passageway. If no containment was used, then dust wipe samples may be taken in any room. A floor and a window in at least four rooms must be sampled. The samples must be tested for lead by an EPA approved laboratory. After exterior paint abatement work is completed, a Lead Paint Visual Inspector or Lead Paint Risk Assessor must perform a visual inspection of the outdoor work area ensure that the lead hazards were properly addressed. The Lead Paint Visual Inspector or Lead Paint Risk Assessor will then look for any paint chips on the ground including the foundation of the house, garage, or below any exterior surface abated. If paint chips are present, the abatement company must remove the chips and debris from the site and properly dispose of them before the clearance can be finished. In Maryland, no dust wipe clearance testing is required for abatement on the exterior of a house or rental property. The results of the clearance testing will be maintained by the State. These testing results will have numbers with units of measurement; the units are different for dust and soil.

14 Ibid.

The EPA and HUD regulations define clearance lead levels with the values and units of measurement shown in the Table 5. These levels will provide the basis for the lead dust clearance process for Program #1.

Table 5: Lead dust clearance standards

Material Tested	Considered hazardous if lead is present at or above these levels*
Bare soil (child play areas)	At or above 400 parts per million (ppm) of lead in the soil
Bare soil (other areas)	At or above 1200 ppm of lead
House dust (floors)	At or above 40 micrograms of lead per square foot of sampled area ($\mu g/ft^2$)
House dust (window sills)	At or above 250 $\mu g/ft^2$ of lead
House dust (window troughs)	At or above 400 $\mu g/ft^2$ of lead
Paint tested by an X-Ray Fluorescence (XRF) analyzer	Equal to or more than 1.0 milligrams per square centimeter (mg/cm^2) of lead on a deteriorated sampled surface or an elevated dust wipe sample corresponding to the lead surface.
Paint tested by paint chip analysis	Equal to or more than 0.5% (one half of 1 percent) lead by dry weight, or equal to or more than 5,000 ppm of lead in paint.

**All levels indicated in the table above will be utilized until and unless more stringent guidelines are promulgated at the state or federal level.*

3) Monitoring Performance, Measuring Progress: Quality Metrics/Reporting Requirements
The State believes that this HSI, once approved, will abate identified lead hazards from homes and improve the health of Medicaid and CHIP eligible individuals. Providing for enhancement and expansion of the lead hazard removal program will reduce the potential for ongoing exposure or re-exposure to lead hazards for the eligible population and future populations.

In order to monitor the performance and quality of Program #1, the State proposes to track the following key metrics and report to CMS quarterly, or at another approved interval, along with other metrics required by CMS:

1. Number of families with eligible children on MDE's CLR who are contacted and informed that they may be eligible to participate in Program #1;
2. Number of referrals received by DHCD to participate in Program #1;
3. Proportion of referrals received that were subsequently enrolled in Program #1;
4. The number of homes scheduled for lead hazard abatement;
5. The number of homes in which lead hazard abatement has occurred;
6. Number of homes abated for CHIP or Medicaid children under the age of 19;
7. Record of actual services provided in each house;
8. Clearance testing results for each home abated, as well as proportion of homes abated that pass the lead dust clearance test the first time in the post-abatement period;

9. Percentage of children receiving blood lead testing under EPSDT statewide and in the areas targeted by this HSI; and
10. Percentage of children with an elevated BLL statewide who have received services under this HSI.

Other metrics may be added at the agreement of the state and CMS during implementation of the HSI.

