OMB #: 0938-0707
Exp. Date:

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

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides 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. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

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

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

State/Territory: 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))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State 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: Charles E. Lehman	Position/Title: Executive Director, Office of Operations and Eligibility, Department of Health and Mental Hygiene (DHMH)
Name: Alison Loughran, JD	Position/Title: Deputy Director for Eligibility Policy, Office of Operations and Eligibility, DHMH
Name: Peggy Owens	Position/Title: Chief, Eligibility Policy/Maryland Children's Health Program Division, Office of Operations and Eligibility, DHMH

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

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. X Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. A combination of both of the above.

Beginning in 1998, Maryland expanded access to health insurance under the terms specified in the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act, through creation of the Maryland Children's Health Program.

Maryland implemented a Medicaid expansion, called MCHP, effective July 1, 1998, and an SCHIP separate State program called MCHP Premium, effective July 1, 2001.

Maryland modified MCHP Premium effective July 1, 2003, and MCHP, effective September 1, 2003.

Maryland modified MCHP and MCHP Premium effective July 1, 2004.

Maryland modified MCHP Premium effective **January 1, 2007, MCHP Premium will transition all of its children from its separate program to its Medicaid expansion program. The Medicaid expansion will include children with family income above 200 percent and at or below 300 percent of the Federal poverty level. Upon approval of this amendment, and after exhaustion of title XXI funds, the state will have the option of reverting to title XIX funds for its Medicaid expansion children. The State will only be permitted to use title XIX funds to cover these children until title XXI dollars are replenished.**

MCHP

MCHP, the Medicaid expansion, implemented July 1, 1998:

- Extended Medicaid coverage (using regular match funds) to pregnant women with income at or below 200 percent of the Federal poverty level (FPL);
  - Extended Medicaid coverage (using enhanced match funds) to eligible children under age 19 who were born: After September 30, 1983 in families with income too high to qualify for SOBRA, but at or below 200 percent of FPL;
  - Before October 1, 1983 in families with income above 40 percent FPL, but at or below 200 percent of

FPL.

MCHP Premium

MCHP Premium, the separate State program, implemented July 1, 2001:

- Expanded eligibility for the Maryland Children's Health Program to include children with family income above 200 percent but at or below 300 percent of the federal poverty level (FPL), using enhanced match funds;

- Created a family contribution requirement for families with income above 200 but at or below 300 of FPL range (two flat amounts will apply - one applies to families with income above 200, but at or below 250 percent of FPL, and one applies to families with income above 250 but at or below 300 percent of FPL);

- Established an Employer Sponsored Insurance (ESI) program to provide comprehensive coverage through employer sponsored health benefit plans that meet all requirements for Title XXI enhanced match funding.

- Provided coverage to children who cannot be served by the ESI program through a stand-alone Medicaid look-alike program that enrolls eligible children in the current HealthChoice program; and,

- Increased eligibility (using regular match funds) for pregnant and postpartum women with income at or below 250 percent of FPL.

MCHP and MCHP Premium Program Changes—July, 2003 through June, 2004

Beginning July 1, 2003, Maryland made the following adjustments to MCHP and MCHP Premium:

MCHP (the Medicaid Expansion)

- Eliminated MCHP coverage for children enrolled in the Medicaid expansion program whose family income is above 185 percent of the Federal Poverty Level (FPL) but at or below 200 percent FPL. Note: This change became effective September 1, 2003, and these children were offered coverage through MCHP Premium, the State's separate child health program.

MCHP Premium (the separate State program)

- Effective July 1, 2003, eliminated Employer-Sponsored Insurance (ESI) as an enrollment option for MCHP Premium-eligible children. Those children enrolled in ESI plans prior to July 1, 2003 were transferred to HealthChoice, the Maryland Managed Care Program, at the end of their benefit coverage period before July 1, 2004.

- Effective July 1, 2003, froze enrollment in MCHP Premium for children in families with income above 200 percent FPL but not greater than 300 percent FPL. Children enrolled before that date, and those who applied before that date and who are then determined to be eligible on or after July 1, 2003, continued coverage as long as there was no break in eligibility.

- Reduced the lower income standard for MCHP Premium from 200 percent FPL to 185 percent FPL. Children currently receiving free health care coverage whose family income places them in

the 185-200 percent income group have to pay a premium to continue coverage after September 1, 2003. The premium was set at 2 percent of FPL for a family of 2 at 185 percent FPL. The premium amount will be adjusted each April, as the FPL changes.

MCHP and MCHP Premium Program Changes, effective July 1, 2004

Effective July 1, 2004, Maryland made the following changes to MCHP and MCHP Premium:

MCHP (the Medicaid Expansion Program)

- Reinstated free MCHP coverage for children whose family income is above 185 percent FPL but at or below 200 percent FPL.

MCHP Premium (the Separate State Program)

- Lifted the enrollment freeze for children in families with income greater than 200 percent FPL but not greater than 300 percent FPL.

- Raised the lower income standard for MCHP Premium from above 185 percent FPL to above 200 percent FPL.

MCHP Premium Program Changes Effective _ January 1, 2007 /Medicaid Expansion

Effective January 1, 2007, MCHP Premium becomes Medicaid Expansion Program. Extended Medicaid coverage (using regular match funds) to children with family income above 200 percent but at or below 300 percent of the federal poverty level (FPL).

1.2 **X** Please 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))**

The State affirms 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.

1.3 **X** Please 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)**

The State assures that it 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.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date: The effective date for MCHP, the Medicaid expansion is July 1, 1998.

The effective date for MCHP Premium, the separate State program, is July 1, 2001.

The effective date for eliminating enrollment in ESI, and freezing enrollment in MCHP Premium for children whose family income is above 200 percent FPL but not greater than 300 percent FPL is July 1, 2003. The effective date for eliminating MCHP coverage for children whose family income is above 185 percent FPL, reducing the lower income standard for MCHP Premium from 200 percent FPL to 185 percent FPL, and charging a premium for coverage for children whose family income is above 185 percent FPL but not greater than 200 percent FPL is September 1, 2003.

The effective date for reinstating free MCHP coverage for children whose family income is above 185 percent FPL but at or below 200 percent FPL is July 1, 2004. The effective date for lifting the freeze for children in families with income greater than 200 percent FPL but not greater than 300 percent FPL is July 1, 2004. The effective date for raising the lower income standard for MCHP Premium from above 185 percent FPL to above 200 percent FPL is July 1, 2004.

Effective January 1, 2007, MCHP Premium will transition all of its children from its separate program to its Medicaid expansion program. The Medicaid expansion will include children with family incomes above 200 percent and at or below, 300 percent of the FPL. Upon approval of this amendment, and after exhaustion of title XXI funds, the state will have the option of reverting to title XIX funds for its Medicaid expansion children. The State will only be permitted to use title XIX funds to cover these children until title XXI dollars are replenished.

