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: Nebraska
(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: Vivianne Chaumont Position/Title: Div of Medicaid & LTC Director
Name: Jenifer Robert-Johnson Position/Title: Acute Care Programs Section Admin
Name: Sam Kaplan Position/Title: Operations Unit Mgr
Name: Jon Sterns Position/Title: Program Specialist

Deleted:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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

1.1.3. ☐ A combination of both of the above.

1.2 ☒ 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 of Nebraska assures the federal government that expenditures for its Title XXI program, to be known as Kids Connection, prior to the time that the State has legislative authority to operate the State plan as approved by CMS. (May 1, 1998)

1.3 ☒ 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 of Nebraska assures the Federal government that it will operate its Title XXI program, to be known as Kids Connection, in accordance with all federal civil rights requirements.

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: Phase I – May 1, 1998

Implementation date:

Phase II – Sept 1, 1998
Phase III – Sept 1, 2009

Phase I – May 1, 1998
Phase II – Sept 1, 1998
Phase III – Sept 1, 2009

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))

Children Below 200% of Poverty

Population:

Based on 1990 U.S. Census data, there are 429,012 children under 18 residing in Nebraska with a total population of 1,578,385. This is 30.3% of the state's population. Projections estimate there will be 478,286 children in year 2000. Of the total children, it is estimated that 167,519 children under age 18 live in homes with incomes below 200% of the federal poverty level (FPL). The number of children under age 18 living in homes with incomes below 185% of the federal poverty level is estimated at 150,088.

The 1990 Census also reports that of the 429,012 children under 18, there are 107,811 children in families with income under 150% FPL, and 58,474 children in families with income under 100% of FPL. Children in families with income at or below the poverty level represent 12.3% of total children. This is essentially constant in comparison to 12.1% in 1980. Children in families with income at or below 150% of poverty represent 23.8% of total children. In 1992, the percentage of children in poor and near poor families with incomes below 150% was 24.7%. A Kids Count (Annie E. Casey Foundation publication) analysis of Current Population Survey (CPS) data since 1990 does not show a statistically significant change in poverty in Nebraska.

U.S. Census Data for Children by Age< 18 and Federal Poverty Level

AGE:	125%-149%	150%-174%	175%-184%	185%-199%	200% Tot. All Income	
Under 5	7,886	8,965	3,418	4,949	65,551	118,312
5-11	11,083	13,085	5,254	7,457	102,713	173,521
12-17	7,005	8,085	3,470	5,025	88,504	132,454
Total 0-17	25,974	30,135	12,142	17,431	256,768	424,287

According to data from the Nebraska Department of Education, approximately two-thirds of Nebraska's school children participated daily in the school lunch program in December 1997. Of that two-thirds, almost 69,000 children were eligible for free lunches and another 26,000 children were eligible for reduced-price lunches. One third of the total school enrollment are eligible for free or reduced lunches.

Total number eligible for reduced price lunches (between 130 and 185% FPL	25,953
Total number eligible for free lunches (less than 130% FPL	68,930
Total avg. daily participation in school lunch	202,023
Total school enrollment in NE	299,852

Race:

Of the children under 18 residing in Nebraska in 1990, approximately 89.6% of the children were white and 10.4% were non-white. Of the children who are currently Medicaid eligible, approximately 69.1% of the children are white and 30.9% are non-white. Applying those race percentages to the number of children under 100% of FPL, 40,406 are white and 18,068 are non-white. Of children under 185% of FPL, 103,711 are white and 46,377 are non-white. White children comprised the majority of births in 1996. Of the 23, 271 births in 1996, 21, 299 (91.1%) were white and 2,071 (8.9%) were non-white births. The 1995 Kids Count report (using data from the Health and Human Services System) shows 9% of children age 19 and under were non-white.

Geographical Distribution:

Over one half of all children (age 18 and under) in Nebraska reside in rural areas according to the 1990 Census. 223,355 children live in the six metropolitan counties (based on U.S. Census definitions) of Cass, Dakota, Douglas, Lancaster, Sarpy, and Washington. 228,253 children reside in all other counties.

Number of Uninsured Children:

Although private insurance and public sector coverage efforts have helped expand health coverage of children in Nebraska, some children still have no coverage. Based on Census Bureau estimates for 1993-95, 7.0% of Nebraska's children have no public or private coverage; for 1994 -96, the estimate was 6.8%. The percent has remained constant over years 1989-1993.

Those children are apt to have 38% fewer medical visits than children with insurance (National Center for Children in Poverty, 1991: Waterman and Woodford, 1993). Medicaid expenditures for children newly eligible for the program have significant dental costs partially due to lack of regular dental

care while in an uninsured status. Preventive and delayed care due to lack of coverage leads to higher treatment costs. The American Hospital Association Health Statistics & the Employee Benefits Research Institute (EBRI) analysis of March 1995 Current Population Survey of Nebraska estimated that of 463,683 children in Nebraska, 45,689 were covered by Medicaid and 43,397 have no health insurance. It should be noted, however, that the figure of 45,689 covered by Medicaid is low; in March 1995, Nebraska Medicaid had 79,834 children eligible in the children's categories (this does not include children who were eligible through programs for persons with disabilities).

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):

The Nebraska Comprehensive Health Insurance Pool (CHIP) program is a state-only insurance program that was created in 1985. Children who qualify for Medicaid are not eligible for Nebraska's CHIP program since persons must be "uninsurable" and CHIP losses are covered by a reduction in state insurance premiums taxes owed by companies who participate in the pool. Individuals in the CHIP pay premiums that are currently 125 percent of the average of the five highest volume plans in the state, and premiums have been as high as 150 percent of the average premium - the Insurance Commissioner sets the rate. Less than 300 children are enrolled in CHIP. HHSS staff has estimated that these children are in families with incomes that exceed the 200 percent threshold so it is unlikely that there will be any substitution with Kids Connection.

In addition to Medicaid, there are other programs and service delivery systems that (1) provide selected services and/or (2) work toward linking families with health services whether it be Medicaid coverage or other community resources. To promote and provide children and youth with comprehensive services and a full continuum of care through Medicaid, the following direct and indirect outreach efforts are utilized:

- Employee newsletters are used to relay updates, changes, and information about initiatives to HHSS employees statewide. Internal electronic mail is used as a vehicle to notify all central and field staff of changes and updates on eligibility and services.

- Provider bulletins that contain policy changes and clarification and claims processing updates are issued.

- Brochures and other information are distributed in local offices and to groups when presentations are made to community groups, other agencies, and professional organizations.

- News releases are issued regarding new initiatives and reports as well as when public hearings will be held. Several news releases regarding Kids Connection have been issued to date.

- The Health and Human Services System employs a full-time system advocate accessible through an 800 number to assist individuals with questions or concerns.

- The agency communicates with client advocacy groups, the Medicaid Medical Care Advisory Committee, the Client Advisory group, and the Physician/Office Staff Advisory group during the rulemaking process to address and obtain input regarding policy issues and agency procedures that impact clients and providers.

- A number of educational/promotional materials are utilized such as HEALTH CHECK posters, HEALTH CHECK video, provider training materials, local office training, and managed care enrollment materials.

- The Health and Human Services System has developed a web page that has information about the various programs and services provided by the System. The web page now has information on Kids Connection with plans to update the information as needed. The web site also has basic information about Medicaid program service coverage and application sites.