Program #2: Childhood Lead Poisoning Prevention & Environmental Case Management

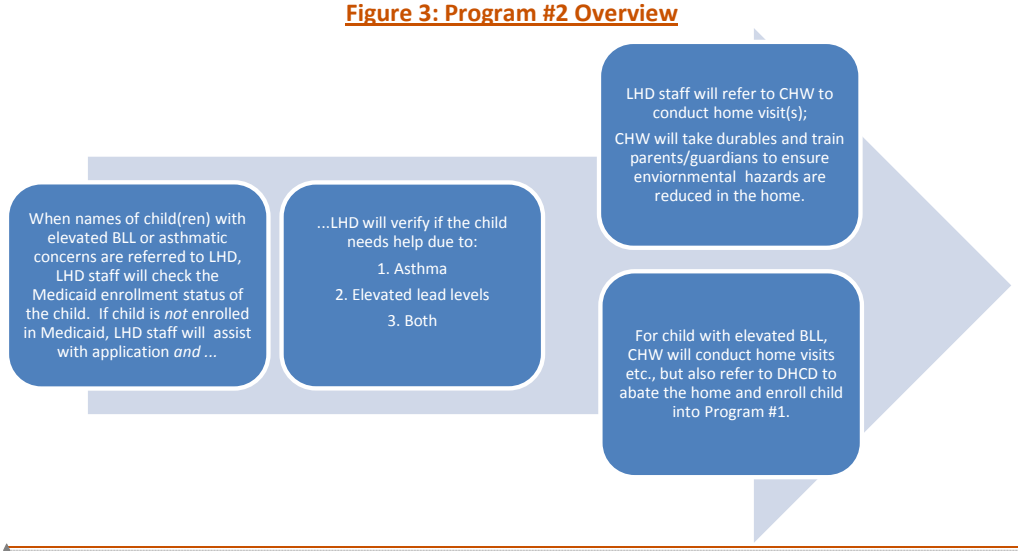
The DHMH Environmental Health Bureau (DHMH-EHB) currently administers a Childhood Lead Poisoning Prevention & Environmental Case Management Program (CMP) in conjunction with MDE. In 2015 CMP provided environmental case management for 377 children with a BLL ≥ 10µg/dL per Maryland statute and regulations. In addition, in 2015 Baltimore City Health Department (BCHD), with CMP's oversight, provided environmental case management services for an additional 904 children with a BLL between 5-9µg/dL.

Beginning in State Fiscal Year (SFY) 2018, the State's CHIP HSI will expand this program to build environmental case management and Community Health Worker (CHW) capacity in LHDs. This program will be a part of an integrated approach to a patient- and community-centered medical home targeting health conditions that have a strong environmental component. Program #2 will focus on improving health outcomes for children with an elevated BLL as well as children with asthma. Improvements in health outcomes will be achieved via a combination of: 1) reductions in environmental hazards in the home; 2) increased medical case management by the primary care provider; and 3) environmental case management by the LHD in conjunction with the primary care provider and the family.

To clarify, the funds under Program #2 will not be used to pay for additional primary care services; these funds will only be used to support the environmental case managers and CHWs. The HSI is intended to fund hazard reduction in the home and environmental case management by the LHD. This will include staff funding (environmental case managers and CHWs) at the LHD level, required durables, and LHD overhead. Funds will not be used to reimburse any Medicaid covered services, including but not limited to primary care and care coordination. Program #2 will not be time limited.

This expanded program will significantly improve the State's ability to address existing disparities in health outcomes for childhood asthma and lead poisoning. A major strength of the program is the linkage and close cooperation between the DHMH Medicaid program, the DHMH Office of Minority Health and Health Disparities (DHMH MHHD), the Environmental Health Bureau within DHMH (DHMH EHB), and the Childhood Lead Poisoning Prevention Program at the Maryland Department of the Environment.

Figure 3: Program #2 Overview



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Program #2: Eligibility

To qualify for services through Program #2, children must meet three primary requirements. First, they must be (1) enrolled in Medicaid or CHIP *or* (2) Medicaid or CHIP-eligible but not yet enrolled. Second, they must reside in one of nine specific counties in Maryland.15 Finally, they must have:

(1) a diagnosis of moderate to severe asthma; or
(2) a BLL of ≥ 5µg/dL; or
(3) a diagnosis of moderate to severe asthma AND a BLL of ≥ 5µg/dL (see Figure 4 below for definitions of moderate to severe asthma).

The expanded program will start in State Fiscal Year (SFY) 2018 with pilots in nine counties: Baltimore City, Baltimore County, Charles County, Prince George's County, St. Mary's County, Harford County, Frederick County, Wicomico County, and Dorchester County. These jurisdictions have been selected because they already have experience with elements of the expanded program, and a demonstrated need for increased capacity.

