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.

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

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

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

The following State officials are responsible for program administration and financial oversight

(42 CFR 457.40(c)):

Name: Meredith Nichols Position/Title: **Med-QUEST Division Administrator**
Name: Position/Title:
Name: Position/Title:

Disclosure Statement: This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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.

This request is aimed at receiving approval to amend Hawaii's Title XXI Medicaid expansion program. The State Plans to provide coverage to uninsured children under 19 whose countable family income does not exceed 200% of the Federal Poverty Level. (Refer to Attachment B – Title XXI Proposed Coverage)

On July 1, 2000, Hawaii expanded Medicaid to provide coverage for uninsured children who are under age 19 years with income not exceeding 200% of the Federal Poverty Level (FPL). The existing QUEST-Net program, one of the programs under Hawaii QUEST (QUEST), Hawaii's Medicaid Section 1115 waiver demonstration, implemented in April 1996, provided Medicaid coverage for uninsured children under age 19 with income up to 300% FPL; thus, uninsured children who become ineligible for S-CHIP could continue their coverage through QUEST-Net. In order to qualify for QUEST-Net, however, the child had to have been covered through Medicaid or S-CHIP, i.e., applicants could not participate in QUEST-Net.

Hawaii's comprehensive Section 1115 demonstration renewal, approved in January 2006, expanded S-CHIP coverage to children with income above 200%, but not exceeding 300% FPL, essentially converting funding for these QUEST-Net children from Title XIX (Medicaid) to Title XXI (S-CHIP), and eliminated the prerequisite for prior coverage.

Beginning with the renewal and expansion of Hawaii's QUEST Expanded Access Section 1115 Demonstration, as of February 1, 2008, the State will no longer receive Federal financial participation under Title XXI for expenditures for QUEST-Net children who are not covered by the S-CHIP State plan. In accordance with the renewed Demonstration's terms and conditions, the State is amending its Title XXI (S-CHIP) and Title XIX (Medicaid) State plans in order to provide eligibility to children with family incomes between 200% up to and including 300% of the FPL as optional targeted low-income children under a Medicaid Expansion S-CHIP State plan. The State is amending its Title XIX and S-CHIP State plans to increase the income limit for optional targeted low-income children to 300% of the FPL, effective January 1, 2008, in accordance with and subject to the special terms and conditions of its Section 1115 waiver.

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))**

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)**

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

Original Plan

Effective date: January 1, 2026

Implementation date: January 1, 2026

Effective Date of State Plan Amendment described in Section 1.1 of this document: No earlier than January 1, 2008.

SPA #26-0006

Purpose of SPA: Allows the State of Hawaii to use administrative funds available under Section 2105(a)(1)(D)(ii) of the Act and regulations at 42 CFR 457.10 to offer oral health screenings, education and outreach using an opt-out consent process to maximize reach. As appropriate, referrals will be made for identified urgent oral health needs.

Proposed effective date: January 1, 2026

Proposed implementation date: January 1, 2026

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

TN No: Approval Date: Effective Date:

Hawaii Med-QUEST Division/Policy & Program Development Office- Our Urban Indian Organization partner ended its contract with Indian Health Services on 04/01/2023. Attached email correspondence in “Document Demonstrating Good Faith Tribal Engagement”. Hawaii does not plan to send tribal consultation for future SPA submissions until contract is renewed.

07/04/2026 Urban Indian Organization partner confirmed that there are no plans as this time to renew contract with Indian Health Services.

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))**

CREDITABLE HEALTH COVERAGE FOR HAWAII'S CHILDREN

Hawaii's Prepaid Health Insurance Act enacted in 1974 established the mandate for Hawaii employers to provide medical benefits to all employees working an average of 20 or more hours per week. While the Act does not require dependent coverage, if offered to employees, it must provide child health services (i.e., immunizations, well-child visits) from the moment of birth through age five.

As a result of this Act, the majority of Hawaii's working population and their families have been covered by creditable medical and psychiatric benefits through employer-based health plans. In 1998, of the estimated 1.148 million people in Hawaii, 93.5%, or 1.073 million people, were covered by health benefits.

Table 1. below presents the insurance status of Hawaii's children under 18 by income levels. This data indicates that 297,022 or 94.8% of Hawaii's children under 18 were among those receiving health coverage, with 15,891 or 5.07%, uninsured. (Please note the .066% unknown status rate.)

Table 1.
NUMBER & PERCENTAGE OF ALL CHILDREN UNDER 18 BY HEALTH INSURANCE COVERAGE AND FPL STATUS

FPL STATUS	INSURANCE COVERAGE			TOTAL
	Insured	Uninsured	Unknown	
0–100%	37,084	5,366	0	42,450 (13.55%)
101–185%	76,979	4,292	0	81,271 (25.95%)
186–200%	11,065	103	0	11,168 (3.56%)
201–300%	60,303	3,054	0	63,357 (20.23%)
>300%	111,591	3,076	207	114,874 (36.68%)
Total	297,022	15,891	207	313,120 (100%)

Source: Hawaii Health Survey, 1998. Office of Health Status Monitoring, Hawaii Dept. of Health *

* The health insurance data collection for the annual Hawaii Health Survey has been jointly funded by a Title V grant through the federal MCH Bureau, and the Primary Care Cooperative Agreement grant through the federal Bureau of Primary Health

SOURCES OF CREDITABLE HEALTH COVERAGE FOR HAWAII'S CHILDREN -- PRIVATE HEALTH PLANS AND MEDICAID

In 1998, employer-based health plans provided benefits for approximately 74.62% of insured children in Hawaii. The remaining 25.38% or 75,396 children were covered by either the state's Medicaid Aged, Blind, and Disabled (ABD) fee-for-service program, or Hawaii's Section 1115 Waiver Program – the QUEST and QUEST-Net Programs.