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105(c)(7)(A)-(B))

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

PUBLIC PROGRAMS PROVIDING HEALTH BENEFITS COVERAGE IN MARYLAND

Public programs in Maryland provide health coverage to children and adults across the State. The Maryland Medical Assistance program, which includes the Maryland Children's Health Program, provides creditable health coverage to eligible recipients and enrollees. Individuals who do not qualify for either Medicaid or the Maryland Children's Health Program may be eligible for programs funded exclusively with State funds or for Federally-funded programs (e.g., Children's Medical Services, funded under Title V of the Social Security Act.) These programs provide services that complement the Maryland Medical Assistance program or that target populations not eligible for Medical Assistance. An individual's eligibility for these public programs is generally determined by case managers at Local Departments of Social Services (LDSS) and Local Health Departments (LHDs).

Maryland Medical Assistance, MCHP and MCHP Premium

The Maryland Medical Assistance Program provides comprehensive health coverage on a statewide basis to low-income children and adults. As a result of Maryland's MCHP expansion in July 1998, eligibility for this creditable health coverage extended to eligible children under age 19 with family income at or below 200 percent of the Federal Poverty Level (FPL). In general, these individuals have been enrolled in Maryland's Medicaid managed care program, HealthChoice.

Effective September 1, 2003 through June 30, 2004, MCHP was a Medicaid expansion program with eligibility for children in families with income at or below 185 percent FPL.
Effective July 1, 2004, the maximum qualifying income level for eligibility for MCHP returned to 200 percent FPL.

The MCHP Premium expansion, effective July 1, 2001, extended eligibility for creditable health coverage to children in families with income above 200 percent FPL but at or below 300 percent FPL. From July 1, 2001 through June 30, 2003, coverage was provided through enrollment in qualifying ESI plans or, if ESI was not available or didn't meet State qualifications, through HealthChoice, the Maryland Managed Care Program. Effective July 1, 2003, enrollment in ESI was discontinued. Effective September 1, 2003 through June 30, 2004, the base income level for MCHP Premium was reduced to 185 percent FPL.

Effective July 1, 2004, the base income level for MCHP Premium eligibility returned to 200 percent FPL.

Effective January 1, 2007 , MCHP Premium will transition all of its children from its separate program

to its Medicaid expansion program. The Medicaid expansion will include children with family incomes above 200 percent and at or below 300 percent FPL. Upon approval of this amendment, and after exhaustion of title XXI funds, the state will have the option of reverting to title XIX funds for its Medicaid expansion children. The State will only be permitted to use title XIX funds to cover these children until title XXI dollars are replenished.

NON-MEDICAID, PUBLIC PROGRAMS

In addition to Medical Assistance and the Maryland Children's Health Program, Maryland has in place a number of alternative programs that enable children to access health care services. These include Children's Medical Services (CMS) (the Title V program for children with special health care needs), Community Health Centers (CHCs), and several local jurisdiction initiatives. While all of these programs provide vital services to low income and uninsured or underinsured individuals, they all have significant restrictions in the benefits they provide (capped funding, limited benefit packages, etc). None of the programs described below provide creditable coverage as defined by Title XXI.

Children's Medical Services (CMS)

The Children's Medical Services (CMS) program is the Title V Program in Maryland that has traditionally assisted families in planning and obtaining specialty medical and rehabilitative care. The program has provided for both direct and wrap around specialty care services to eligible children with special health care needs. Program activities have concentrated on the purchase of direct care services through community providers, local health departments and academic institutions through both fee-for-service reimbursement and grants.

Prior to Maryland's MCHP expansion in July 1998, the CMS program provided specialty care services to approximately 6,500 children. Most of these children have since become eligible for the Maryland Children's Health Program and enrolled in the HealthChoice Program. As a result, the CMS program's focus is shifting from that of providing direct and wrap around services to that of systems building activities. During the transition, the program will continue to pay for direct and wrap around services for underinsured children who meet the program's eligibility criteria. At this time, CMS provides services to children who are uninsured (children 19 to 22 who have aged out of MCHP), underinsured, and undocumented, and meet the following eligibility requirements:

- Are age 22 or younger;
- Have or are at risk for disabilities, chronic illnesses, or health-related educational problems; and
- Are in families with adjusted income below 200 percent of the FPL.

WIC

Prior to the MCHP expansion, WIC participants were required to have a household income not exceeding 185 percent of the FPL. Concurrent with Maryland's MCHP expansion, the WIC program increased its income eligibility threshold to 200 percent of FPL. Besides establishing financial eligibility, WIC recipients must have an identifiable nutritional risk factor and be:

- Pregnant;
- Less than 6 months postpartum;
- Breast-feeding an infant up to one year old; or

- Less than five years of age.

In establishing eligibility only an individual's income is examined. Participants are eligible for food packages, nutritional counseling, and linkage to other health and social services. Food packages vary slightly depending on nutritional needs, but may include milk, cheese, juice, eggs, cereal, beans, peanut butter, infant formula, infant cereal, carrots and tuna fish.

Family Planning Program (Title X)

The target population for this program includes women of reproductive age (including adolescents) at risk for unintended pregnancy and poor pregnancy outcomes, although all women and men are eligible for services. Client fees are assessed according to a sliding fee scale based on ability to pay. Funding for this program is a combination of State and Title X Federal Family Planning Program funds. Enrollment is handled through local health departments, community health centers or Planned Parenthood Centers. Clients receive a broad range of preventive health services including contraceptive care, preconception care, education and counseling for all contraceptive choices and women's health issues, sexually transmitted disease diagnosis and treatment, HIV/AIDS prevention services, breast and cervical cancer screening, cardiovascular screening and referrals for additional health and social services.

Maryland Family Planning Program (Title XIX)

Maryland also operates a limited-coverage program that provides family planning and related preventive reproductive services to women who were eligible for comprehensive Medicaid coverage during pregnancy and the two month postpartum period, but lost their SOBRA eligibility at the end of their postpartum period. The Maryland Family Planning Program was originally established under a §1115 waiver. Maryland has been granted authority to expand its current §1115 Medicaid managed care program, HealthChoice, to include providing family planning and related preventive reproductive services to this population for five years postpartum.

LOCAL JURISDICTION INITIATIVES

Prior to Maryland's MCHP expansion, a number of local jurisdictions had developed initiatives that attempted, with extremely limited resources, to provide some coverage to low income children. A measure of success of MCHP is that many of the children served by these programs have become eligible for MCHP and gained comprehensive coverage through that program. As a result, a number of these gap filling programs have disbanded. Several local programs with different missions and target populations remain active and are described below:

Carroll County Children's Fund Health and Wellness Care Program

The Carroll County Children's Fund Health and Wellness Care Program is designed to provide primary and preventive health care for children ages birth to age 18 who do not qualify for Medicaid, or any publicly funded program. It is targeted at families who are not able to afford health insurance either on their own or through their employer. Eligibility is determined at the local level through the Carroll County Health Department. The Care program includes access to primary and preventive care, limited pharmacy assistance, basic diagnostic x-ray and laboratory services. The services provided to children are delivered through a partnership with Carroll County General Hospital, New American Health, LLC, and providers who participate in the Carroll County Contract Management Organization.