- The 800 numbers for agency access for information and for applications are currently listed on HCFA's (CMS') web site.

- The local HHSS offices accept mail-in applications for Medicaid eligibility.

- The agency utilizes outstationed eligibility sites in a number of hospitals where hospital staff complete the eligibility applications with patients and send them to the local HHSS office for eligibility determination. The local office staff liaisons with the outstationed eligibility providers regarding training and information and contract payment.

- There are currently 13 presumptive eligibility (PE) providers statewide where

pregnant women can apply for presumptive Medicaid eligibility. Staff from these sites have ongoing communications during the PE process with local office staff and are familiar with Medicaid and how it can be accessed for other family members. These include the state's two federally qualified health centers (FQHCs) and the two teaching hospitals and several community action agencies. Approximately 2,000 PE applications for pregnant women were completed annually at these qualified provider sites. Regular Medicaid applications are available at most sites.

- Of the 13 presumptive eligibility providers, ten are recipients of Title V/Maternal and Child Health Block Grant funds. Through a Medicaid-MCH partnership, these community-based agencies already conduct outreach to low-income children and pregnant women for Medicaid. In addition, all Title V grantees in Nebraska identify and refer potentially eligible children and pregnant women to the Medicaid program whenever possible. Services for prenatal health care, pediatric primary care, health education, lead screening, and adolescent pregnancy prevention and support are all provided to low-income and other at-risk populations in Nebraska through Title V funds. A large proportion of recipients of these services are identified as uninsured and are provided either the support necessary to pursue health care coverage, or primary health care services and case management paid for by Title V.

- In addition, all Title V grantees in Nebraska are provided state-level support to identify and refer potentially eligible families to the Medicaid program whenever possible. Services for prenatal health care, preventive and primary care for children, health education, lead screening, and adolescent pregnancy prevention and support are all provided to low-income and other at-risk populations in Nebraska through Title V funds. A large proportion of recipients of these services are identified as uninsured and are provided the support necessary to pursue health care coverage.

- Children with special health care needs who do not have health care coverage are often identified through the Medically Handicapped Children's Program (MHCP), which is Nebraska's Title V program dedicated specifically to providing specialty and subspecialty services to this population of children. MHCP services are commonly promoted by communities as a means for getting children with special health care needs into the publicly-funded health care system, particularly Medicaid. All children referred to MHCP clinics or services are screened for Medicaid eligibility.

- In addition, the hospitals, schools, and community-based organizations that provide Early Intervention (EI) services to children with special health care needs up to three years of age are an excellent resource for identification and

enrollment into Medicaid. The EI services coordinators are very familiar with Medicaid rules and regulations, and are able to advocate on behalf of the children with whom they work to get them enrolled.

- MHCP works collaboratively with Shriners Hospitals and the CHOICES (Children's Healthcare Options Improved Through Collaborative Efforts and Services) program to provide seamless support to families in their communities after receiving hospital care. As a child is released from Shriners Hospital in Minneapolis and returns home to Nebraska, the MHCP and CHOICES care coordinators work together to assure that the child not only has health care coverage - often through Medicaid - but also to assure that there is an established medical home for continuous care once the child is settled at home.

- Currently the second largest county health department in the state, Lancaster County Health Department, through the Medicaid Access Coordination project and two rural county health departments and one community action agency through the Community Access to Coordinated Healthcare (CATCH) project, have Medicaid administration contracts to perform outreach and provide centralized nurse-staffed phone access, triage, and referral for potential Medicaid-eligible children and their families. They also encourage preventive care and link families with other community health resources and other public health programs.

- The agency provides training and information to the Title V Healthy Mothers/Healthy Babies 800 Helpline which links families with Medicaid and Title V providers. The Helpline also has information on the locations where families can apply for assistance. In the last year, the Helpline received almost 1,000 calls, and 64% of referrals were for medical/prenatal care and social services, including Medicaid.

- The Medicaid agency, as part of the WIC/Medicaid interagency agreement, provides information on coverage and eligibility to WIC staff as tools for them to outreach to families currently receiving WIC benefits. Through collaborative efforts, Medicaid eligible families are contacted and provided with WIC information.

- Through a cooperative interagency agreement with the community action agency covering 22 central Nebraska counties, outreach efforts are being performed to connect Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible children and potential Medicaid eligible children with well child care and home visitation services provided by the community action agency with the support of Title V/MCH Block Grant funds. An additional

cooperative agreement between the Medicaid and Title V programs at the state level is in negotiation, which would allow for a proportion of the Title V "overmatch" to be used to support further Medicaid outreach efforts throughout the State.

- Special efforts will be made to identify eligible children in rural areas of the state, through the efforts of county health departments, community action agencies, rural health clinics, and FQHC's.

- Many of the state's schools have been enrolled as Medicaid providers of therapy services (physical, speech, and occupational) and, thus, have become more aware of Medicaid coverable services for their families. School health nurses periodically receive information on the HEALTH CHECK (EPSDT) program, and they often refer youth for assistance. School nurses receive ongoing information from the state's School Health Consultant regarding their role in providing outreach for Medicaid to uninsured children, including updates on rules and regulations, brochures, and information on EPSDT rates for the counties served by their school districts.

- With the support of their state-level grantors, immunization clinics and reproductive health clinics encourage recipients of their services who are potentially eligible to pursue enrollment into Medicaid.

- Medicaid staff serve on a tribal advisory board to provide technical assistance setting up a clinic facility for members of the tribe who are Medicaid-eligible. Staff are also working with tribally-owned and leased clinics to meet the IHS/HCFA(CMS)Memorandum of Agreement terms and provide training and information on services and billing. Presentations and technical assistance have been provided to the Northern Plains Healthy Start staff.

- HHS System staff held initial meetings with Tribal representatives, including the Ponca Tribe (April 17), the Santee Sioux Tribe (April 28), the Omaha Tribe (May 13), and the Winnebago Tribe (May 13). In addition, HHS System staff presented information on Kids Connection at a meeting of the Nebraska Indian Commission on May 8 in South Sioux City. HHSS staff met with the Omaha Tribe on July 8 for a follow-up meeting. Staff are also consulting with the Director of the Indian Affairs Commission to develop appropriate outreach plans. Additionally, letters will be sent to organizations which serve large minority populations, telling them about Kids Connection and letting them know that HHS System staff are available to meet with them if they choose. Those organizations include the Nebraska Association of Farmworkers (NAF),Asian Community Center, Malone Community Center, Hispanic Center, Indian Center, the Urban League, and Charles Drew Health Center. HHS

System staff also plan to schedule meetings with the Indian Chicano Center, the Urban Indian Health Center, and in Western Nebraska - NAF, Panhandle Community Services Health Center, Northwest Community Action, and the Mark Monroe Health Center. Please refer to Section 9.9, specifically the sections regarding outside meetings in which HHSS staff have participated. HHSS staff have traveled to a wide variety of locations to meet with a broad range of organizations and interests to begin discussing the outreach needs for this 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: Currently there is no public private partnership providing coverage for Nebraska children.

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))

Phase II of the Title XXI plan will expand eligibility for children through age 18 up to 185% of the federal poverty level. The outreach efforts currently employed by the agency will be continued or enhanced. Also refer to Section 9.9.

Promotional materials will be developed and provided to community agencies, schools, and local offices to use to outreach to families. Several options are being considered for a toll-free help line for this program. Other health/medical help lines will be targeted to receive Kids Connection information to include in their inventory of information on financial resources.