Medicaid Aged, Blind and Disabled (ABD) Program

Medicaid's Title XIX program provides health coverage for children with disabilities who meet SSI criteria and are:

- Ages 0 < 1 with family incomes up to 185% FPL with no asset test requirement;
- Ages 1 < 6 with family incomes up to 133% FPL, also without an asset test requirement;
- Ages 6 < 17, born after 9/30/83, who have family incomes up to 100% FPL with no application of an asset test; and
- Children < 19, born before 9/30/83 with family incomes up to 100% FPL, who must meet the asset test.

In SFY 1999, 1,537 children under 19 years of age were categorized as blind or disabled recipients, eligible for the Medicaid fee-for-service program. This represents about 4% of all recipients in the Aged, Blind and Disabled (ABD) population. In contrast, there were only 1,389 children, categorized as blind and disabled in SFY 1998.

Hawaii's Section 1115 Waiver Program

Hawaii QUEST Program

In SFY 99, 93% of the children receiving Medicaid Program services are being provided comprehensive health benefits, including EPSDT services, through the QUEST program – Hawaii's Section 1115 waiver program. In FY 1999, of the 123,402[1] persons enrolled in QUEST, 69,859 or 56.6% were children under age 19.

Reflecting the State's overall population distribution, the majority of QUEST-enrolled children (66%) are Oahu residents, with the number of children on the islands of Hawaii, Maui, Kauai, Molokai and Lanai following, respectively. As

with Medicaid's FFS population, about 8% of all QUEST children (5,800) are under the age of one.

Care. Both grants are administered by the State's Title V agency - the Family Health Services Division of the Department of Health.

[1] This figure denotes equivalent member years, and not unique member count.

QUEST Program Changes

Initiated in August 1994, the QUEST Medicaid expansion program provided coverage for approximately 108,000 recipients who had been enrolled in three separate public-funded medical assistance programs -- Aid to Families with Dependent Children (AFDC, now TANF), the General Assistance program, and the State Health Insurance Program (SHIP). The latter program, with an enrollment of 20,000, was a state-funded initiative developed to provide limited health benefits to adults and children in the uninsured gap group.

With an income eligibility limit of 300% FPL and a no-asset test requirement, the QUEST managed care program received an overwhelming response in the first year of operation – approximately 157, 000 persons were enrolled in QUEST, 47,000 above the initial membership projection of 110,000.

While the implementation of QUEST had resulted in decreased per capita costs, the State recognized that Medicaid's overall budget could not sustain the continuing enrollment growth. Initial amendments to QUEST's eligibility criteria and premium sharing provisions were therefore, initiated in August 1995. In February 1996, a further adjustment was applied to the sliding premium share scale, adult dental benefits were reduced to emergency care only, and a QUEST enrollment cap of 125,000 was activated. While the QUEST cap continues to be in place, protections continue for the following groups of people:

- Recipients of AFDC or General Assistance;
- Pregnant women and infants (age 0 < 1) whose countable family income does not exceed 185% FPL;
- Children age 1 but less than 6, whose countable family income does not exceed 133% of FPL;
- Children 6 years to under age 19 born after September 30, 1983 whose countable family income does not exceed 100% FPL;
- Persons whose countable family income does not exceed the AFDC standard of assistance;
- Children in foster care, under the relative placement program administered by the Department, or covered by Title IV-E, or state-funded subsidized adoption agreements; Individuals who lose employer-sponsored health coverage due to loss of employment within 45 days prior to application.
- Individuals whose health coverage in a group health plan is extended as a result of loss of employment and such coverage ends within 45 days prior to application; and

- Individuals and families covered under the provisions of section 1931 of the Social Security Act as described in the Hawaii Administrative Rules.

In April 1996, additional changes to QUEST were initiated in response to a legal challenge maintaining that QUEST's eligibility criteria violated the equal accommodations provision of the Americans with Disabilities Act (ADA). An asset test consistent with Medicaid's fee-for-service program was applied to QUEST members. Additionally, adults with a family income above 100% FPL were required to pay 100% of their medical, dental and catastrophic care premiums. And, in December 1997, to address the same lawsuit calling for parity between the QUEST and ABD programs, the state lowered QUEST's income limit from 300% FPL to 100% FPL. Budgetary constraints could not support the option of increasing the ABD populations' income limit to 300% FPL.