Montgomery County Care for Kids Program

The Care for Kids Program serves undocumented children in Montgomery County.

Prince George's County Medical Care for Children Partnership

The Medical Care for Children Partnership (a Catholic Charities Program) serves children between 200 and 250 percent of poverty. It serves children from birth to age 18 and undocumented children.

Healthy Teens and Young Adults Initiative

The Maryland Healthy Teens and Young Adults (HTYA) Initiative was developed as a Governor's Special Initiative in 1990. Designed to reach and serve young people at risk for unintended pregnancy, the program operates in three Maryland metropolitan jurisdictions, Baltimore City, Prince George's County, and Anne Arundel County. There are also plans to expand services within the three jurisdictions in which HTYA currently operates, as well as to expand the initiative into other jurisdictions. The target population includes males and females ages 10-24. Service sites offer a holistic approach to health care and community-based prevention services. In addition to receiving counseling about a broad range of family planning methods, attention is also given to addressing clients' general health and psychosocial well being. Special services for men have been developed ranging from mentoring to direct clinical services.

Community Health Centers

Maryland has a number of Community Health Center sites, including Federally Qualified Health Centers (FQHC), which are comprehensive primary care providers offering care to low-income, uninsured individuals on a sliding fee scale; Maryland Qualified Health Centers (MQHC), which are non-profit health centers providing the same scope of services as an FQHC and offer discounted fees to low-income uninsured; Health Centers; and Private Practice Centers (PRIV) which offer discounted fees to low-income uninsured.

2.2 Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

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

Maryland uses a variety of methods to identify and enroll all eligible children in Maryland for Medicaid and the Children's Health Program. We have implemented a broad-based and diverse outreach program. Some of our activities include:

- Brochures, flyers and posters;
- Radio and TV public service announcements;
- Outreach through primary care provider offices and pediatric specialty providers;
- Outreach and information and enrollment at the Local Health Departments and the Local Departments of Social Services;
- Direct mailings to individuals receiving unemployment checks;
- Outreach through schools, licensed child care providers, the Maryland Infants and Toddler's Program and Head Start;
- Outreach by established advocacy groups such as the Maryland Committee for Children and the Advocates for Children, Youth and Families; and
- Public presentations by members of the Department of Health and Mental Hygiene (DHMH) speakers bureau.
- Web-based materials provided to inform the public of new issues and requirements.

In addition, Maryland has taken the following actions to streamline the eligibility process:

- Adoption of a shortened, simplified application form (3 pages);
- Allowing applicants two new application options—applying by mail or face-to-face at local health departments (instead of the still-available alternative of applying at local departments of social services);
- Allowing self-declaration of income;
- Elimination of the mandatory face-to-face interview; and
- Establishing a "1-800" number for anyone who has questions or wants an application form.

As demonstrated by the higher than anticipated enrollment levels during MCHP Phase I, Maryland's outreach efforts have been quite successful. These efforts, as well as Maryland's plans for additional outreach consistent with the goals of MCHP Phase II, are discussed in detail in Section 5 of this application.

Maryland uses a combined application for Medicaid, MCHP and MCHP Premium. Applicants determined eligible to participate in Medicaid or MCHP who subsequently have a change in circumstances which qualifies them for the other program are reassigned without requirement for completion of another application and without any impact on their HealthChoice enrollment. MCHP Premium applicants who become ineligible for MCHP Premium due to a reduction in income which would qualify them for Medicaid or MCHP must complete the brief application form to move from MCHP Premium into the appropriate program.

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

There are currently no public-private partnerships in Maryland that provide creditable health insurance coverage.

2.3 Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and 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. *(Previously 4.4.5)*
(Section 2102)(a)(3) and 2102(c)(2) AND 2102(b)(3)(E)) (42CFR 457.80(c))

Coordination with Other Public and Private Programs

- *Children's Medical Services (CMS).* The CMS program is the Title V Program in Maryland that has traditionally assisted families in planning and obtaining specialty medical and rehabilitative care. In order to receive services paid for by CMS, a child must first apply for Medicaid/MCHP and be determined ineligible. CMS mailed a letter to all children who received services through CMS and provided a copy of the short, 3-page MCHP application. CMS assisted with MCHP outreach by mailing letters and MCHP applications to children who had received CMS services. Many CMS clients became eligible for comprehensive coverage through MCHP once it was implemented. This caused the program to shift focus from providing direct and wrap around services to systems building activities. CMS has provided noncreditable coverage for both direct and wrap around specialty care services to eligible children with special health care needs through the purchase of direct care services through community providers, local health departments, and academic institutions through both fee-for-service reimbursement and grants. CMS provides services to uninsured, underinsured, and undocumented children. Services are provided directly through hospital and community-based specialty care providers and local health department-based specialty clinics.

- *WIC.* WIC helps distribute MCHP applications and materials and helps potential applicants complete the application. Prior to the MCHP expansion, WIC participants were required to have a household income of less than or equal to 185 percent of the FPL. Concurrent with MCHP implementation, the WIC program increased its income eligibility threshold to 200 percent of FPL. Besides establishing financial eligibility, WIC recipients must have an identifiable nutritional risk factor and be pregnant, less than six months postpartum, breast-feeding an infant under age one, or under age five. WIC provides food packages, nutritional counseling, and linkage to other health and social services.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

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

3.1 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 2101)(a)(4) (42CFR 457.490(a))**

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

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

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. Geographic area served by the Plan:

MCHP Premium is available on a Statewide basis.

4.1.2. Age:

For MCHP Premium, children covered under Title XXI must be under 19 years old.

4.1.3. Income:

4.1.4. □ Resources (including any standards relating to spend downs and disposition of resources):

The eligibility determination for MCHP Premium considers the applicant's family income only; assets are not considered.

4.1.5. Residency (so long as residency requirement is not based on length of time in state):

Current residency in the State is required.

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:

Once an applicant is determined eligible for MCHP Premium and enrolled in the program, eligibility will be redetermined annually. If there is any change in income, employment or insurance status, the parent or guardian must notify the State.

4.1.9. Other standards (identify and describe):

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 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.

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

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

See Section 4.4.4.3 below for prevention of substitution of coverage.