Title V/MCH Block Grant community-based grantees are planning their programs for the upcoming year with Kids Connection in mind. As providers of services geared toward low-income and uninsured families, these grantees want to assure they are able to do their part to recruit uninsured children where they live, play, and go to school and church. Dialogue regarding Kids Connection has been ongoing between state-level Title V staff and their grantees since last fall to help educate community-level programs on this new program and their role in it. Three grantees have even held community forums to begin discussing and educating themselves on the impact this program can have on their community. Title V grantees have also contacted each other to find out strategies that they will be using to reach out to this growing uninsured population of children to assure the success of Kids

Connection. State-level Title V staff have also been involved since last fall in the planning of Kids Connection.

Current sites of presumptive eligibility for pregnant women will be recruited and trained to take applications for children through age 18 years. In order for children to access Medicaid/Kids Connection through a 'single entry' point, the presumptive eligibility form will be changed to accomplish two purposes. It will be changed to a two-page application for presumptive eligibility and can be, if the family so chooses, the application for Medicaid/Kids Connection. Current outstationed eligibility sites will also receive the eligibility information to enable them to take applications children though age 18.

Because many of the current presumptive eligibility providers are Title V-funded, they are already aware of Kids Connection and are preparing to broaden the marketing of their program to find uninsured children where they live.

A work group charged with developing a plan for presumptive eligibility activities convened as a result of public Kids Connection team meetings. This work group has made recommendations to the Nebraska Health and Human Services System on possible partners for outreach. These recommendations include the following agencies or organizations that could provide outreach to the potentially eligible: community action agencies, child care providers, refugee resettlement sites; human service agencies, homeless/runaway shelters, domestic violence/emergency shelters, family preservation and support teams, reproductive health clinics, faith communities, social security offices, employers, job service offices, employee assistance programs, WIC offices, Early Intervention service coordinators, community mental health providers, food pantries and distribution centers, soup kitchens, immunization clinics, child-serving recreational programs (Boy Scout/Girl Scout, YMCA, etc.), Head Starts and Early Head Starts, Child Care Food Program sponsors, minority advocacy programs, HUD housing authorities, county extension programs, community colleges, technical training programs, GED programs, juvenile court officers, school nurses, and parent/teacher organizations.

In addition to presumptive eligibility for children, Kids Connection - as a Medicaid expansion program - will also offer twelve-month continuous eligibility. This will ensure continuity of care for children and should improve access to care by assuring providers they will be paid for services for at least 12 months. This feature is supported by both provider groups and client advocacy groups.

Mail-in applications will continue. The feasibility and cost/benefit of phone-in applications, extended hours at eligibility offices, and other open access

strategies will be explored with the local office eligibility workgroup which has representatives from all six service areas of HHSS.

Outreach and promotional efforts will also be extended to providers of services. This will be done in collaboration with the Nebraska Chapter of the American Academy of Pediatrics and Nebraska Chapter of the American Academy of Family Practice. See Appendix A for provider outreach letters sent to physicians in May 1998 and to other providers in June 1998.

Efforts will continue to identify dental providers not enrolled or who have a very limited number of Medicaid clients, and who practice in underserved dental areas. Dentists will receive personal invitations to participate or to increase participation. A survey to dentists regarding Kids Connection and the need for increased access was mailed in May 1998. Compilation of responses will follow. See Appendix B for a copy of the survey. This has begun in collaboration with the Nebraska Dental Association.

Children with special health care needs will continue to be identified and enrolled in Medicaid/Kids Connection through the same avenues as are currently being used. Staff within the Medically Handicapped Children's Program, Early Intervention, and CHOICES (Children's Healthcare Options Improved Through Collaborative Efforts and Services) program will be informed of the new rules and regulations surrounding Kids Connection, as well as the additional locations within communities that can be accessed for enrollment.

Focus groups and key informant interviews will be utilized to obtain the customers' and providers' input and assistance in communicating with hard-to-reach populations, to identify needs specific to this group, and to determine methods and resources to address those needs.

Head Start and Early Head Start providers in Nebraska are eager to assist in providing outreach to families with uninsured children. Representatives from the Head Start community have been involved with the planning of Kids Connection since last fall, and these programs will play an integral role in identifying and enrolling children of all ages in Kids Connection. Coordination with schools in Nebraska has been a priority in planning for Kids Connection. Discussions with Nebraska Department of Education administrators, school officials and local school boards have helped to gain the support and involvement of educational institutions. Strategies identified thus far around school activities include adding information about Kids Connection, including the mail-in application form, to the summer mailings and news releases regarding eligibility for free or reduced-price meals, determining the most effective locations to provide presumptive eligibility for children, and

developing protocols for participation in outreach for Kids Connection by school nurses, counselors, coaches, special education staff, and Early Intervention service coordinators. Presentations on Kids Connection by HHSS staff to the Nebraska Association of School Boards are scheduled for the following dates and locations: August 31, Valentine, NE; September 1, Gering, NE; September 2, North Platte; September 3, Kearney, NE; September 15, Auburn, NE; September 16, York, NE; September 22, Norfolk, NE; September 29, Fremont, NE.

Special emphasis will be made to reach out to minority groups and organizations representing clients. A list of state and local organizations which may have an interest in enrolling children in Kids Connection will be compiled, to be used as a data base for mailings regarding Kids Connection and to request assistance in promoting the program, and increasing enrollment and participation in the program.

Planning for Kids Connection currently includes the development of community-based networks for outreach to and referral of uninsured children. The Nebraska Health and Human Services System has been in contact with identified community-level partners for outreach statewide, providing preliminary information and gauging interest in the varying roles each partner could have in the outreach/presumptive eligibility/enrollment process. HHSS staff in local offices are providing valuable insight about which community-based partners have the best access to and ability to attract children who are potentially eligible for the program. HHSS staff are currently planning "talking points" outlines and outreach material to share with providers, community organizations, local agencies, and other interested groups in an effort to provide uniform and timely information.

Training efforts are being planned for presumptive eligibility qualified entities. A determination of which pediatric providers serve the highest number of children in each county will help identify potential presumptive eligibility providers for recruitment efforts.

Since Nebraska's Title XXI chosen option is a Medicaid expansion and there are no other state-only or public-private partnership insurance programs enrolling only children, there will be no need for a referral mechanism at this time. Coordination with outstationed eligibility services has already been addressed in Sections 2.2.1 and 5.1.

Vaccines for Children

Since targeted low income children will be provided coverage through the Medicaid expansions, these children will receive the same benefits as other

children receiving coverage under the Nebraska Medicaid Program. This includes full coverage of Vaccine for Children benefits.

Potential for Substitution

Although Nebraska's Title XXI proposal will expand Medicaid to cover all uninsured children age 18 and younger with family incomes at or below 185 percent of the federal poverty level, it is not anticipated that there will be a significant crowd-out effect - families substituting Kids Connection coverage for family coverage. Crowd-out is not anticipated because family coverage for persons in this income group is not affordable. The national rate of family health insurance premiums is estimated to be in excess of $3,500 annually. It is unlikely that employers provide family health insurance to workers earning wage rates that are consistent with an income of 185 percent of FPL (an income of $25,253 for a family of three or $30,433 for a family of four), especially given the relatively large number of small businesses in the State. Therefore, substitution is not likely despite the relatively high overall level of health insurance in Nebraska, broader benefit coverage for children under Medicaid and the adoption of Kids Connection name, which may be more palatable to some families than Medicaid.