To the extent eligible children served under Program #1 live within the geographic area of Program #2 and meet Program #2's other qualifications, they would be eligible to receive services through Program #2. If there is a child with an elevated BLL in a home, Maryland's goal is to abate the home and enroll the child into Program #1.

15 Baltimore City, Baltimore County, Charles County, Prince George's County, St. Mary's County, Harford County, Frederick County, Wicomico County, and Dorchester County.

LHDs are already active partners with the Medicaid program and play a role in enrolling individuals into the Medicaid and CHIP Programs. They have the capacity to verify whether a child is currently enrolled in benefits using Medicaid's eligibility verification system (EVS). If a child is identified as possibly eligible for Program #2 and is not yet enrolled in Medicaid or CHIP, the LHD will assist them in applying for benefits using Maryland Health Connection before enrolling them in Program #2.

Figure 4: Moderate to severe persistent asthma definitions to be utilized by Program #2

Level of severity (Columns 2–5) is determined by events listed in Column 1 for both impairment (frequency and intensity of symptoms and functional limitations) and risk (of exacerbations). Assess impairment by patient's or caregiver's recall of events during the previous 2–4 weeks; assess risk over the last year. Recommendations for initiating therapy based on level of severity are presented in the last row.

Components of Severity		Intermittent			Persistent								
					Mild			Moderate			Severe		
		Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years
Impairment	Symptoms	≤2 days/week			>2 days/week but not daily			Daily			Throughout the day		
	Nighttime awakenings	0	≤2x/month		1–2x/month	3–4x/month		3–4x/month	>1x/week but not nightly		>1x/week	Often 7x/week	
	SABA* use for symptom control (not to prevent EIB*)	≤2 days/week			>2 days/week but not daily	>2 days/week but not daily and not more than once on any day		Daily			Several times per day		
	Interference with normal activity	None			Minor limitation			Some limitation			Extremely limited		
	Lung function		Normal FEV_1 between exacerbations	Normal FEV_1 between exacerbations									
	➔ FEV_1* (% predicted)	Not applicable	>80%	>80%	Not applicable	>80%	>80%	Not applicable	60–80%	60–80%	Not applicable	<60%	<60%
	➔ FEV_1/FVC*		>85%	Normal†		>80%	Normal†		75–80%	Reduced 5%†		<75%	Reduced >5%†
Risk	Asthma exacerbations requiring oral systemic corticosteroids‡	0–1/year			≥2 exacerb. in 6 months, or wheezing ≥4x per year lasting >1 day AND risk factors for persistent asthma	≥2/year		*Generally, more frequent and intense events indicate greater severity.*			*Generally, more frequent and intense events indicate greater severity.*		
		*Consider severity and interval since last asthma exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. Relative annual risk of exacerbations may be related to FEV_1.**											
Recommended Step for Initiating Therapy *(See "Stepwise Approach for Managing Asthma Long Term," page 7)* *The stepwise approach is meant to help, not replace, the clinical decisionmaking needed to meet individual patient needs.*		Step 1			Step 2			Step 3	Step 3 medium-dose ICS* option	Step 3	Step 3	Step 3 medium-dose ICS* option or Step 4	Step 4 or 5
								Consider short course of oral systemic corticosteroids.					
		In 2–6 weeks, depending on severity, assess level of asthma control achieved and adjust therapy as needed. For children 0–4 years old, if no clear benefit is observed in 4–6 weeks, consider adjusting therapy or alternate diagnoses.											

* **Abbreviations:** EIB, exercise-induced bronchospasm; FEV_1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICS, inhaled corticosteroid; SABA, short-acting $beta_2$-agonist.

† Normal FEV_1/FVC by age: 8–19 years, 85%; 20–39 years, 80%; 40–59 years, 75%; 60–80 years, 70%.