The QUEST-Net Program – A Safety Net

Recognizing that changes in QUEST's eligibility criteria would result in people becoming ineligible for QUEST, the State initiated the QUEST-Net program in April 1996. Developed as a safety net program for persons with incomes above 100% FPL, QUEST-Net has provided health coverage through the QUEST health and dental plans for: 1) persons enrolled in QUEST who no longer meet QUEST's income and asset criteria; and 2) persons enrolled in Medicaid's FFS program, who, among other criteria, have assets that rise above the Medicaid asset limit, but fall within the higher asset limit of QUEST-Net.

A required monthly premium of $60 per person for all QUEST-Net enrollees with incomes above 100% FPL provides QUEST-Net adults with a limited health benefit package. Children in QUEST-Net however, continue to receive full QUEST benefits. For QUEST enrolled families with incomes above 100% FPL who were required to pay the full premium share for each child (approximately $152 PMPM), the QUEST-Net program's $60 premium has provided a more affordable alternative.

In December 1999, a total of 2,726 children were enrolled in QUEST-Net out of the approximately 5,800-member enrollment.

HAWAII'S UNINSURED CHILDREN BY AGE AND INCOME LEVEL

The following Tables present the findings of the 1998 Hawaii Health Survey conducted by the State's Department of Health. *The variance between the numbers in the individual cells and total is due to rounding to the nearest whole number.*

Unlike the 1997 Hawaii Health Survey, the 1998 "Survey" did not gather data on uninsured children from uninsured/insured households; therefore, Tables 1,

Uninsured Children From Insured Households By FPL Status; and 3, Uninsured Children From Uninsured Households By FPL Status are deleted.

Table 1.
TOTAL UNINSURED CHILDREN BY FPL STATUS

AGE	INCOME					TOTAL
	0–100%	101–133%	134–185%	186–200%	201–300%	
0	0	137	48	0	407	592
1 – 6	1,609	843	458	0	974	3,884
7 – 14	2,107	471	1,452	69	1,218	5,317
15 – 18	1,651	215	669	34	455	3,024
TOTAL	**5,367**	**1,666**	**2,627**	**103**	**3,054**	**12,817**

According to this 1998 Hawaii Health Survey data:

- Approximately 12,817 children with family incomes up to 300% FPL were uninsured; and
- 9,763 or 76.17% of these uninsured children had family incomes up to 200% FPL.

Additionally, the 1998 data also indicates that approximately 5,305 children or (41.39% of 12,817) may have met Medicaid's 1998 income eligibility criteria but had not been enrolled in the Medicaid program. (See Table 2 below.) And 4,458 children (34.78% or 12,817) who are projected to be eligible for the Title XXI Medicaid expansion. (See Table 3 below.)

Table 2.
UNINSURED CHILDREN BY FPL STATUS WHO ARE PROJECTED TO BE MEDICAID ELIGIBLE BUT NOT YET ENROLLED

AGE	INCOME LEVEL			TOTAL
	0 – 100%	101 – 133%	134 – 185%	
0	0	137	48	**185**
1 – 6	1,609	843		**2,452**
7 – 14	2,107			**2,107**
15 – 18	561			**561**
			TOTAL	**5,305**

According to the data above, the largest group of children meeting Medicaid's income eligibility criteria who were not yet enrolled were preschool-age children, 1 up to age 6 with family incomes up to 133% FPL (approximately 2,452 children). School-age children, ages 7–14 follow, with teens, ages 15–18, next. The number of uninsured children under age 1 with family incomes up to 185% FPL appears to be significantly lower – approximately 185. This most probably reflects the proactive advocacy efforts in the State aimed at identifying and enrolling low income pregnant women and their newborns.

Table 3.
UNINSURED CHILDREN BY FPL STATUS WHO ARE PROJECTED TO BE ELIGIBLE FOR TITLE XXI PROGRAM

AGE	INCOME LEVEL				TOTAL
	62.6–100%	101–133%	134–185%	186–200%	
0	0	0	0	0	**0**
1 – 6	0	0	458	0	**458**
7 – 14	0	471	1452	69	**1,992**
15 - 18	1090	215	669	34	**2,008**
TOTAL	**1090**	**686**	**2,579**	**103**	**4,458**

The overall projections of the number of uninsured children are sobering and unsettling in light of the State's current economic difficulties. Today, business failures in Hawaii are up 60% over 1996, the number of bankruptcies are second in the nation, the State's unemployment rate has surpassed the national average, and Hawaii's ailing economy continues to suffer from the ripple effect of the unstable Asian market. At a time when the State's health and social service programs increasingly become targets of funding reductions, there are numerous indications that the number of uninsured persons in Hawaii will continue to grow.

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):

With the increasing restrictions on the State's Medicaid budget and the existing enrollment cap for QUEST, current State outreach efforts have primarily focused on targeting children with disabilities as well as those groups (see page 7) who are protected from the enrollment cap.

☐ To address the potential needs of persons who are losing their jobs due to downsizing or closing of businesses, the Public Information Officer and other staff from the Med-QUEST Division, Hawaii's Medicaid agency, participate in the State's Rapid Response Program and conduct on-site Medicaid informational sessions. While adults are often ineligible, children may qualify for QUEST, or if disabled, the Medicaid FFS program.