4.4.2 The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(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. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. **X** Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

4.4.4.2. **X** Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. **X** Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4___ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

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))**

SECTION 5 Outreach (section 2102(c))

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)) (42CFR457.90)**

MARYLAND CHILDREN'S HEALTH PROGRAM OUTREACH STRATEGY

The effective date for MCHP outreach was July 1, 1998. The effective date for MCHP Premium outreach was July 1, 2001. The outreach strategy for the Maryland Children's Health Program is guided by the following goals:

- Design a program that is easy for the general public to understand and access;
- Conduct a culturally sensitive public information campaign, targeted to those individuals and organizations that have the most direct contact with the low-income uninsured population;
- Identify, inform, and enroll the low-income uninsured population into either the State's Medicaid program, MCHP or MCHP Premium, as appropriate; and
- Coordinate enrollment into these programs with other public or private health insurance.

To effectively achieve the goals of enrolling the targeted uninsured population into the Maryland Children's Health Program, Maryland uses a multifaceted strategy. In order to target families, Maryland will continue with a grassroots information dissemination campaign involving collaboration with the following entities:

- State agencies;
- Advocacy and community-based groups; and
- Provider organizations.

This grassroots approach complements Maryland's comprehensive HealthChoice education and outreach campaigns targeted at low income pregnant women and children. Maryland has conducted public media and advertising campaigns using some of the same strategies which have been effective during the implementation of HealthChoice.

Grassroots Information Dissemination Campaign

The primary objective of the grassroots public information campaign is to educate families of the eligibility provisions and benefits under the Maryland Children's Health Program. State agencies as well as local community-based organizations, advocacy groups, and providers serve as information links to low-income working families. Each of these groups is asked to distribute brochures and other forms of information, assist with mail-in applications, use their own newsletter for communication, and host meetings for others to be educated on the outreach process. In all of these activities, the State serves as a central contact and clearinghouse, as well as providing technical assistance.

The State coordinates its outreach efforts closely with Local Health Departments, Community Health Centers, Managed Care Organizations, (MCOs) and other public and private providers with historic experience in providing information, services, and referrals for low income uninsured populations. The State also works through children's services providers such as schools, licensed day care providers, and Head Start programs. Each of the grassroots outreach entities are outlined below with a description of their major area of responsibility.

STATE AGENCIES

Department of Health and Mental Hygiene (DHMH)

DHMH is responsible for strategic planning of Statewide outreach. DHMH efforts include the following:

- *Consultation with the Maryland Medicaid Advisory Committee.* DHMH, in consultation with the Maryland Medicaid Advisory Committee, refines mechanisms for outreach with a special emphasis on identifying children who may be eligible for program benefits under the Maryland Children's Health Program.

- *Toll Free Information Line*. DHMH operates a toll free information line to field questions about the program and take requests for enrollment applications. DHMH's toll free line is linked to the national 1-877-KIDSNOW hotline.

- *Printed Materials*. The following materials are distributed to those groups who have the most direct contact with the uninsured population such as Community Health Centers, Local Health Departments, the Department of Social Services offices, advocacy groups for children, school systems, community outreach organizations, and churches:

  - Mail-in applications
  - Brochures, posters, and flyers
  - Question and answer information packets for enrollees
  - Question and answer information packets for professionals
  - Training materials for Local Health Departments
  - Training materials for public speaking engagements
  - Scripts for newsletters and newsprint.

☐ *Web based materials. Materials are posted on a public-access agency website, to include applications, general information, eligibility updates and topic specific information*

The largest percentage of non-English speaking populations in the State speak Spanish and Vietnamese. Outreach for HealthChoice and MCHP included specific efforts to reach these populations. Other identified languages spoken frequently in the State include Russian, Korean and Chinese. Maryland provides application forms and brochures in English and Spanish, and will evaluate whether to translate additional outreach brochures and posters into other languages for jurisdictions with large non-English speaking populations.

Local Health Departments (LHD)

Public health services in Maryland are provided through a network of 24 local health departments that have a longstanding history of service delivery to maternal and child health populations through the following programs: Family Planning Services (Title X); preventive health care and specialty care to low income children and prenatal care to low-income pregnant women (Title V); WIC; and immunization programs.

Through funding from the HealthChoice program, each LHD has created a care coordination unit responsible for outreach to low-income families, as well as follow-up of certain hard-to-reach and special needs populations enrolled in HealthChoice who fail to keep appointments. These Statewide networks of Medicaid supported outreach units have the knowledge, skills, and tools to conduct outreach activities to identify, track, enroll, and educate the low-income uninsured population into the Maryland Children's Health Program. LHDs perform community outreach through collaborative efforts with schools, family and center-based day care centers, family support centers, churches, medical and mental health providers, work site wellness programs, business and service organizations (e.g., Chamber of Commerce), non-profit organizations (e.g., March of Dimes), youth activity, and sports programs.

Department staff meet regularly with LHD outreach staff to keep them abreast of changes in the Maryland Children's Health Program, to ensure that all grantees understand outreach goals, and to provide information on statewide outreach strategies. DHMH will also seek input from grantees regarding the development of performance measures for these activities. Local health department outreach staff will also be asked to evaluate local strategies.

Department of Human Resources (DHR)

DHMH works closely with DHR to coordinate eligibility issues especially for those who fall between the 200 and 300 percent of FPL. The introduction of the family contribution requirement and Maryland's efforts to assure that Maryland Children's Health Program enrollees do not have any other creditable coverage present challenges for the eligibility process. DHMH and DHR (which does CARES eligibility processing for MCHP and MCHP Premium) work closely to identify and resolve any issues relating to eligibility determination for the Maryland Children's Health Program.

Maryland State Department of Education (MSDE)

MSDE plays a key role in encouraging low income families to apply for insurance coverage for their children by developing and implementing a school based outreach program. Examples of cooperative efforts with DHMH include:

- *Boards of Education*. DHMH may enter into contracts with county boards of education to provide information at public schools on the Maryland Children's Health Program.

- *National Free and Reduced Price School Lunch Program*. The Maryland State Department of Education (MSDE) maintains information concerning public school children who participate in the National Free and Reduced Price School Lunch program for children in families with income below 185 percent of the Federal poverty line (FPL). DHMH and MSDE have developed a two-part targeted outreach strategy that permissively uses the National Free and Reduced Price School Lunch Program to direct outreach information to children who are likely to be eligible for public health insurance coverage under either Medicaid or the Maryland Children's Health Program. This strategy will

concentrate on schools that (based on their relatively high proportion of children who qualify for the National Free and Reduced Price Lunch Program) are likely to enroll a relatively high number of children who are eligible for Medicaid or the Maryland Children's Health Program.

- When a child applies for the National Free and Reduced Price School Lunch Program and is determined to be eligible, the school will send a notice of eligibility to the child's parents; outreach information about the Maryland Children's Health Program will be included with the notice; and

- For school years 2000 and 2002, a Maryland Children's Health Program application was sent home with every child. For school year 2001, new entrants in prekindergarten, kindergarten and first grade received applications.

- *School-Based Health Centers*. School-based health centers are located in schools in Maryland which serve large numbers of children in low income families. SBHCs will encourage families of uninsured children to apply for Maryland Children's Health Program coverage.