‡ Data are insufficient to link frequencies of exacerbations with different levels of asthma severity. Generally, more frequent and intense exacerbations (e.g., requiring urgent care, hospital or intensive care admission, and/or oral corticosteroids) indicate greater underlying disease severity. For treatment purposes, patients with ≥2 exacerbations may be considered to have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Figure courtesy of the U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute. Asthma Care Quick Reference, Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3, 2007. https://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/quick-reference-html

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Program #2: Enrollment Strategies

Referrals to Program #2 for children with *elevated blood lead levels* will come from a wide range of sources including:

- Primary care and specialty care providers;
- State and county social services agencies;
- MDE's Childhood Lead Registry;
- Local housing agencies;
- Public health agencies (based on either direct inquiries from the public, or from health care providers following up on BLLs >5µg/dL);
- MDE, based on public inquiries, regulatory referrals from their enforcement unit, or notices of defect from renters; or
- Requests from homeowners, rental property owners, or tenants.

Referrals to Program #2 for children diagnosed with *moderate to severe asthma* will come from a wide range of sources including:

- Primary care providers;
- Specialty care providers;
- Managed care and inpatient care coordinators;
- School-based health personnel, social services personnel;
- LHDs;
- Emergency departments;
- Emergency services personnel;
- Parents/guardians; or
- Social service agencies.

Program #2: Services

The HSI will provide funding for LHDs to hire and train environmental case managers and CHWs to provide educational support and outreach to the parents and guardians of low-income children who have specific health conditions including asthma and lead poisoning, as well as to reduce other hazards to children in homes.

Program #2 will build off of the model utilized by BCHD's Community Asthma Program (CAP). BCHD's current program includes three home visits spaced 3-6 weeks apart, which focus on engaging and supporting families to:

- Identify and reduce environmental asthma triggers; recognize early warning signs of asthma attacks;

- Track respiratory symptoms; and
- Take medications as prescribed with the correct technique; create, review, share, and update asthma action plans with other family members and care providers; and improve coordination with medical providers.

Under Program #2, the environmental case managers and CHWs will focus on building on BCHD's goals as well as:

- Indoor air quality, pests, and secondhand smoke;
- Provide individualized referrals and case management; and
- Sustainable environmental risk reduction including integrated pest management (IPM) practices.

Program #2 specifically aims to use evidence-based strategies to reduce environmental hazards in the home that adversely affect health outcomes associated with asthma and exposure to lead. These hazards include:

- Secondhand smoke;
- Allergens associated with mice, cockroaches, dust mites, other animals, and pollen (all of which have been associated with poor asthma outcomes).;
- Lead dust;
- Improperly applied or illegal pesticides used by many families to combat mice/ cockroaches that have been linked to childhood poisonings, as well as teratogenic effects.

The core components of an environmental case management team will include an environmental case manager (e.g., community health nurse) and CHWs. The environmental case manager, located in the LHD, will manage the needs of the child, coordinate with other medical providers, and oversee the work of the CHWs. The CHWs will be trained to perform environmental assessments, as well as provide education and resources to support the family of the affected child. The State will coordinate oversight, management, and evaluation to assure that program goals are met and that services covered under Medicaid are not funded under the HSI authority.

The environmental assessments that will be conducted by CHWs will be based on the environmental assessments currently employed by BCHD CAP staff and will focus on triggers for asthma and risk for lead poisoning. These assessments are aligned with "healthy homes assessments", which focus on determining hazards in the home as well as providing families and landlords with tangible feedback on how the environment can be improved to reduce triggers and hazards in the home. The assessments also focus on medication adherence, nutrition, and safe cleaning techniques, which also play an essential role in reducing the impact of asthma and lead poisoning.

The environmental assessments performed by CHWs will not be considered an "in-home assessment"

that is eligible for Medicaid reimbursement. CHWs do not currently have a Medicaid provider category in the state of Maryland and their services cannot be reimbursed for by Medicaid at this time. Additionally, CHWs will be trained for clinical assessment, but will not receive compliance training because they do not have regulatory authority. Currently, community health workers are not considered health professionals under Maryland law.

As previously mentioned, the approved SPA 09-05 provides on-site environmental lead inspections for primary residences, limited to Medicaid enrollees under age 21 with confirmed elevated BLL of ≥5µg/dL. On-site inspections are not included for asthma.