☐ Informational brochures about Medicaid programs and Medicaid applications continue to be placed in:

- The State Office of Information;

- QUEST health plan offices;

- All State welfare offices. These brochures and informed State welfare staff have played an increasingly important role since the implementation of TANF and the "de-linking" of welfare and medical assistance benefits. For eligible persons, State welfare staff coordinate with Medicaid's Eligibility Branch.

- Community health centers. According to Hawaii's community health centers operating in 26 sites on the islands of Oahu, Maui and Hawaii, nearly 70% of their clients had income levels below 100% of FPL in 1996. As a result of their efforts to target outreach and care to particularly vulnerable groups, the greatest proportion of their clients are persons with low incomes who are Medicaid eligible, and include indigenous native Hawaiian/part-Hawaiian people, persons who are homeless, and those in immigrant populations. With the intensified difficulties in Hawaii's economy, these primary care centers have experienced increasing numbers of uninsured visits. Medicaid provides reimbursement for staff at these primary care centers who provide Medicaid information to clients and assist with the application process.

☐ Outstationing – In addition to the staff cited above who work out of primary care FQHC's on Oahu, Medicaid also provides reimbursement for staff stationed at an Oahu-based hospital serving large numbers of Medicaid recipients (DSH). These persons assist with expeditious enrollment of Medicaid eligible persons, particularly, pregnant women, newborns, other protected classes, and children with disabilities.

☐ Informational sessions have been conducted by the Med-QUEST Division for groups such as:

- Pregnant teens at various high schools in conjunction with St. Francis Medical Center;
- Head Start programs such as Parents and Children Together (PACT); and
- Community-based organizations, such as the AIDS Community Care Team, a statewide consortium of HIV-related care and case management agencies.

And at events such as:

- Health fairs; and
- The annual statewide QUEST informational presentations for the community-at-large.

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

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

Pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act, Hawaii will use administrative funds to offer a Health Services Initiative (HSI) under this Plan with the goal of improving the health of children, defined as "individual(s) under the age of 19," per 42 CFR § 457.10. Hawaii assures that it will use no more than 10 percent of the total expenditures under this Plan, as specified in 42 CFR § 457.618, to fund the State's HSI and other administrative costs. The HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

Additionally, Hawaii assures that reporting metrics designed to evaluate and monitor the effectiveness and outcomes of this HSI initiative will be included in the CHIP Annual Report Template System (CARTS). At a minimum, these metrics will include the percentage of children receiving vision screening that required a vision exam and the percentage of children receiving a vision exam that require glasses.

I. Background

Access to vision exams and glasses is critical to promoting positive educational achievements and health outcomes, as 80 percent of all learning during a child's first 12 years is visual.[i] Students with vision problems tend to have lower academic performance, as measured by test scores and grades, and students' performance in school affects future employment earnings, health behaviors, and life expectancy.[ii]

Given the importance of ensuring access to vision health services for children, Hawaii seeks to use the HSI option to deliver needed vision services and glasses to low-income children through a targeted, school-based initiative. Hawaii intends to contract with:

- A qualified vision screening provider to provide vision screening exams onsite at certain Hawaii schools. Hawaii is currently engaged with Project Vision Hawaii, a nonprofit organization and the only mobile health screening program in Hawaii that provides statewide services in medically underserved communities.[iii]
- A qualified vision services provider to offer vision exams and glasses onsite at certain Hawaii schools. Hawaii is currently engaged with Vision To Learn, a non-profit, philanthropically-funded entity that provides free eye exams and glasses to students at schools in low-income communities. Vision To Learn is a Medicaid participating provider and has been serving Hawaii children since 2015.[iv]

II. Operational Details

The vision services CHIP HSI will operate as follows.

Process for Identifying and Providing Services to Children in Need of Glasses

- The qualified vision screening provider and qualified vision services provider will together serve Hawaii's low-income children in Title I schools in which at least 51 percent of the student body receives free or reduced price meals ("target schools").
- In these schools:
  - The qualified vision screening provider and qualified vision services provider will jointly provide children in the targeted schools with parent/guardian consent forms that provide information about the services and allow a parent/guardian to opt-out of, or decline, the services. An opt-out consent process is consistent with Hawaii law with respect to these types of services and settings. The school will maintain a list of children whose parents have consented to the services.
  - The qualified vision screening provider will conduct an initial screening exam of all participating children to identify which children require an eye exam and potentially glasses.
  - The qualified vision screening provider will supply the qualified vision services provider with a list of children who have failed the vision screening.
  - For children who have failed the vision screening, the qualified vision services provider will perform one vision exam (onsite in a mobile eye clinic) and, if needed, will provide corrective lenses and frames (onsite at the school campus).
  - For children who receive corrective lenses and frames, the qualified vision services provider will complete a glasses fitting and will also provide replacements, as needed.