While HHSS staff do not anticipate crowd-out to be a significant issue for Kids Connection, LB 1063 (mentioned previously) establishes a committee to study the implementation of Kids Connection as Nebraska's Title XXI program and other alternatives for implementing Title XXI, including the use of private health insurance. The committee's report is due to the Legislature by September 1, 2000 and must address the number of children moving from private insurance programs to Kids Connection; a comparison between the costs and coverages of Kids Connection and the private health insurance market in implementing Title XXI; and recommendations regarding the continued funding and future provision of health insurance for children eligible under LB 1063.

Should crowd out prove to be an issue that needs to be remedied, the Health and Human Services system will consider appropriate action, such as a three-month or six-month waiting period, premiums, copayments, or tax credits to families who maintain private coverage. These items would have to be authorized in statute.

Furthermore, HHSS staff believe that the substitution will be insignificant based on the experience in Minnesota and Florida. Like Nebraska, Minnesota has a relatively high rate of insurance coverage. Also, both states have programs that have more friendly sounding names, Minnesota's MinnesotaCare and Florida's Healthy Kids. While the benefits may be slightly

less than the benefits under Kids Connection, both programs have eligibility levels above the federal minimum: Florida's is 185 percent of FPL and Minnesota's 275 percent of FPL. Despite these high coverage levels and attractive program names, there is little evidence that the crowd-out of these programs was significant:

A study in the October 1997 Journal of the American Medical Association (JAMA) found that only three percent of MinnesotaCare enrollees previously had employer-based coverage and only four percent had individually purchased insurance before enrolling in the state program.

A September 1997 study found that only two percent of children in Florida's Healthy Kids program had previous employer-based coverage and one percent had individually purchased insurance at any time during the year before enrollment.

Also, a study by the Alpha Center reported that officials in states that expanded health coverage did not find crowd-out to be a genuine problem in programs for children or for people with incomes up to 200 percent of the federal poverty level.

Therefore, while there may be some substitution of coverage in the short run, it is anticipated that it will be no more than two to three percent.

In the long run, there may be greater impact, but the state will monitor this issue. However, even in the longer run there is reason to believe that Medicaid coverage will only make up for reduced employer-based coverage of families and dependents. As pointed out by the Children's Defense Fund: "Employer-based coverage of children has dropped steadily year after year since the mid-1970s, whether Medicaid coverage of children was increasing, decreasing, or stagnant. In February 1997, the General Accounting Office (GAO) reported that three of five studies found no relationship between Medicaid expansions and declining private coverage. Of the two studies finding a relationship, one candidly admitted that losses in children's employer-based coverage could be unrelated to Medicaid.

Employers cut health benefits because of competitive pressure for cost-control, not changed public benefits rules. The 1997 GAO report also found that private coverage has fallen nearly twice as quickly for children as for the population as a whole because economic forces cause employers to limit employee benefits to workers alone rather than helping employees' families. Few employees replace coverage of spouses and children with coverage of children alone. Most employer-sponsored family insurance covers the spouse, not just children. Few families would shift from such dependent coverage to a

new child health program if that move would end coverage for the worker's spouse."

The State anticipates that Nebraska's employers and families are likely to respond in the same way that the studies and rationale listed above indicate. Nebraska's rate of uninsured non-elderly has more than doubled in the past decade despite the state's low unemployment rate and the need for employers to compete for workers. Any likely continued reductions in employer offerings of fringe benefits such as health insurance, and the inability of employees to afford family coverage of health insurance, will be due to other causes such as premium increases. It will not be influenced by the mere availability of children's health coverage through Kids Connection.

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

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

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

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

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

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

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:
- 4.1.2. ☐ Age:
- 4.1.3. ☐ Income:
- 4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):
- 4.1.5. ☐ Residency (so long as residency requirement is not based on length of time in state) :
- 4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):
- 4.1.7. ☐ Access to or coverage under other health coverage:
- 4.1.8. ☐ Duration of eligibility:
- 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)

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☒ Check here if this section does not apply to your state.

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 a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))

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

4.4.4.2. ☒ 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. ☒ 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)) (42CFR 457.90)

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))** LB 1063, which was passed by the 1998 Nebraska Legislature and signed into law by Governor Nelson on April 13, 1998, contains various provisions related to the Children's Health Insurance Program in Nebraska. LB 1070, also passed by the 1998 Nebraska Legislature, provides for the Children's Health Insurance Trust Fund, and also contains other provisions related to Children's Health Insurance.

LB 1063 requires each public school district to provide written information to every student describing the availability of services under Kids Connection. This information (to be provided by HHS and HHS Finance & Support) must be distributed annually, at the beginning of the school year.

LB 1063 requires each hospital to provide written information about Kids Connection to the mother of every child born in the hospital at the time of birth. The written information is to be provided by HHS and HHS Finance & Support and will describe the availability of health services under Kids Connection.

LB 1063 requires the Director of Health and Human Services and the Director of Finance and Support to develop and implement other activities designed to increase public awareness of the availability of health services under Kids Connection. These activities may include public service announcements, the development and distribution of printed materials describing the program, periodically locating agency staff at public health sites outside the HHSS offices to receive applications for the program, contracting with organizations to assist the public in applying for Kids Connection benefits and to receive referrals for medical services as deemed necessary, and other activities deemed appropriate by the Directors. These activities will include materials and efforts designed to increase participation in the program by minority populations.

LB 1063 requires the Department to establish a toll-free help line for this

program. The help line is already operational.

LB 1070 provides funding that may be used for hiring school nurses by educational service units, school districts, public health entities, or partnerships between schools and public health entities, with one purpose being to identify children for Medicaid eligibility.

LB 1070 authorizes HHS to contract with health clinics of Nebraska's federally recognized Native American tribes, Indian health organizations, or other public health organizations that have a substantial Native American clientele, to provide educational and public health services targeted to Native American populations. The activities include identifying and enrolling children in state and federal programs providing access to health insurance and health care, including Medicaid and Kids Connection.

Outreach efforts for Phase I of Kids Connection will continue. These include:

1. Using a shortened, single-purpose Medicaid application form;
2. Allowing mail-in application forms;
3. Improving access by not requiring a resource test for this group of children;
4. Working with advocacy agencies in disseminating information on Medicaid eligibility, the application process, etc. to the low income community; and
5. Using informational pamphlets.

For additional information on outreach efforts, please refer to sections 2.2.1 and 2.3.

LB 603, which was passed by the 2009 Nebraska Legislature and signed into law by Governor Heineman on May 22, 2009, contains a provision to include as eligible for Medical Assistance under Title XXI, children under nineteen years of age with a family income equal to or less than two hundred percent (200%) of the OMB Income Poverty Guideline. LB603 will become effective September 1, 2009, and will be codified at Nebraska Revised Statutes Sec. 68-915.