Program #2: Reducing Lead Dust Hazards

In regard to lead dust, Program #2 will reduce lead dust hazards in the home by providing HEPA vacuums, mops, buckets and other cleaning supplies that, when used regularly, have been shown to reduce the presence of lead dust in the home. Program #2 will also reduce lead hazards in the home by assisting parents of children with lead poisoning to either enroll in Program #1 proposed in this HSI, or work with their landlord and MDE to reduce chipping and peeling paint in accordance with Maryland's laws.

As previously mentioned, the approved SPA 09-05 provides on-site environmental lead inspections for primary residences, limited to Medicaid enrollees under age 21 with confirmed elevated BLL of ≥5µg/dL. On-site inspections are not included for asthma.

Program #2: Improving Asthma Outcomes

Secondhand smoke has been shown to negatively impact respiratory function and serves as a trigger for asthma episodes. Program #2 will reduce this hazard in homes by providing parents and guardians with education regarding how to reduce their child's exposure to secondhand smoke, as well as assistance with enrolling in programs that will support them to quit smoking if that is their desire.

Allergens associated with mice, cockroaches, and dust mites are known triggers for poor asthma outcomes. Asthmatic children who are allergic to these allergens experience additional inflammation and mucus production reducing their capacity to breathe. Program #2 will educate parents on the associations between exposure to these allergens and poor asthma outcomes, sources of these allergens, and how to limit exposure to these allergens in their homes. Strategies will include the use of HEPA vacuums which have been shown to significantly reduce the level of allergens present in the home and improve asthma outcomes. In addition families will be provided with dust mite covers and educated on their use. Dust mite covers reduce exposure to the allergens present in beds and have been shown to be an effective intervention as well.

In regard to cockroaches and mice, Program #2 will provide parents with education regarding the

impact of exposure to allergens associated with pests on asthma outcomes. In addition Program #2 will provide parents with education regarding integrated pest management as well as how to use the durables provided to perform integrated pest management.[16] Integrated pest management has been shown to be the most effective manner of reducing cockroach and mouse burden, and has been associated with improved respiratory function among asthmatic children.[17] It has the added benefit of relying sparsely on pesticides. One of the additional benefits of this educational programing is that parents will learn which pesticides to NOT use in their homes. Misapplication of pesticides, and use of illegal pesticides poses a significant poisoning risk for children. Thus by introducing integrated pest management practices in the home Program #2 will not only reduce the hazards associated with pests, but also some of the hazards that are commonly associated with attempting to control pests through traditional methods.

Program #2: Home Visits

As part of CAP, BCHD shares a report with participants' medical providers regarding progress towards the aforementioned goals, successes, challenges, and needs for additional follow-up, education or referrals. Similar environmental case management activities and reporting protocols already exist for lead in LHDs and will be expanded with the new lead HSI SPA. Program #2 will offer 3-6 home visits, based on the family's needs and the child's BLL.

The number of home visits is a function of the child's underlying condition and severity. For children with asthma, the literature supports a range of home visits up to six, depending on the severity of the asthma symptoms.18 Currently, BCHD provides only 3 home visits due primarily to funding limitations. It is anticipated that children with asthma as a diagnosis will receive three to six visits, depending on the severity of the asthma.

Children with a diagnosis of lead exposure generally also receive three home visits, but may receive more depending on clinical severity, the need for case management, or other factors.

Children who are enrolled in Program #2 who have both diagnoses of lead exposure and asthma will be assessed and managed for both conditions simultaneously, and will receive the same number of visits (three to six) as children with only one diagnosis based on the factors enumerated above.

Typical services to be provided for asthma home visits are shown below:

16 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3934496/
17 http://www.sciencedirect.com/science/article/pii/S0277953606002607
18 See the *Reducing Asthma Disparities* page for a description of the Baltimore City demonstration project using six visits, accessible at: http://dhmh.maryland.gov/innovations/Pages/reducingasthmadisparities.aspx