Process for Billing and Reimbursement for Services Covered by the CHIP HIS

Vision Screenings

Collecting insurance information, becoming credentialed as in-network providers, and billing insurers for vision screenings provided to children in school-based settings poses a substantial administrative burden and diminishes access to vision services. As such, Hawaii plans to reimburse the qualified vision screening provider for vision screenings provided to children in target schools as follows:

- The qualified vision screening provider will send a monthly invoice to Hawaii's Medicaid agency, the Med-QUEST Division, that reflects all vision screening services furnished by the qualified vision screening provider for children under the age of 19.
- Med-QUEST will reimburse the qualified vision screening provider using CHIP HSI funding.

Vision Exams and Glasses

In part because the number of children who receive vision exams and glasses is much lower than the number of children who are screened (approximately 20 percent of screened children require exams)—and because a higher reimbursement rate is associated with these services—the qualified vision services provider will conduct a "Medicaid matching" process (described further below) that allows the provider to bill Medicaid managed care plans for the services provided to children enrolled in Medicaid.

Additionally, to prevent HSI funds from being used to furnish services for children who have private insurance, the qualified vision service provider will deduct a pre-determined percentage from the fee for exams and glasses billed to the CHIP HSI.

Medicaid Matching Process and Billing Medicaid MCOs

- The qualified vision services provider will collect identifying information on all children it serves (including first name, last name and date of birth) from each school it visits. The qualified vision services provider will then submit this information to a third-party billing service ("pVerify") that uses the Hawaii Department of Human Services online state Medicaid portal to identify children with an active Med-QUEST plan.[1] For these children, the portal provides a Medicaid identification number and the plan in which they are enrolled.
- The third-party billing service and qualified vision services provider will use the Medicaid identification number and plan information to submit bills directly to the identified MCOs with which it is credentialed. The MCOs will pay the qualified vision services provider for the services delivered based on negotiated, standard fees. To the extent the qualified vision services provider is not credentialed with a Medicaid MCO, it will not seek HSI reimbursement for children identified as enrolled in that Medicaid MCO.

ESI Enrollment Deduction

- The majority of children who receive vision services at Title I schools are likely to be covered by Medicaid/CHIP or be uninsured.
- However, to prevent HSI funds from being used to furnish services for children who have private insurance, the qualified vision services provider will deduct a pre-determined percentage of services—20%—from the fee for exams and glasses billed to the CHIP HSI.
- This percentage deduction reflects the ESI coverage rate that the qualified vision services provider has observed over two years of program implementation and through the use of pVerify, the third-party billing service that also provides information on children with active ESI coverage. Through this experience, the qualified vision services provider has found that 20% of the 7,000 students who have received HSI services to date and have not been identified as having Medicaid coverage have active ESI coverage.

HSI Reimbursement

- The qualified vision services provider will then submit information to the Med-QUEST Division describing services (e.g., vision exams, corrective lenses and frames) provided for which it seeks HSI reimbursement.
- The invoice will:
  - Reflect all vision screening services furnished by the qualified vision screening provider for children under the age of 19;
  - Reflect all vision exams, corrective lenses and frames furnished to children under age 19 who were not identified by the third-party billing service as being enrolled in Medicaid or CHIP;
  - Apply the ESI deduction to exams and glasses; and
  - Identify the full payment owed to the qualified vision services provider.
- Med-QUEST will reimburse the qualified vision services providers for the remaining bill using CHIP HSI funding.

Annually, Hawaii expects that the HSI will serve up to approximately 20,000 children who will receive vision screenings, approximately 4,000 of whom will need and receive vision exams, and approximately 80% of those children receiving vision exams (or 3,200 children) will need and receive corrective lenses and frames.

A budget is included in Section 9.10.

[1] This source, pVerify, is a third-party all-payer real-time patient insurance eligibility verification database. pVerify is active in a number of states. https://www.pverify.com/

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

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

Pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act, Hawaii will use administrative funds to offer a Health Services Initiative (HSI) under this Plan with the goal of improving the health of children, defined as "individual(s) under the age of 19," per 42 CFR § 457.10. Hawaii assures that it will use no more than 10 percent of the total expenditures under this Plan, as specified in 42 CFR § 457.618, to fund the State's HSI and other administrative costs. The HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.
Additionally, Hawaii assures that reporting metrics designed to evaluate and monitor the effectiveness and outcomes of this HSI initiative will be included in the CHIP Annual Report Template System (CARTS). At a minimum, these metrics will include the percentage of children who received a hearing screening that identified early hearing loss or impairment as well as the percentage of children who received a hearing exam that required hearing devices.

I. Background

The CDC estimates that almost 15 percent of children between the ages of 6-19 experience low or high-frequency hearing loss in one or both ears.[i] Hearing loss can happen at any age and can affect a child's early ability to develop communication, language, and social skills.[ii] Moreover, hearing loss or difficulties in childhood can have long-term consequences; a CDC longitudinal study found that approximately 40 percent of young adults who experienced hearing loss during childhood reported experiencing at least one limitation in daily functioning in early adulthood.[iii] To promote development and well-being in the short- and long-term, it is imperative to identify and, as needed, intervene to address hearing loss in children as early as possible.