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

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

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

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

6.2.2. ☐ Outpatient services (Section 2110(a)(2))

6.2.3. ☐ Physician services (Section 2110(a)(3))

6.2.4. ☐ Surgical services (Section 2110(a)(4))

6.2.5. ☐ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6. ☐ Prescription drugs (Section 2110(a)(6))

6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☐ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. ☐ Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))

6.2.10. ☐ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

6.2.11. ☐ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

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

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

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

6.2.15. ☐ Nursing care services (See instructions) (Section 2110(a)(15))
6.2.16. ☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)
6.2.17. ☐ Dental services (Section 2110(a)(17))
6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
6.2.19. ☐ Outpatient substance abuse treatment services (Section 2110(a)(19))
6.2.20. ☐ Case management services (Section 2110(a)(20))
6.2.21. ☐ Care coordination services (Section 2110(a)(21))
6.2.22. ☐ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
6.2.23. ☐ Hospice care (Section 2110(a)(23))
6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))
6.2.26. ☐ Medical transportation (Section 2110(a)(26))
6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3 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

☒ 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: (2102(a)(7)(B)) (42CFR 457.495)

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

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

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

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

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

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

8.1. Is cost-sharing imposed on any of the children covered under the plan? (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:
8.2.3. Coinsurance or copayments:
8.2.4. Other:

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

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

8.4.1. ☐ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)
8.4.2. ☐ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)
8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

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

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

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

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))

*Phase III is defined as expanding Medicaid program eligibility for uninsured children who are under 19 years of age and whose families have incomes equal to or less than **200%** of the federal poverty level. LB 603 which provides authorization to cover children whose family income does not exceed **200%** of the FPL was signed into law on May 22, 2009.*

Phase II is defined as expanding Medicaid program eligibility for uninsured children who are under 19 years of age and whose families have incomes equal to or less than 185% of the federal poverty level. LB 1063 which provides authorization for Kids Connection was signed into law on April 13, 1998.

Phase I, defined as expanding Medicaid program eligibility for uninsured youth who are under 19 years of age, born on or before September 30, 1983, and whose families have incomes equal to or less than 100% of the federal poverty level, was submitted previously.

STRATEGIC OBJECTIVE #1: Reduce the number of uninsured children in Nebraska by providing health care coverage through Medicaid/Kids Connection Program.

STRATEGIC OBJECTIVE #2: Create the HHS System infrastructure for determining and tracking those children eligible under Medicaid/Kids Connection.

STRATEGIC OBJECTIVE #3: For those children participating in Medicaid Managed Care, provide clients with a medical home through a primary care provider under Managed Care. Note: Under Nebraska's Medicaid Managed Care program, clients are enrolled into the medical/surgical plans by the enrollment broker.

STRATEGIC OBJECTIVE #4: Increase children's access to primary care providers.

STRATEGIC OBJECTIVE #5: Improve children's health outcomes through proxy measures of well-child visits, dental care, visual care, and hearing.

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

Performance Goal 1.1: Market the Medicaid/Kids Connection Program.

Performance Goal 1.2: Determine children eligible for Medicaid/Kids Connection under the new income eligibility guidelines. This is estimated to be 24,000 children.

Performance Goal 2.1: Make needed systems changes in the N-Focus Eligibility Data System.

Performance Goal 2.2: Hire needed eligibility staff to implement this program.

Performance Goal 2.3: Train eligibility staff on the new eligibility guidelines and systems changes.

Performance Goal 2.4: Offer a streamlined method of entry for Medicaid/Kids Connection applications.

Performance Goal 3.1: Clients mandatory for Medicaid Managed Care will be actively enrolled on a priority basis by the enrollment broker, Access Medicaid.

Performance Goal 4.1: Recruit new Medicaid health care providers.

Performance Goal 4.2: Address barriers voiced by providers who are reluctant to become Medicaid providers or who are reluctant to take additional patients.

Performance Goal 5.1: Increase access of previously uninsured children to well-child care through EPSDT/HEALTH CHECK.

Performance Goal 5.2: Increase children's access to dental services.

Performance Goal 5.3: Increase children's access to visual care.

Performance Goal 5.4: Increase children's access to hearing screenings.

Performance Goal 5.5: Promote better outcomes for children with asthma through promotion of comprehensive quality care.

Performance Goal 5.6: Promote better outcomes for children with diabetes through promotion of comprehensive quality care.

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

Measure 1.1.1:
A. By July 1, 1998, 10 informational sessions will be delivered to targeted groups of clients, health care providers, and community partner/client advocate groups.

B. By July 1, 1999, 10 additional informational sessions will be delivered to targeted groups of clients, health care providers, and community partner/client advocate groups.

C. By July 1, 2000, 10 additional informational sessions will be delivered to targeted groups of clients, health care providers, and community partner/client advocate groups.

Measure 1.1.2:
A. By August 1, 1998, an ongoing distribution system for education/marketing materials will be approved by Nebraska HHS System.

B. By August 1, 1999, the above plan will be reviewed and updated based on feedback from providers and clients.

Measure 1.2.1: By December 31, 1998, eligibility will be determined for 25% of the estimated group of 950 children who may qualify for Medicaid/Kids Connection identified for Phase I.

Measure 1.2.2: By July 1, 1999, eligibility will be determined for 50% of the estimated group of 950 children who may qualify for Medicaid/Kids Connection identified for Phase I.

Measure 1.2.3: By June 30, 1999, eligibility will be determined for 12,000 additional children who qualify for Medicaid/Kids Connection, over the number eligible in April 1998.

Measure 1.2.4: By June 30, 2000, eligibility will be determined for 18,000 additional children who qualify for Medicaid/Kids Connection, over the number eligible on April 1998.

Measure 2.1.1: By September 1, 1998, systems changes related to the new income eligibility guidelines for Medicaid/Kids Connection will be functioning.

Measure 2.1.2: On December 31, 1999, a report will be issued detailing numbers of children enrolled by county/region from the N-Focus data.

Measure 2.1.3: On December 31, 2000, a report will be issued detailing numbers of children enrolled by county/region from the N-Focus data.

Measure 2.2.1: By September 1, 1998, 2 additional eligibility staff will be hired in the HHSS system.

Measure 2.2.2: By September 1, 1999, 17 eligibility staff will be hired to accommodate the increased numbers of children enrolling in Medicaid/Kids Connection.

Measure 2.3.1: By September 1, 1998, training will have been offered in all six HHS service delivery areas.

Measure 2.3.2: By September 1, 1999, training will be offered in all six HHS service delivery areas to accommodate the new staff hired to enroll the increased numbers of children.

Measure 2.4.1: By September 1, 1998, develop and implement a shortened single purpose eligibility form for applications for Medicaid/Kids Connection.

Measure 2.4.2: By January 1, 1998, identify and develop a training plan for non-HHS eligibility sites that will accept applications for Medicaid/Kids Connection.

Measure 2.4.3: By April 1, 1999, 3 non-HHS eligibility sites (1 each location) will accept applications for Medicaid/Kids Connection.

Measure 2.4.4: By January 1, 2000, at least 7 additional non-HHS sites (one each location) will accept applications for Medicaid/Kids Connection.

Measure 3.1.1: By September 1, 1999, 70% of the children identified as mandatory for managed care under the Phase I Plan will be enrolled into managed care within 90 days following the date they are found eligible for Medicaid.

Measure 3.1.2: By September 1, 2000, 70% of children identified as mandatory for managed care will be enrolled into managed care within 90 days following the date they are found eligible for Medicaid.

Measure 4.1.1: By December 31, 1998, develop a plan to exceed the current participation rate (83.7%) of physicians providing services to Medicaid-eligible children.

Measure 4.1.2: By December 31, 1999 and by December 31, 2000, the numbers of physicians providing services to Medicaid eligible children will be increased from the previous year.