Table 6: Asthma Home Visit Services

Home Visit 1 Personnel	
• Community Health Worker	Hours
○ Field work to complete HV1: In-home interview, environmental assessment, education	3
○ Office work to complete documentation, encounter form, care coordination	2
○ Transportation time for visit (round trip)	2.0
Total time	6.5 hours
Home Visit 1 Supplies	
• Mattress and pillow encasements	
• Spacer	
• Educational binder	
Home Visit 2 Personnel	
• Community Health Worker	Hours
○ Field work to complete HV2: In-home interview, environmental assessment, education	1.5
○ Office work to complete documentation, encounter form, care coordination	1.5
○ Transportation time for visit (round trip)	2.0
Total time	4.5 hours
Home Visit 2 Supplies	
• Green Cleaning Kit (bucket, mop, spray bottle, baking soda, vinegar, GreenWorks)	
• Integrated Pest Management supplies	
Home Visit 3 Personnel	
• Community Health Worker	Hours
○ Field work to complete HV3: In-home interview, environmental assessment, education	1
○ Office work to complete documentation, encounter form, care coordination	1.5
○ Transportation time for visit (round trip)	2.0
Total time	4 hours
Home Visit 3 Supplies	
• Doormat	
• HEPA vacuum (10% of clients)	

Under Program #2, CHWs will assess what durables a family needs. The listed items under Table 6 are for the families to keep; they are not loaned to the families. Although refills for families may be

provided while actively enrolled in the program if needed, families will not be enrolled indefinitely in the program. The goal is to assist and educate the families so families can independently maintain their home environment so asthma triggers and lead levels do not escalate.

Table 7: Program #2 Required Durables

Asthma Durables	Lead Durables
HEPA Vacuum	HEPA Vacuum
Bucket	Bucket
Mop	Mop
Sponges	Sponges
Mouse traps	Micro-fiber cleaning cloths
Cockroach traps / baits	Soap
Dust mite covers for mattress	
Medication storage containers	
Spacers (for inhalers)	
Caulk	
Copper Mesh	
Sticky Traps	
Soap	

Program #2: Staffing

The core components of an environmental case management team will include an environmental case manager (e.g. community health nurse) and CHWs. The environmental case manager, located in the LHD, will manage the needs of the child, coordinate with other medical providers, and oversee the work of the CHWs.

As part Program #2, CHWs will be identified and recruited in targeted communities in part with the assistance of the DHMH MHHD's Minority Outreach and Technical Assistance program. Training of the environmental case managers and CHWs is described below. The State plans to use the current training vendor to train additional environmental case managers and community health workers. The State will also review the curriculum available for other training vendors in the area to determine if the curricula would meet the needs of the staff hired under this HSI were it to be approved. Funding from the HSI will also ensure coordination between Programs #1 and #2, analysis, and reporting to DHMH regarding project outcomes focusing specifically on health disparities that have been identified as priorities.

The current training vendor, a non-governmental non-profit organization, is supported by one part of the existing State-funded Childhood Lead Poisoning Prevention & Environmental Case Management Program to provide education, outreach, and training to LHDs, community-based organizations, and communities affected by lead poisoning. Under the new program, these ongoing efforts would be augmented with funding under the HSI to provide healthy homes training to LHD environmental caseworkers and CHWs. Under the proposed Program #2, LHDs would have the opportunity to leverage current staff to assist with program implementation; however, in many instances the State expects that LHDs will hire new staff that will be paid for by HSI funds. These new staff would be employed by the LHD.

The supported organization has extensive experience training personnel. The healthy homes curriculum includes training on how to reduce environmental hazards related to both asthma and lead poisoning, as well as how to perform in-home environmental hazards assessments. There are other organizations that have the potential to deliver training to the environmental case managers and CHWs, and DHMH will evaluate the suitability of these trainings and organizations for the purposes in the near future and utilize these additional organizations as appropriate.

Program #2: Quality Metrics

The State will ensure that Program #2 is meeting performance goals and providing quality services using a set of core reporting metrics that will be reported to CMS quarterly or at another agreed upon schedule. These metrics include:

1) Number of children enrolled in Program #2;
2) Number of children enrolled in Program #2 who received at least three home visits;
3) Number of children in Program #2 who receive at least three home visits in the specified time frame;
4) Of the children served by Program #2 who have been diagnosed with asthma, the proportion who report an improvement in asthma symptom management;
5) Of the children served by Program #2 who have been diagnosed with asthma, the proportion who report having an up-to-date asthma action plan that has been shared with their care provider and school or daycare facility as appropriate;
6) Of the children served by Program #2 who have elevated BLL, the proportion who received a follow-up blood lead test during the program time-frame; and
7) Of the children served by Program #2 who have an elevated BLL, the proportion whose follow up blood lead test was below 5µg/dL.