Given the importance of ensuring access to hearing services for children, Hawaii seeks to use the HSI option to deliver needed hearing services and referrals for hearing devices to low-income children through a targeted, school-based initiative. Hawaii intends to contract with:

- A qualified hearing screening provider to provide hearing screenings onsite at certain Hawaii schools. Hawaii is currently engaged with Project Vision Hawaii, a nonprofit organization and the only mobile health screening program in Hawaii that provides statewide services in medically underserved communities. [iv]
- A qualified hearing services provider to offer hearing exams and screenings onsite at certain Hawaii schools.

[i] CDC. "Data and Statistics About Hearing Loss in Children." https://www.cdc.gov/ncbddd/hearingloss/data.html [ii] CDC. "What is Hearing Loss in Children?" https://www.cdc.gov/ncbddd/hearingloss/facts.html
[iii] CDC. "Data and Statistics About Hearing Loss in Children." https://www.cdc.gov/ncbddd/hearingloss/data.html [iv] Project Vision Hawaii. https://www.projectvisionhawaii.org/ [v] Total number of Title I schools in Hawaii in 2022-2023: https://www.hawaiipublicschools.org/DOE%20Forms/TitleI2223.pdf; Total number of public schools in Hawaii in 2022-2023: https://www.hawaiipublicschools.org/DOE%20Forms/Enrollment/HIDOEenrollment2022-23.pdf

II. Operational Details

The hearing services CHIP HSI will operate as follows.

Process for Identifying and Providing Services to Children in Need of Hearing Devices

- The qualified hearing screening provider and qualified hearing services provider will together serve Hawaii's low-income children in Title I schools in which at least 51 percent of the student body receives free or reduced price meals ("target schools"). In Hawaii, these schools represent approximately 54 percent of non-charter public schools.[v]
- In these schools:
  - The qualified hearing screening provider and qualified hearing services provider will jointly provide children with parent/guardian consent forms that provide information about the services and allow a parent/guardian to opt-out of, or decline, the services. The parent or guardian will have two opportunities to opt out of the hearing screening service. The consent form will be sent at 2 weeks and at 1 month.
  - An opt-out consent process is consistent with Hawaii law with respect to these types of services and settings. The school will maintain a list of children whose parents consented to the services.
  - The qualified hearing screening provider will conduct a hearing screening ONLY for all participating children to identify which children require a hearing exam and potentially hearing devices.
  - If the screening results in identifying additional testing to determine if additional hearing services and/or equipment is needed, a separate consent form will be sent to parents for permission.
  - The qualified hearing screening provider will supply the qualified hearing services provider with a list of children who have been identified as needing further hearing services.
  - For children who have been identified as needing services by the hearing screening, the qualified hearing services provider will perform one hearing exam (which could be fitted onsite at the school campus) and, if needed, will coordinate service for hearing devices needed (which could be fitted onsite at the school campus).

Process for Billing and Reimbursement for Services Covered by the CHIP HSI

Hearing Screenings

Collecting insurance information, becoming credentialed as in-network providers, and billing insurers for hearing screenings provided to children in school-based settings poses a substantial administrative burden and diminishes access to hearing services. As such, Hawaii plans to reimburse the qualified hearing screening provider for screening exams provided to children in target schools.

To do so:

- The qualified hearing screening provider will send a monthly invoice to Hawaii's Medicaid agency, the Med-QUEST Division, that reflects all hearing screening services furnished by the qualified hearing screening provider for children under the age of 19.
- Med-QUEST will reimburse the qualified hearing screening provider using CHIP HSI funding. CHIP HSI funding will be used to reimburse qualified hearing screenings by the provider.

Hearing Exams and Hearing Devices Referral

Because the number of children who receive hearing exams is much lower than the number of children who are screened (approximately 5% of screened children)—and because a higher reimbursement rate is associated with these services—the qualified hearing services provider will conduct a "Medicaid matching" process (described further below) that allows the provider to bill Medicaid managed care plans for the services and equipment provided to children enrolled in Medicaid.

Medicaid Matching Process and Billing Med-QUEST/Managed Care Organization (MCO)s

- The qualified hearing services provider will collect identifying information on all children it serves (including first name, last name and date of birth) from each school it visits. The qualified hearing services provider will then submit this information to a third-party billing service ("pVerify") that uses the Hawaii Department of Human Services online state Medicaid portal to identify children who are active in Medicaid and/or enrolled in a Med-QUEST/MCO. [1] For these children, the portal provides a Medicaid identification number and the Med-QUEST/MCO for which they are enrolled.
- The third-party billing service and qualified hearing services provider will use the Medicaid identification number and Med-QUEST/MCO plan information to submit bills directly to the identified MCOs with which it is credentialed. The MCOs will pay the qualified hearing services provider for the services delivered based on negotiated, standard fees. To the extent the qualified hearing services provider is not credentialed with a Medicaid MCO, it will not seek HSI reimbursement for children identified as enrolled in that Medicaid MCO.

HSI Reimbursement

- To prevent HSI funds from being used to furnish services to children in Title I schools who may have private insurance, the qualified hearing service provider will deduct a pre-determined percentage of services from the total fee billed to the CHIP HSI to account for estimated private insurance coverage within Title I schools.