- *Licensed Day Care Centers*. The Child Care Administration (CCA) is responsible for licensing and monitoring day care centers and family day care programs in Maryland. In addition, it administers the child care subsidy payment program for eligible families. CCA will provide general information about the Maryland Children's Health Program through education articles in a quarterly newsletter and by distributing outreach materials to 2,200 day care centers and 14,400 family day care providers.

Head Start

Head Start programs serve over 7,200 children in Maryland. The program predominantly serves four year old children with some available space for younger children. One component of Head Start is to promote access to health care for the children and families served in each program. Ten percent of the children served must have documented disabilities and ten percent of the children enrolled may come from families whose income exceeds the Head Start income guidelines, which are at the Federal poverty line. The Maryland Head Start Collaboration Network project was established to facilitate coordination of services between Head Start and Health care providers, education agencies, child care programs, employment projects, and other community organizations. It provides an open access arena for communication to the 31 Head Start programs in every county in the State. The project collaborates with the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program to improve access to health care services and to make sure that children enrolled in Head Start receive EPSDT screening and treatment services. Local Head Start programs provide Medicaid and Maryland Children's Health Program eligibility information and explain the importance of obtaining an EPSDT screen and immunizations during their annual spring recruitment phase.

Governor's Office on Children, Youth and Families

DHMH coordinates with this agency, as appropriate to assist in its outreach efforts.

Office of the State Comptroller

DHMH coordinates with this agency, as appropriate, to assist in its outreach efforts.

ADVOCACY AND COMMUNITY BASED ORGANIZATIONS

HealthChoice Linkages

Maryland has been highly successful in working in partnership with advocacy organizations for HealthChoice outreach and education activities. These partnerships will be strengthened to enhance outreach efforts as we move forward with the Maryland Children's Health Program. These advocacy organizations represent children and pregnant women of varying health status, geographic location and ethnic backgrounds. The advocacy organizations have a vested interest in child health and have grounded experience in overcoming the barriers that keep children and pregnant women from getting care.

During the planning stages for MCHP, regional meetings were conducted to seek input from the public. Numerous advocacy organizations participated in these regional meetings and expressed their willingness to assist in outreach efforts. A few examples of these established groups that have proven their commitment to reach the uninsured include:

- The Maryland Committee on Children
- Advocates for Children and Youth
- The Maryland Developmental Disabilities Council
- The Maryland Association of Resources for Families and Youth
- Workgroup on Managed Care for Children in State-Supervised Care
- The Lutheran Office on Public Policy
- The United Baptist Missionary Convention and Auxiliaries, Inc.
- Collington Life Center (Senior Center)
- The Mid-Atlantic Association of Community Health Centers

DHMH works closely with these and other groups to implement an outreach plan that complements other simultaneous outreach efforts and that specifically attempts to identify potential eligibles who are in rural areas, who are homeless, or who are members of special needs populations. Such activities as creating meeting participant lists, providing input on brochures and applications, distributing materials through churches and libraries, and speaking to parent groups are requested of these organizations.

Linkage with Robert Wood Johnson Outreach Grant - Covering Kids and Families - Maryland

Discontinued/Grant Period Ended June 30, 2006.

Linkage with Insurance Brokers

When issuing or renewing group health insurance policies with an employer that does not include dependant coverage, insurers and non-profit health service plans (those that issue or deliver group health insurance policies in the State) provide enrollment information to insured employees regarding methods for enrolling dependants of the insured employee.

PROVIDER OUTREACH

Primary and Specialty Care Providers

Health care providers are an invaluable resource in providing information concerning Medicaid coverage for low income children, children with special health care needs, and families. Primary care and specialty providers are encouraged by DHMH to identify individuals, especially pregnant women and children, in need of health care coverage and to make appropriate referral to local and State agencies for assistance.

Professional Medical Organizations

DHMH coordinates with recognized medical organizations such as the American College of Obstetrics and Gynecology (ACOG), the American Academy of Pediatrics (AAP) and the Maryland Association of Family Practitioners to promote access to Medicaid coverage. These organizations provide information to their providers through their professional meetings and newsletters. The EPSDT program supplies primary care physician's offices with outreach materials such as flyers and brochures to inform patients about Medicaid and the Maryland Children's Health Program.

Managed Care Organizations (MCOs)

Through a variety of existing communication forums including biweekly information sharing meetings, DHMH works closely with its HealthChoice MCOs to request assistance in the distribution of applications and information to its community networks.

Community Based Diagnostic and Treatment Centers

Maryland has a number of community-based diagnostic and treatment centers such as the Diagnostic and Evaluation Service Centers for individuals with HIV/AIDS and Planned Parenthood offering women's health services, where the most current information on the Maryland Children's Health Program will be disseminated.

Community Based Providers

As discussed in Section II of this application, Maryland has a number of locally operated programs (e.g., Montgomery County Care For Kids Program) as well as community health centers that already serve the uninsured. These programs provide direct information to the families that they serve so that children who receive partial benefits under these programs can receive comprehensive medical coverage.

GENERAL OUTREACH

Public Information Campaign-Media Relations and Advertising

Maryland has conducted three grassroots public information dissemination campaigns intended to target those families of the working uninsured who might have children eligible for the Maryland Children's Health Program. Designed to complement the outreach activities described above, the Statewide media campaigns have been successful in reaching individuals and families who were not contacted through these other

mechanisms or who may have been ineligible at the time they received the information and had a change in their financial situation.

Mass Media

Prior to implementation of MCHP Premium, DHMH mounted an initial kick-off campaign to encourage media interest in MCHP Premium. The kick-off consisted of a combination of information dissemination activities, which included press releases, press conferences, and television and radio interviews of State officials. DHMH also used public service announcements to inform potential program eligibles about the Maryland Children's Health Program, and radio ads, billboards, and mass transit posters.

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

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

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

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

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

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

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

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

6.1.3. □ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage"

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

6.1.4.3 □ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

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"

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 (Please provide a sample of how the comparison will be done)

6.1.4.7 □ Other (Describe)

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))**
(Limited to insulin and enteric coated aspirin for arthritic conditions)
6.2.8. □ Laboratory and radiological services **(Section 2110(a)(8))**
6.2.9. □ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**
6.2.10. □ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**
(Not part of the HealthChoice benefit package but provided by the State to HealthChoice enrollees, including MCHP and MCHP Premium eligible children, through a separate Public Mental Health System)
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)**
(Except for primary mental health services, which are provided through MCOs, these services are generally not included in the HealthChoice benefit package, but are provided by the State to HealthChoice enrollees, including MCHP and MCHP Premium eligible children, through a separate Public Mental Health System)
6.2.12. □ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

6.2.13. □ Disposable medical supplies **(Section 2110(a)(13))**

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

(Home health services are covered.)