Measure 4.1.3: By December 31, 1999 and by December 31, 2000, the numbers of dentists providing services to Medicaid eligible children will be increased from the previous year.

Measure 4.2.1: By September 1, 1998, regulations authorizing HHS to offer 12-month continuous eligibility for children will be finalized.

Measure 4.2.2: By September 1, 1998, regulations authorizing HHS to offer presumptive eligibility to children will be finalized.

Measure 5.1.1: By September 30, 1999, children will have equal or more well-child care visits per 1000 eligibles compared to the previous 12 months for the same age group (Phase I children).

Measure 5.1.2: By September 30, 2000, children will have equal or more well-child care visits per 1000 eligibles compared to the previous 12 months for the same age group (Phase I and Phase II children).

Measure 5.2.1:
A. By September 30, 1999, children will have equal or more preventive dental care visits per 1000 eligible children compared to the previous 12 months for the same age group (Phase I and Phase II children).

B. By September 30, 2000, children will have equal or more preventive dental care visits per 1000 eligible children compared to the previous 12 months for the same age group (Phase I and Phase II children).

Measure 5.2.2:
A. By September 30, 1999, children will have equal or more treatment dental care visits per 1000 eligible children compared to the previous 12 months for the same age group (Phase I children).

B. By September 30, 2000, children will have equal or more treatment dental care visits per 1000 eligible children compared to the previous 12 months for the same age group (Phase I and Phase II children).

Measure 5.3.1:
A. By September 30, 1999, children will have equal or more visual care check ups per 1000 eligible children compared to the previous 12 months for the same age group (Phase I children).

B. By September 30, 2000, children will have equal or more visual care check ups per 1000 eligible children compared to the previous 12 months for the same age group (Phase I and Phase II children).

Measure 5.3.2:
A. By September 30, 1999, children will have equal or more prescriptive lenses per 1000 eligible children compared to the previous 12 months for the same age group (Phase I children).

B. By September 30, 2000, children will have equal or more prescriptive lenses per 1000 eligible children compared to the previous 12 months for the same age group (Phase I and Phase II children).

Measure 5.4.1: By July 1, 2000, HHS staff will develop a plan for tracking data for the state's recommended plan for newborn hearing screening (if such a state plan is developed as of that date).

Measure 5.5.1: By July 1, 1999, the Medicaid Quality Assurance Subcommittee on Asthma in Children will identify and distribute standards of care to all Medicaid providers caring for children.

Measure 5.5.2: By July 1, 2000, the number of emergency room visits/1000 children with asthma compared to the previous year will decrease.

Measure 5.5.3: By July 1, 2000, the number of acute inpatient hospital admissions/1000 children with asthma compared to the previous year will decrease.

Measure 5.5.4: By July 1, 2000, the number of practitioner office visits/1000 children with asthma compared to the previous year will increase.

Measure 5.6.1: By July 1, 1999, the Medicaid Quality Assurance Subcommittee on Diabetes will identify and distribute standards of care to all Medicaid providers caring for children.

Measure 5.6.2: By July 1, 2000, the number of emergency room visits/1000 children with diabetes compared to the previous year will decrease.

Measure 5.6.3: By July 1, 2000, the number of acute inpatient hospital admissions/1000 children with diabetes compared to the previous year will decrease.

Measure 5.6.4: By July 1, 2000, the number of physician office visits/1000 children with diabetes compared to the previous year will increase.

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

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

9.3.8. ☐ Performance measures for special targeted populations.

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

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

The State will comply with the required annual assessments and the evaluation required by March 31, 2000. HHSS Finance and Support staff will support this program and will develop any evaluations and reports required by HCFA(CMS). If outside services are required for any of these reports, the agency may be required to obtain these services through the RFP process, and cannot, at this time, identify who would perform the services.

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

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

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

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

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))

The State of Nebraska involved the public in the design and implementation of Kids

Connection in the following manner:

Kids Connection Committee: The State Medicaid Director convened a committee to address design and implementation of Kids Connection, Nebraska's Children's Health Initiative. This group was composed of Health and Human Services System staff as well as representatives of United Health Care, Mutual of Omaha, HMO Nebraska (Blue Cross/Blue Shield of Nebraska), a marketing advisor, Polk County Health Department, Lincoln/Lancaster County Health Department Access Medicaid, Blue Valley Community Action, Primary Care Services, University of Nebraska Medical Center Pediatrics, Indian-Chicano Health Center, Association of Community Action Agencies, Governor's Office, Department of Administrative Services' Budget Office, Nebraska Association of Hospitals and Health Care Systems, Nebraska Medical Association, Voices for Children, Iowa/Nebraska Primary Care Association, Appleseed Association, State Senator Chris Beutler, Head Start, Wellness Option, Children's Hospital and Health Center, Nemaha County Health Department, CATCH Program, Winnebago Maternal and Child Health; and the Urban Indian Health Center. The Health and Human Services System staff represent a broad spectrum from the three agencies, Services, Regulation & Licensure, and Finance & Support. The team has met on the following dates: October 2,9, 16, 30, November 6, 13 and 20, December 4 and 18, 1997; January 15, February 5 and 19, March 5 and 19, and April 2, 16, and 30, 1998. On-going twice-monthly meetings are planned to continue work on development and implementation of the State's Children's Health Insurance Program.

The team identified work groups for the following areas:
1. Marketing and Outreach
2. Presumptive Eligibility
3. State Eligibility
4. Systems
5. Managed Care and Rural Nebraska
6. Federal Plan
7. Local Office

The activity level of these groups will vary throughout the planning and implementation phases of the Children's Health program.

News Release on October 2, 1997: Governor Ben Nelson announced that he would propose during the next legislative session development of a health care plan for Nebraska's low-income children. Nebraska will take advantage of federal funding of approximately $14.8 million during fiscal year 1998 to create expanded health insurance coverage for uninsured children under the federal Balanced Budget Act of 1997. The plan will -

- improve access to quality health care and promote continuity of care;

- cover as many young Nebraskans as possible in a cost-effective manner; and
- improve the health of children by providing preventive care and treatment.

Expanding health care services for uninsured children is a significant component of Governor Nelson's Success 2000 program. It builds on the Governor's Nebraska Good Beginnings program, which emphasizes improved access to community-based services that promote the development of strong families and healthy children from birth to age two. First Lady Diane Nelson has been the honorary chair of the Good Beginnings program since its inception in 1992.