Hawaii anticipates that these services will grow over time. Annually, Hawaii expects that the HSI will serve up to approximately 30,000 children who will receive hearing screenings. The estimated percentage of insured children will be 20%. Approximately 5% of those children will receive hearing exams.

- The qualified hearing services provider will then prepare an invoice describing services (hearing screenings and exams) provided to children under age 19 enrolled in Medicaid, CHIP or private insurance and send the invoice to the appropriate Med-QUEST/MCO.

- Med-QUEST will reimburse the qualified hearing screening provider for the bill using CHIP HSI funding if not covered under Med-QUEST/MCO or private insurance.

A budget is included in Section 9.10.

[1] This source, pVerify, is a third-party all-payer real-time patient insurance eligibility verification database. pVerify is active in a number of states. https://www.pverify.com/

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Additionally, Hawaii assures that reporting metrics designed to evaluate and monitor the effectiveness and outcomes of this HSI initiative will be included in the CHIP Annual Report Template System (CARTS). At a minimum, these metrics will include the percentage of children who received an oral health screening, those identified as needing routine care or those needing urgent dental care and were referred to a community dental provider for urgent dental care.

Hawaii seeks to use the HSI option to deliver needed oral health screenings, prevention education, and referrals for low-income children through a targeted school-based initiative.

I. Background

Dental caries, or tooth decay, are the most common chronic disease among children, but it is largely preventable. Unfortunately, Hawaii ranks among the states with the highest rates of dental issues in children. According to the Hawaii State Department of Health, 70.6% of third graders in the state have experienced tooth decay.[i] Historically, Hawaii has placed near the bottom compared to 47 other reporting states, significantly above the national average of 52% for similar cases.[ii]

Additionally, 9.9% of children aged 1 to 17 had cavities or decayed teeth in 2023-2024, which is slightly lower than the U.S. average. Moreover, 10.9% of children reported oral health problems in that same year[iii]. Overall, Hawaii faces high rates of oral disease among both children and adults.

Neighbor islands and rural communities have few dentists. They also have fewer dental visits. Only 8.8% of Hawaii's public water is fluoridated.[iv] The national target is 77.1%.

Poor oral health has several causes. These include environmental issues, policy limitations, limited access to dental care, lack of awareness and education, fear related to COVID-19 and unhealthy lifestyles.

[i] Hawai'i Department of Health, Family Health Services Division. (2015). Hawai'i Smiles 2015: The Oral Health of Hawai'i's Children. https://health.hawaii.gov/about/files/2013/06/Hawaii-Smiles-Report.pdf
[ii] Hawaii Public Health Institute. Hawaii Oral Health Data Tracker, 2023. https://www.hiphi.org/hawaii-oral-health-data-tracker/
[iii] Hawai'i Department of Health, Family Health Services Division. (2015). Hawai'i Smiles 2015: The Oral Health of Hawai'i's Children. https://health.hawaii.gov/about/files/2013/06/Hawaii-Smiles-Report.pdf
[iv] Hawai'i Department of Health, Family Health Services Division. (2015). Hawai'i Smiles 2015: The Oral Health of Hawai'i's Children. https://health.hawaii.gov/about/files/2013/06/Hawaii-Smiles-Report.pdf

Even with local dentists, families face challenges. Transportation, scheduling, and work conflicts make it hard to get kids to appointments. Economic hardship also plays a role. Preventive dental care may be less of a priority for families. Many adults are unemployed. They have limited funds for basic needs.

Untreated dental problems cause pain. They also lead to missed school days and long-term health issues. Poor oral health causes pain, eating difficulties, and low self-esteem. It can also cause severe infections. Academic performance and development are negatively impacted. The US Department of Health and Human Services reports that over 51 million school hours are missed each year due to dental problems.

Hawaii intends to contract with qualified oral health service providers to offer these services onsite at Hawaii schools. To date, Hawaii Keiki (HK) and Project Vision Hawaii (PVH) have implemented Dental Programs in the Title I Schools as described below:

- The HK Oral Health Program started in 2019 and has continued to grow with services being provided to over 90 Title 1 Elementary schools per year. The HK Oral Health Program is the largest school-based oral health program providing statewide services in medically underserved communities by a team of licensed dentists, dental hygienists and health technicians.

- The HK Oral Health program enhanced the HK program by supporting the states' effort in documenting oral health status of children and providing a much-needed service for those that have limited access to dental care.

- The HK Oral Health Program began a pilot project providing Kindergarten oral assessments and education in the Fall 2025 with plans to expand to additional schools and islands in the coming years, similar to the expansion of the assessment/sealant school-based program. Since 2019 the HK Oral Health Program has identified over 220 keiki during oral health screenings with urgent dental needs. These keiki were successfully referred to community dental providers and received the necessary dental care.

- PVH is the state's largest mobile health provider, operating for over a decade and delivering school-based vision and hearing screenings to students across all islands. PVH manages Hawaii's largest mobile health fleet and operates the state's only HRSA-designated free clinic, ensuring access to care for medically underserved communities. Since 2013, PVH has provided preventive health services in schools, community centers, and rural areas, with a proven track record of effective outreach and care coordination for children and adolescents.