6.2.15. □ Nursing care services (See instructions) **(Section 2110(a)(15))**

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

6.2.17. □ Dental services **(Section 2110(a)(17))**

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

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

6.2.20. □ Case management services **(Section 2110(a)(20))**

(Case management is covered, when appropriate, for enrollees who are members of special needs populations.)

6.2.21. □ Care coordination services **(Section 2110(a)(21))**

(HealthChoice enrollees' Primary Care Practitioners [PCPs] are expected to coordinate care of enrollees assigned to them, including making appropriate referrals for case management services.)

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

(Although these services are not included in the HealthChoice benefits package that is delivered through MCOs, the State covers these services for HealthChoice enrollees, including MCHP and MCHP Premium eligible children, who access the services through providers of their choice who are reimbursed by the State on a fee-for-service basis.)

6.2.23. □ Hospice care **(Section 2110(a)(23))**

6.2.24. □ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

(Covers all early and periodic screening, diagnostic, and treatment services.)

6.2.25. □ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. □ Medical transportation **(Section 2110(a)(26))**

6.2.27. □ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

(Coverage of non-emergency transportation to access covered services when the MCO chooses to provide the service at a location outside of the closest county in which the service is available; MCO accommodation of the special access needs of enrollees who do not speak English or are deaf and require qualified interpreters; MCOs are required to perform specified outreach activities.)

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3 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 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

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))**

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))**

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 relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A))** **(42CFR 457.1010(a))**

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))

Section 7. Quality and Appropriateness of Care

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

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

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

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))**

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

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

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. YES

8.1.2.□ NO**, skip to question 8.8.**

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 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: None
8.2.3. Coinsurance or copayments: None
8.2.4. Other: None

8.3 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))**

8.4 Describe how the state will ensure that the annual aggregate cost-sharing for the 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 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

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

State had 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. **(42CFR 457.570(a))**

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))**

See Section 8.2.4 for policies related to non-payment of premium.

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, copays, 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 (Section 2107)

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

MCHP Premium features four complementary objectives for increasing the number of low and moderate income children with creditable health insurance. Those objectives are:

- Develop and implement a multi-faceted ***outreach strategy*** that targets the eligible population for the program, including low and moderate income families.
- Reduce the percentage of uninsured children in Maryland.
- Increase access to health care services for enrollees in low and moderate income populations.
- Increase the use of appropriate preventive services by enrollees.

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

MCHP

Maryland measures outreach efforts by:

- The number of Medicaid-eligibles enrolled in the Maryland Children's Health Program as compared to projections; and
- Reduction in the percentage non-covered children.

Maryland will increase access to health care services for low-income populations as measured by:

- Increase in provider network capacity in areas where capacity is lowest;
- Increase in the number of primary care and dental providers participating in HealthChoice;
- Increase in the number of enrollees who indicate that they have improved access to the health care delivery system through satisfaction survey reports; and
- Increase in the number of participating specialty health care resources.

MCHP Premium

Maryland uses the following performance goals to evaluate its success in meeting each of its strategic objectives.

- Provide appropriate preventive care to enrollees.
- Reduce the percentage of uninsured children under 300 percent FPL.

- Meet or exceed the number of MCHP Premium enrollees as compared to projections.
- Increase in the number of enrollees who indicate that they have improved access to the health care delivery system. This will be measured through satisfaction survey reports.
- Increase in the number of enrollees who indicate that they are satisfied with specialty care resources.

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

9.3.2. **X** The reduction in the percentage of uninsured children.

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

Performance measured applies to MCHP only.

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

Performance measure applies to MCHP only.

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

Performance measure applies to MCHP only.

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

Performance measure applies to MCHP only. NOTE: The State is in the process of developing these measures.

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. **X** Well child care

9.3.7.3. □ Adolescent well visits

9.3.7.4. **X** Satisfaction with care

9.3.7.5. □ Mental health

9.3.7.6. **X** Dental care

9.3.7.7. □ Other, please list:

9.3.8. Performance measures for special targeted populations.
Performance measure applies to MCHP only.

The State segregates the data for its MCHP Premium program. This is made possible through the use of coverage group codes to identify distinct coverage groups of individuals eligible under MCHP Premium. This includes separate information on the number of children enrolled in MCHP Premium by income level (effective July 1, 2004, for income levels 200-250% FPL and 250-300% FPL). For September 1, 2003 through June 30, 2004, children in income level 185-200% FPL were included in MCHP Premium data and, for July 1, 2001 through June 30, 2003, MCHP Premium children were reported separately by source of coverage (Medicaid look-alike and ESI). Effective January 1, 2007 children in income levels from 200 % up to 300% (MCHP Premium) will continue to be tracked by distinct coverage groups.

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

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

The Maryland HealthChoice Quality Improvement Program (QIP) outlines the monitoring, evaluation and reporting methodologies the State will use to oversee the quality of health care services delivered to enrollees in the Maryland Children's Health Program.

9.6. **X** The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. **X** The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(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. **X** Section 1902(a)(4)(C) (relating to conflict of interest standards)

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

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

9.8.4. **X** Section 1132 (relating to periods within which claims must be filed)

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

MCHP:

In 1997, Governor Parris N. Glendening and the Secretary of the Department of Health and Mental Hygiene Martin P. Wasserman engaged in an extensive public process to obtain input on the design and implementation of the Maryland Children's Health Program. To ensure broad public input, the process began with four public hearings throughout the State and culminated with Governor's Round Table on Children's Health Insurance, which Governor Glendening personally chaired. The hearings and Round Table were followed by four regional briefings. Finally, there was an extensive legislative process which resulted in the Children and Families First Health Care Act of 1998. The Department of Health and Mental Hygiene will assure ongoing public involvement in the Maryland Children's Health Program through consultation with the Maryland Medicaid Advisory Committee and through monthly communication with the Local Health Department's health officers. The strategies used by the Department in this public involvement process are described below.

Public Input—Design and Implementation

- **Public Hearings**

  The four public hearings were publicized through appropriate advocacy and provider groups as well as direct mailings to over 200 representatives of consumers, providers and advocacy groups. The first public hearing, for Western Maryland, was held in Hagerstown on October 28, 1997; the second public hearing, for Central Maryland, was held in College Park on October 30, 1997. The third public hearing, for the Eastern Shore, was held in Wye Mills on November 3, 1997; the fourth public hearing, for Baltimore City, was held in Baltimore on November 6, 1997. All hearings were held at 7 p.m. to assure maximum public participation. Each hearing began with the Governor's representative explaining the provisions of the Children's Health Insurance Program under Title XXI and the options available for implementing the program in Maryland. Individuals were then given an opportunity to offer their views. A total of 193 individuals attended the four hearings and 94 testified. Of those individuals who addressed the issue, 60 recommended implementing Title XXI by expanding the current Medicaid program. Only five individuals recommended establishing a new program rather than expanding Medicaid.