Other metrics may be added at the agreement of the state and CMS during implementation of the HSI.

The estimated costs per child (which include core services, administration, training of new personnel, as well as direct services) served by Program #2 are between $1,500 - $2,500 per child/per year. Therefore, Program #2 will be able to provide services to approximately 1,200-2,000 children annually. These costs will vary based on two factors: 1) the number of home visits that are required (3–6) to optimally support the family, and 2) the complexity of the environmental case management efforts required based on the individual family/child's needs. Ultimately, the number of children to be served by Program #2 will depend on the cost per unit per year.

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.

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))

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))

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 :

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.

4.1.1 ☐ Geographic area served by the Plan if less than Statewide:

4.1.2 ☐ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

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):

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):

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7 ☐ Access to or coverage under other health coverage:

4.1.8 ☐ Duration of eligibility, not to exceed 12 months:

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.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☐ Continuous eligibility

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.

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)

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.

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)

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.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

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.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

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.

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.

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))

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))

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))

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 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.

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 should describe below how it's 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))

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.

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.

5.3 Strategies

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.

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, plus additional coverage. Under this 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 use of a 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[19]) 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)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
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)
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[20] 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

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))

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))

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))

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.

Section 8. Cost-Sharing and Payment

☐ 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:
8.2.2. Deductibles:
8.2.3. Coinsurance or copayments:
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))

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)
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))

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)

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))

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))

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))

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)

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))

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))

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).

9.9.2 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.

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

Program Budget

Both of the HSI Program initiatives will expand the current resources available in Maryland to identify and abate lead-related health hazards for low-income children. Maryland assures that CHIP funding for the HSI Lead Initiative will not be claimed as a match for federal funds under any existing county, municipal, State or federal program.

Program #1: Healthy Homes for Healthy Kids

The Healthy Homes for Healthy Kids Program proposes to expand upon the DHCD's existing lead abatement activities statewide to serve low-income children in eligible properties with lead contamination using $500,000 in State funding and $3,666,667 in CHIP federal matching funds. The State's share will be funded through existing State General Funds.

Program #2: Childhood Lead Poisoning Prevention & Environmental Case Management Program

The Childhood Lead Poisoning Prevention & Environmental Case Management program will use $360,000 of State General Funds and $2,640,000 in CHIP federal matching funds to expand capacity to build environmental case management and CHW capacity in LHDs. The expansion of the Lead Poisoning Prevention & Environmental Case Management program will be funded through State general funds of $360,000 under the DHMH EHB's annual budget allocation.

These initiatives will expand the current resources available in Maryland to identify and abate lead-related health hazards for low-income children. Maryland assures that CHIP funding for the HSI Lead Initiative will not be claimed as a match for federal funds under any existing county, municipal, State or federal program.

COST OF PROPOSED SCHIP PLAN

	FFY 2017
Enhanced FMAP Rate	**88% FMAP**
Benefit Costs	
Insurance payments	
Managed Care	$228,981,530
per member/per month rate	$128.42
Fee for Service	$139,295,880
Total Benefit Costs	$368,277,410

(Offsetting beneficiary cost sharing payments)	$(8,212,586)
Net Benefit Costs	$360,064,824
Cost of Proposed SPA Changes - Benefit	$0
Administrative Costs	$33,812,443
Personnel	$2,462,620
General Admin	$16,944,615
Contractors	$3,254,734
Claims Processing	
Outreach / Marketing Costs	$1,065,846
Health Services Initit. Costs	
HSI – Poison Control	$2,917,961
HSI – Program 1	$4,166,667
HSI - Program 2	$3,000,000
Total Administrative Costs	$33,812,443
10% Administrative Cost Ceiling	$40,007,203
Costs of Proposed SPA Changes	$7,166,667

Federal Share	$346,611,995
State Share	$47,265,272
TOTAL PROGRAM COSTS	$393,877,267

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.

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.

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.