Legislative hearing On 10/31/97: The Nebraska Legislature held a hearing to consider Legislative Resolution 186, introduced in the 1997 Legislative session. The purpose of this resolution is to study health care availability for uninsured children. Because of the ensuing passage of the Balanced Budget Act of 1997, including the State Children's Health Insurance Program (SCHIP), this hearing became a forum to consider the proposed Children's Health Initiative in Nebraska. Individuals testifying at this hearing included: Senator Chris Beutler; Jeff Elliott, Director of Finance & Support - who described the framework for expanding Medicaid to include targeted low income children under Title XXI; Steve Frederick, HAS Finance & Support; Marcia Spilker, Nebraska Association of School Nurses; Allen Dvorak, M. D., president of the Nebraska Medical Association; Kris Morrissey, Director of Policy with Voices for Children in Nebraska; David Corbin, Ph.D., President of the Nebraska Public Health Association; Ric Compton, Medicaid Administrator; Lorrie Benson, Executive Director of Nebraska Community Action Agencies; Randy Boldt, Blue Cross/Blue Shield of Nebraska; Stacie Bleicher, M.D., president of the Nebraska chapter of the American Academy of Pediatrics; Dick Netley, parent of a consumer; Father Val Peter of Boys Town; Bill Arfman, Director of NAPE/AFSME; Mike Zgud, Chair of the Board of Directors of NAPE/AFSME; Sister Norita Cooney, chair of the Board of Alegant Health; Donna Polk, Executive Director of Nebraska Urban Indian Health; Dennis DeRoin, M.D., Nebraska Academy of Family Physicians; Natalie Clark, Executive Director of the Lancaster County Medical Society; Earl Brown, member of the Nebraska Medicaid Client Advisory Group; Ann Oertwich, Executive Director of the Nebraska Nurses' Association; Roger Keetle, Nebraska Association of Hospitals and Health Systems; Merv Riepe, Executive Director of the Children's Health Network; Jay and Peggy Chasen, citizens; and Tom Bassett, Executive Director of the Nebraska Dental Association. The testimony presented at this hearing was generally supportive of the proposed Children's Health Insurance Program. .

Joint Statement On Children's Health: On December 15, 1997, Governor Ben Nelson announced the release of a Joint Statement on Comprehensive Health for Nebraska Children and Youth. The statement was developed over the past 18 months by the Nebraska Health and Human Services System, Nebraska Chapter of the American Academy of Pediatrics, Nebraska Academy of Family Physicians, and Voices for

Children in Nebraska. The statement called for a partnership with families, health care providers, businesses, insurers and government to ensure the health and well-being of children and their families.

Public Hearing On December 18, 1997: The Health and Human Services System held a public hearing on proposed rules that would expand Medicaid eligibility for children age 15 to 18 years old up to 100% of federal poverty level (phase 1 of the Children's Health Initiative). This is the initial phase of Nebraska's plan to implement Title XXI of the Social Security Act. A notice of rulemaking was published on November 17, 1997 in the Omaha World Herald.

News Conference On January 8, 1998: The Governor held a news conference on the Children's Health Plan on January 8, 1998, at Beals School in Omaha. The purpose of this news conference was to announce his plan to provide health care coverage to Nebraska children who are not insured because of low income. The program, named Kids Connection, is part of the Governor's Success 2000 agenda, and one of his initiatives for the 1998 session of the Nebraska Legislature. Kids Connection would improve access to quality health care and promote continuity of care, cover as many young Nebraskans as possible in a cost-effective manner, and improve the health of children by providing preventive care and treatment.

State of the State Address on January 12, 1998: In his state of the state address, Governor Nelson emphasized the importance of making sure Nebraska's children are growing up healthy. With a focus on children and families, the Governor proposed the Kids Connection program (under Title XXI of the Social Security Act) to provide Nebraska's children with basic health coverage by using existing state funds to match new federal funding. The state funding for Kids Connection is part of a new health trust fund, another Success 2000 initiative. This fund is designed to slow the rapid rise in health care costs by making sure appropriate care is available across the state.

News Conference on April 13, 1998: Governor Nelson signed LB 1063, which expands health care coverage for children up to 185 % of the federal poverty level under a new program called Kids Connection. Governor Nelson signed the legislation surrounded by children at the University Child Care program housed at Lincoln's YWCA.

Public Hearing on July 2, 1998: A rulemaking hearing was held on July 2, 1998, to consider proposed regulations related to Kids Connection, including eligibility for children through age 18 up to 185% of the federal poverty level and 12-month continuous eligibility. A notice of this hearing was published in the Omaha World Herald and Lincoln Journal Star on June 15, 1998.

Outside Meetings: Health and Human Services System staff have been involved in the

following meetings or presentations to discuss Kids Connection (this is not an all-inclusive list):

The Policy Secretary has participated in the following meetings, appearances, etc. regarding Kids Connection:

December 11 - Kids Count
December 15 - Access Medicaid
December 17 - Meeting with Governor Nelson
December 18 - Nebraska Partnership Council
December 23 - Meeting with Senators Beutler, Landis and Wesely, and Tim Becker, Governor's Chief of Staff
January 8 - Governor's Press Conference on SCHIP
January 9 - Governor's Committee for Protection of Children
January 14 - Lincoln Bridge Team
January 14 - Nebraska Health Care Association
January 24 - Southeast Nebraska Rural Physicians Association (SERPA)
January 28 - CAP and Local Health Directors
January 28 - CAP and Local Health Directors
January 28 - Report to Senator Beutler
January 29 - Legislative Hearing on Children's Health Insurance
February 9 - Meeting with Natalie Clark, Lancaster Co. Medical Association.
February 9 - Meeting with Senators Landis, Suttle, and Wesely
February 17 - Meeting with Senator Beutler
February 27 - Blue Ribbon Commission Meeting
March 6 - Meeting with Senator Beutler
March 6 - Meeting with Senator Wesely's Office
March 24 - Meeting with Senator Beutler
April 13 - Signing of LB 1063 at University Child Care Center

Steve Frederick, Strategic and Financial Planning (in addition to public hearings and other meetings):

August and September: Three meetings were held with Blue Cross/Blue Shield, Don Macke, and Don Leuenberger (Policy Secretary at the time) and Nebraska Community Development about developing a Caring Program in light of Title XXI.
September 18: Health and Human Services System Partnership Meeting in Chadron
October 16: HHS Partnership Health and Well-Being Subcommittee Meeting
November 5 and 19: Children's Health Clinic Meeting in Omaha
February 11: Meeting with Northeast Area Hospital Administrators in Norfolk to discuss Title XXI proposal (Note: Four other meetings were held in Scottsbluff, North Platte, Geneva, and Kearney where Dennis Mohatt and Dave Palm presented on Title XXI.)

Tom Ryan, Project Manager for Kids Connection, participated in the following:

- March 26: Presentation to approximately 600 members of the Nebraska Rural Community Schools Association in Kearney
- April 17: Meeting with representatives of the Ponca Tribe (with Jane Elliott)
- April 17: Conference call with approximately 12 Nebraska WIC directors
- April 21 and 22: Area meetings with the Nebraska Association of Hospitals and Health Systems in Lincoln and Norfolk (in addition, Ric Compton participated in similar meetings in Ogallala (in person) and in Kearney (via video)
- April 28: Meeting with representatives of the Santee Sioux Tribe (with Jane Elliott)
- May 2: Meeting with pediatricians' office managers in Lincoln (with Sandi Kahlandt and Lorelee Novak)
- May 8: Presentation to the Nebraska Podiatric Medicine Association in Omaha (with Jane Elliott) May 8: Presentation to the Nebraska Indian Affairs Commission in South Sioux City (with Jane Elliott)
- June 4: Presentation to the Nebraska Medicaid Medical Care Advisory Committee on Kids Connection
- June 30: Meeting in Bridgeport, NE with the Panhandle Partnership Council at their invitation to discuss Kids Connection (with Jane Elliott and Bill Wiley)
- July 6: Meeting in South Sioux City with NAF Multicultural Human Development Corporation to discuss outreach efforts for local minority populations
- July 6: Meeting in South Sioux City with the South Sioux City Public Schools and the community resource coordinator for IBP to discuss Kids Connection and outreach activities
- July 13: Meeting in Columbus with the Columbus Community Hospital to discuss outreach efforts for local minority populations
- July 17: Meeting with Fred Wright Director of the Urban League of Nebraska to discuss providing information to individuals who come into contact with this organization
- July 18: Meeting with the board of the Nebraska Counseling Association in Kearney to brief them on Kids Connection and to ask for their support and ideas on outreach
- July 21: Meeting with Mary Lee Fitzsimmons, director of the Indian-Chicano Health Center in Omaha to discuss Kids Connection and outreach activities