- **Governor's Round Table on Children's Health Insurance**

  Governor Glendening chaired the Governor's Round Table on Children's Health Insurance in Baltimore on November 18, 1997. There were approximately 20 participants in the Round Table, including several key members of the Maryland General Assembly, representatives of provider and advocacy groups, community leaders, and a representative from the Children's Defense Fund and the National Governor's Association. The representative of the National Governor's Association explained the provisions of the Federal law and the Secretary of Health and Mental Hygiene explained the current situation in Maryland and options for implementing the new program. The Governor then chaired a discussion focusing on the expansion population, the benefit package, options for implementation, and whether there should be co-payments and premiums for enrollees. The discussion included all of the Round Table participants. Of those Round Table members who expressed a preference, all recommended implementing Title XXI through expanding the current Medicaid program. In addition to the participants, there were approximately 250 people in the audience observing the proceedings of the Round Table. Approximately 15 members of the audience made comments or raised questions during a question-and-answer session; only one person expressed opposition to implementing the program by expanding the Medicaid program.

- **Regional Briefings on Maryland Children's Health Program**

  Subsequent to the four regional Public Hearings and the Governor's Round Table Discussion, the Department and the Governor's Office conducted four regional briefings. These briefings were held in eastern, central, southern, and western regions of Maryland. This provided an opportunity for the public, consumers, advocates, Local Health Departments, and service providers to learn about the legislative proposal submitted by the Governor to the Maryland General Assembly. The briefings offered an additional opportunity for local and regional recommendations regarding the design and implementation of the Maryland Children's Health Program. The regional briefings were conducted by the Secretary or Deputy Secretary of the Department of Health and Mental Hygiene and a member of the Governor's executive staff. Interested parties, including State Legislators and Local Health Departments, were notified about the briefings through mailings and press releases.

The dates and locations of the briefings were as follows:

- Eastern Maryland—Salisbury, MD, January 22, 1998
- Central Maryland—Baltimore, MD, January 28, 1998
- Southern Maryland—Rockville, MD, February 2, 1998
- Western Maryland—Cumberland, MD, February 2, 1998

- **Maryland Legislature 1998**

The expansion of coverage to uninsured children was one of the major policy initiatives of Governor Glendening and the 1998 Maryland legislative session. Prior to the start of the session the Governor proposed legislation to address the needs of uninsured children. The legislature then engaged in an extensive debate on proposals regarding uninsured children. The legislative process included the formation of a work group of key legislative leaders who met regularly throughout the session. The work group invited representatives from the insurance industry, hospital, physician, provider and child advocacy groups to attend and participate in their work sessions. April 11, 1998, legislation entitled The Children and Families First Health Care Act of 1998, authorizing the Maryland Children's Health Program passed with overwhelming bipartisan support. This legislation closely follows the legislation originally proposed by Governor Glendening.

Ongoing Public Involvement

- **Maryland Medicaid Advisory Committee**

The Maryland Medicaid Advisory Committee reviewed and discussed the provisions of Title XXI and the options available to the State at its meetings of October 23 and November 24, 1997. The Committee recommended expanding the existing Medicaid program to implement the new program.

In order to assure on-going public involvement and input in program implementation and continuing administration, the State uses the Maryland Medicaid Advisory Committee, established under the Section 1115 Maryland Medicaid waiver for the HealthChoice program.1 The Maryland Medicaid Advisory Committee consists of 27 members including State legislators, consumers, and providers. The Committee is currently charged with advising the Department of Health and Mental Hygiene on the implementation, operation and evaluation of the Medicaid program, including the following activities: reviewing and making recommendations on regulations; reviewing and making recommendations on standards used in contracts with Managed Care Organizations; reviewing and making recommendations on the Department's oversight of quality assurance standards; reviewing data collected from Managed Care Organizations and data collected by the Maryland Health Care Access and Cost Commission; promoting the dissemination of Managed Care Organization performance information; assisting the Department in the evaluation of the enrollment process; reviewing reports of the Ombudsman; and publishing an annual report to the Governor and Maryland General Assembly. The Committee has added the Title XXI program to each of these areas of its responsibility, as appropriate. The Committee meets monthly and periodically conducts regional public hearings.

1. The role of the Medicaid Advisory Committee is explicitly outlined in the "Children and Families First Health Care Act of 1998."

- **Monthly Meetings with the Local Health Departments**

  On a monthly basis, local health officers representing the 24 LHDs have a round table discussion on issues affecting the implementation of the HealthChoice program.

MCHP Premium

The Maryland General Assembly, in its 1999 session, enacted Senate Bill 738, requiring the Department of Health and Mental Hygiene (the Department or DHMH) to study how to expand eligibility for the Maryland Children's Health Program by using private market insurance (private option) coverage. SB 738 directed the Department to:

> Study and make recommendations regarding the ability of the State to expand the Children and Families Health Care Program beyond the current income eligibility level to individuals who would qualify for the enhanced federal match provided for under Title XXI of the Social Security Act as part of the program established under §15-301 of this subtitle through private market, employer-sponsored health benefits plans and private market, individual health benefit plans.

To fulfill this legislative mandate, the Department formed a Technical Advisory Committee (TAC) composed of representatives of the Department, the Maryland Insurance Administration, the Maryland Health Care Foundation, the Maryland Health Care Commission, the business community, the health care insurance industry, and State employees. In the interest of gaining as broad and informed a perspective as possible, the Department expanded the membership of the TAC to also include advocates representing additional relevant interest groups.
The University of Maryland, Baltimore County (UMBC), Center for Health Program Development and Management (CHPDM), conducted all relevant research and provided staff to support the TAC. The Department and the TAC pursued an open and inclusive approach to soliciting information and assuring that complex (and potentially contentious) design issues were thoroughly reviewed and discussed. Two methods were used:

- *Full meetings of the TAC.* The full TAC met on five separate occasions from June to October 1999. Each of these meetings lasted for roughly three hours and, in the aggregate, touched on all aspects of the private option. At its initial meetings, the TAC reviewed proposed approaches to the private option, adopted a workplan, and addressed basic issues, such as benefit design. At later meetings, staff recommendations were presented, discussed, and modified.

- *Issue-specific workgroups.* Five workgroups supplemented the deliberations of the full TAC. The workgroups were composed primarily of TAC members, but also included additional individuals with relevant expertise or experience (e.g., employers). The workgroups explored the following issues: benefit design, administrative concerns for employers and insurers, outreach processes, and cost sharing requirements. At the recommendation of the TAC, a sixth workgroup of consumers met in November, 1999 and discussed the program's overall design and implementation. The consumer focus group paid particular attention to the potential effects of various cost sharing mechanisms.