In addition to meetings with Tom Ryan, Jane Elliott has participated in the following meetings:

- June 22: Jane and LoreLee Novak (HHS F&S) met with Robert Sellars at the Charles Drew Center in Omaha to discuss Kids Connection, outreach,

applications, and presumptive eligibility
June 22: Jane and Lorelee met with Sherriann Moore, Administrator of the Ponca Health and Wellness Center in Omaha and her staff; they discuss Kids Connection, outreach, applications, and presumptive eligibility.
July 20: Jane met with Dr. Hieu and staff at the Shelton Medicaid Clinic in Shelton to discuss Kids Connection and presumptive eligibility

This is not an all-inclusive list; other HHSS staff have also participated in meetings related to Kids Connection that are not listed in this document.

Staff in the Governor's Policy Research Office have also participated in outside meetings related to Kids Connection. Jennifer Williams Brinkman participated in the following meetings:

9/11-9/12 - National Governor's Association Children's Health Insurance Program Conference in Washington, D.C.
9/19 - Meeting with Senators Chris Butler, Don Wesely and David Landis, Tim Becker, Don Leuenberger, Steve Frederick
11/07 - Commission for the Protection of Children
11/14 - Child Care and Early Childhood Education and Coordinating Committee (CCECECC)
11/17 - Meeting with Randy Boldt of Blue Cross/Blue Shield
11/20 - Head Start State Collaboration Team
1/9 - HHS Regional Conference on Children's Health Insurance Program in Kansas City, MO
2/3 - NGA Title XXI Conference Call
2/17 - Meeting with HHS Representatives and Senator Beutler
3/6 - Meeting with HHS and Senator Beutler
4/30 & 5/1 - NGA Children's Health Conference in Chicago, IL

Deleted: – – – – – – Page Break – – – – – –

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))

Response included in 9.99.9.2
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).

Response included in 9.9

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).

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)

- 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. (See Note 2)
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

The budget figures reported below are in addition to those reported in Nebraska's Phase I Plan and assume a start date of September 1, 1998.

The estimated costs used in the budget for this program are based on current Medicaid experience. Estimates were prepared on a State fiscal year basis (July 1 - June 30) and adjusted to the Federal fiscal year (FFY) for this plan. It assumes full participation in the third year with 2/3 of a full year in the first year. The second year is a midpoint between year one and year three. The cost per child is based on our current experience, adjusted down with the assumption that these children may be less expensive than the current Medicaid population. Annual increases also reflect adjust for inflation.

Approximately 1,250 new children would be added in FFY 1998; 12,450 in FFY 1999; and 16,050 in FFY 2000 due to increasing the Medicaid standard up to 185% of poverty. Program costs for children related to the change in eligibility standard are estimated at $67,200 in FFY 1998; $9,262,000 in FFY 1999; and $15,621,800 in FFY 2000.

It is estimated that approximately 250 additional children would be eligible in FFY 1998 through presumptive eligibility; 2,450 in FFY 1999; and 3, 100 in FFY 2000. Program costs for children eligible related to presumptive eligibility are estimated at $69,400 in FFY 1998; $1,912,500 in FFY 1999; and $3,040,900 in FFY 2000.

Twelve months continuous eligibility would allow eligible children to be on for 12 months before having eligibility redetermined. It is estimated that no new children would be added each month due to 12 months continuous eligibility. However, children would be eligible for medical services for longer periods of time. It is estimated that the additional months of eligibility would cost $381,000 in FFY 1999 and $600,500 in FFY 2000.

Additional staff would be needed to administer the Title XXI program, support eligibility workers, provide technical assistance to presumptive eligibility providers, approve providers, perform eligibility functions, and work with providers in the process. Outreach costs include targeted outreach, printing, mailings, computer system changes, computer support for other agencies, and managed care enrollment broker contract costs.

Administrative expenditures are anticipated to be broken down as follows:

	1st full year	2nd year and thereafter
Eligibility Determination	63%	67%
Outreach	14%	15%
Managed Care Enrollment	7%	9%
Administration	5%	6%
Systems Costs	11%	3%
Total		

The source for the state match will be state general funds and cash funds, except for the local share provided by certain providers performing part of the eligibility process. Cash funds for this program are designated for this purpose as Children's Health Insurance Case Fund per LB 1070 of the 1998 Nebraska Legislature.

	Costs FFY 1998	Costs FFY 1999	Costs FFY 2000	Persons FFY 1998	Persons FFY 1999	Persons FFY 2000
Standard Change - Children Title XXI	$67,200	$9,262,000	$15,21,800	1,250	12,450	16,050
Presumptive Eligibility Title XXI	$69,400	$1,912,500	$3,040,900	250	2,450	3,100
12-Month Cont. Elig. Title XXI	NA	$381,300	$600,500	0	0	0
Total Program Title XXI	$136,000	11,555,800	19,263,200	1,500	14,900	19,150
Admin. & Outreach	$13,600	$1,155,580	$1,926,320			
Federal Share of Program & Admin.	$108,982	$9,281,850	15,472,588			

*Note: Matching rate estimated at FFY 99 level. If expenditures exceed current year allotment, funds from prior years will be used

SCHIP Budget	
STATE:	**FFY Budget**
Federal Fiscal Year	**2010**
State's enhanced FMAP rate	**(FF) 72.39% vs (GF) 27.61%**
Benefit Costs	
Insurance payments	
Managed care (See Note 1)	$ 4,865,000
per member/per month rate	
Fee for Service (See Note 1)	51,973,000
Total Benefit Costs	**$56,838,000**
(Offsetting beneficiary cost sharing payments)	0
Net Benefit Costs	**$56,838,000**
Administration Costs	
Personnel	$3,772,423
General administration	$160,654
Contractors/Brokers	0
Claims Processing	$1,155,923
Outreach/marketing costs	(included with General Admin)
Other	0
Total Administration Costs	**$5,089,000**
10% Administrative Cap	$6,315,333
Federal Share	$45,716,698
State Share	$17,436,635
Total Costs of Approved SCHIP Plan	**$63,153,333**
The Source of State Share Funds:	**Legislative Appropriation**

NOTE 1: "Managed Care" costs include "capitation payments" only. "Carved-out Services" costs such as those for dental services and pharmaceuticals provided to children enrolled in Managed Care are included with "Fee-for-Service" benefit cost total.

NOTE 2: Expected enrollment:

2010 Estimate:	24,080
Additional per Impact Statement	5,430
TOTAL EXPECTED ENROLLMENT	29,510

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

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

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

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

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

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

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

- 11.2.1. ☐ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☐ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☐ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☐ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☐ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☐ Section 1128E (relating to the National health care fraud and abuse data collection program)

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

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

12.1. Eligibility and Enrollment Matters

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

12.2. Health Services Matters

Please describe the review process for health services matters that comply with 42 CFR 457.1120.

12.3. Premium Assistance Programs

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