In addition to discussions designed to capture input from the TAC and the workgroups, staff researched and analyzed a number of topics necessary to inform these groups' deliberations. Staff prepared the following:

- *Discussion papers.* Staff produced a series of papers presenting pertinent research and analysis of key issues that are central to the design and development of a private option program under Title XXI. Discussion papers on the following topics were distributed to workgroup participants and the TAC as a whole:

  - Benefit Design Options;
  - Estimating the Target Population; and
  - Cost Sharing Issues.

- *Employer survey*. Maryland has always been concerned that the HCFA guidance calling for an employer contribution of at least 60 percent of the cost of family coverage for employer-sponsored coverage under Title XXI, represented a significant barrier to employer participation in a private option program. Therefore, Maryland was very interested in collecting Maryland-specific data on this issue. In cooperation with TAC members, staff developed a brief employer contribution survey to gather information on employee health insurance contribution patterns among Maryland employers. The survey was mailed to over 23,000 Maryland employers and responses were received from over 2,600 employers. The results of the survey provide a strong basis for Maryland seeking a lower employer contribution threshold of 50 percent for the private option. Based on final federal regulations and Maryland's experience since July, 2001 in implementing and operating the private option program, Maryland reduced the required employer contribution threshold to 30 percent. This allowed the State to provide access to the MCHP Premium through employer-sponsored insurance for children in families where the family size was large enough to meet the cost-effectiveness test.

- *Research of approaches being used by other states.* A very limited number of other states have either developed or attempted to develop employer-sponsored approaches to providing health insurance coverage for children through a separate state plan under Title XXI. To understand how they designed and implemented their Title XXI employer-sponsored insurance programs, and to assess their current status, staff contacted each of the states (Massachusetts, Wisconsin, Mississippi, and Oregon) that have either been approved by, or submitted a proposal to, HCFA to use an employer-based approach to Title XXI.

- *Interim Report.* As required by SB 738, the Department prepared an interim report recounting the TAC process and progress. The interim report (submitted September 15, 1999) did the following. It:

  - Presented TAC discussions of major policy issues, especially benefit design;
  - Outlined the remaining issues to be addressed;
  - Described a strategy for completing the Committee's efforts; and,
  - Included copies of all issue papers.

The process outlined above was invaluable in the development of workable recommendations for a Maryland Children's Health Program private option that adhered to the goals and requirements detailed in SB 738. The Department especially benefited from the active participation of the membership of the TAC, in particular from the TAC's willingness to openly discuss issues and consider opposing viewpoints. The TAC's spirited and insightful discussions were indispensable to understanding the complexities of the private option.

Using the final December 3, 1999 report of the TAC as a starting point, the Maryland legislature passed the HB2, the Maryland Health Programs Expansion Act of 2000. Thus, this state plan amendment is the culmination of an extensive public process.

Since enactment of the legislation in April of 2000, DHMH has reconvened the TAC to discuss its implementation plans. DHMH will continue to hold regular meetings with the TAC and arrange meetings with technical experts as needed.

Legislative Adjustments to MCHP and MCHP Premium effective July 1, 2003

In the 2003 session of the Maryland General Assembly, changes were made to MCHP and MCHP Premium pursuant to House Bill 40 of 2003 (the Budget Bill 2003) and House Bill 935 of 2003 (the Budget Reconciliation and Financing Act of 2003).

House Bill 40 and House Bill 935 froze enrollment in MCHP Premium for children in families with incomes above 200 percent FPL but at or below 300 percent FPL, eliminated ESI enrollment for MCHP Premium children, and required MCHP children above 185 percent FPL to pay a premium for continued coverage. The legislation set the premium for children above 185 percent FPL at 2 percent FPL for a family of two at 185 percent FPL. All changes are effective July 1, 2003, per the legislation. (NOTE: Implementation of changes to MCHP Premium occurs effective July 1, 2003. Imposition of a premium on children in families with incomes above 185 percent FPL but at or below 200 percent FPL will occur effective September 1, 2003.)

Maryland agency regulations for MCHP and MCHP Premium are amended effective July 1, 2003, to implement the changes mandated by the legislation.

The Medicaid Advisory Committee was advised of all changes in May and June 2003.

Legislative Adjustments to MCHP and MCHP Premium effective July 1, 2004

The changes made to MCHP and MCHP Premium effective July 1, 2003 pursuant to House Bill 40 of 2003 and House Bill 935 of 2003 are applicable to state fiscal year 2004 only. These changes expire at the end of the state fiscal year, on June 30, 2004. The sole exception is the elimination of the ESI program, which the Maryland General Assembly terminated July 1, 2003 by amendment to the Annotated Code of Maryland.

Effective July 1, 2004, children in families with income above 185 percent FPL but at or below 200 percent FPL will not be required to pay a premium for coverage. The upper income limit for MCHP (the free Medicaid expansion program) and the lower income standard for MCHP Premium (the contributory separate child health program) will change from above 185 percent FPL to above 200 percent FPL.

Also effective July 1, 2004, the freeze on new enrollment in MCHP Premium for children in families with income above 200 percent FPL but not greater than 300 percent FPL will be removed.

Maryland agency regulations for MCHP and MCHP Premium will be amended effective July 1, 2004, to implement these changes.

The Medicaid Advisory Committee was advised of these changes in May, 2004.

Effective January 1, 2007, MCHP Premium will transition all of its children from its separate program to its Medicaid expansion program. The Medicaid expansion will include children with family income

above 200 percent and at or below 300 percent of the FPL. Upon approval of this amendment, and after exhaustion of title XXI funds, the State will have the option of reverting to title XIX funds for its Medicaid expansion children. The State will only be permitted to use title XIX funds to cover these children until title XXI dollars are replenished.

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. **(Section 2107(c)) (42CFR 457.120(c))**

Maryland has no federally or State-recognized Indian tribes. Any Maryland resident, including those who are American Indians or Alaska natives, may participate in the review of amendments to State law or regulation and may offer comments on all Program policies, including those relating to provision of child health assistance to American Indian or Alaska native children. The process for review and comment is outlined in 9.9.2 below.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in ∋457.65(b) through (d).

N/A

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

1.• 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.

1.• Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

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Section 10. Annual Reports and Evaluations (Section 2108)

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

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

Maryland has filed Annual Reports for MCHP (effective July 1, 1998) for fiscal years 1998— 2006. The 1999 Annual Report was incorporated into the State's evaluation submitted on March 31, 2000. The 2001 Annual Report included information on MCHP Premium (effective July 1, 2001) for the last quarter of fiscal year 2001. The data to measure the State's progress in reducing the number of non-covered children do not exist at this time. We believe the 1999 Current Population Survey (CPS) for Maryland is significantly flawed. The earlier years of the CPS do not cover the time period during which the Maryland Children's Health Program has been in existence. To address this lack of data, we conducted a State survey of the uninsured. Data are currently being assembled for analysis.

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

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

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

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

11.1.1 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 IX: **(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 11224 (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))

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

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR 457.1120.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please 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.