- The qualified school-based oral health program has a list of all providers state-wide available with contact information at time of referral available by phone at 808 792-1070 or toll free at 1-888-792-1070 and will also have information available online.

Access to care remains a significant challenge for many Hawaiʻi families, particularly in rural and neighbor island communities. The Health Resources and Services Administration (HRSA, 2025) identifies numerous areas throughout Hawaiʻi, including communities on Hawaiʻi Island, Molokaʻi, Lānaʻi, portions of Maui, and rural Oʻahu, as Dental Health Professional Shortage Areas (HPSAs). These designations indicate a shortage of dental providers and highlight barriers such as transportation challenges, geographic isolation, and limited access to preventive dental services.[v]

HRSA (2025) reports that more than 60 million Americans live in areas with inadequate access to dental care, contributing to higher rates of untreated oral disease and preventable health complications.[vi]

Pilot events conducted within Title I school populations identified nearly 80% of middle school students as needing follow-up dental care.

Approximately 10.8% of Hawaiʻi children experienced tooth decay or cavities.[vii] This remains higher than the U.S. average.

These local disparities mirror national trends. The Centers for Disease Control and Prevention (CDC) Oral Health Surveillance Report (2024) found that children living in high-poverty households experience untreated tooth decay at more than twice the rate of children living in low-poverty households. [viii]

National data from the National Institute of Dental and Craniofacial Research (NIDCR, 2024) indicate that nearly 57% of adolescents ages 12–19 have experienced dental caries in their permanent teeth, demonstrating that oral health challenges persist well beyond elementary school.[ix]

According to the 2023 Hawaiʻi Youth Risk Behavior Survey (YRBS), 79.6% of public high school students reported seeing a dentist for a check-up, teeth cleaning, or other dental care within the previous 12 months, meaning that approximately 20% of students did not receive preventive dental care during the past year. These findings suggest that access to routine oral healthcare remains a challenge for a significant proportion of Hawaiʻi adolescents.[x]

The Hawaii Keiki Dental Sealant, which serves Hawaii Public Schools with dental assessment and sealants since 2019 has documented their screening outcomes of over 8,900 elementary school students (2nd/3rd graders) in greater than 90 Title 1 schools. Data from school year 2025-2026 consists of 1,941 students screened with 88 of those students requiring urgent dental needs and 66% needing sealants. Pilot events conducted by PVH in Title 1 populations during 2025-2026 identified nearly 80% of middle school students in need of follow up care.

By providing school-based oral health screenings and education in Title I schools across the K-12 continuum, we will help address critical gaps and ensure continuity of preventive care from kindergarten through adolescence.

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[v] Health Resources and Services Administration, Maternal and Child Health Bureau. (2025). *National Survey of Children's Health, 2023–2024.* https://mchb.hrsa.gov/data-research/national-survey-childrens-health

[vi] Health Resources and Services Administration, Maternal and Child Health Bureau. (2025). *National Survey of Children's Health, 2023–2024.* https://mchb.hrsa.gov/data-research/national-survey-childrens-health

[vii] KFF. (2024). Percent of children (ages 1–17) with oral health problems. https://www.kff.org/state-health-policy-data/state-indicator/children-with-oral-health-problems/)

[viii] Centers for Disease Control and Prevention. (2024). *Oral Health Surveillance Report: Dental Caries, Tooth Retention, and Edentulism, United States, 2017–March 2020.* U.S. Dept of Health and Human Services. https://www.cdc.gov/oral-health/php/2024-oral-health-surveillance-report/index.html

[ix] National Institute of Dental and Craniofacial Research. (2026). Dental Caries (Tooth Decay) in Adolescents (Ages 12 to 19 Years). https://www.nidcr.nih.gov/research/data-statistics/dental-caries/adolescents

[x] Hawaiʻi Health Data Warehouse. (2024). *2023 Hawaiʻi Youth Risk Behavior Survey (YRBS): State results.* University of Hawaiʻi at Mānoa, Hawaiʻi Department of Health, and Hawaiʻi Department of Education. Retrieved from the Hawaiʻi Health Data Warehouse. https://hhdw.org/data-sources/youth-risk-behavior-survey/

Partnership with Med-QUEST under this HSI will increase resources to provide dental screenings, outreach and referrals to more Keiki across the State.

II. Operational Details

The oral health CHIP HSI will operate as follows.

Process for Identifying and Providing Services to Children in Need of referral for Immediate & Urgent Oral Health Conditions.

- The qualified school-based oral health program will work to serve Hawaii's low-income children in Title I schools in which at least 51 percent of the student body receives free or reduced price meals ("target schools") from families experiencing financial hardship with a focus on low-income families.

- In these schools:
  - The qualified school-based oral health program will provide children with parent/guardian consent forms that provide information about the services and allow a parent/guardian to opt-out of, or decline, the services. The parent or guardian will have two opportunities to opt out of the oral health screening service. The consent form will be sent at 2 weeks and at 1 month prior to screening

  - An opt-out consent process is consistent with Hawaii law with respect to these types of services and settings. The school will maintain a list of children whose parents consented to the services.

  - The qualified oral screening provider will conduct an oral screening ONLY for all participating children to identify which children require an urgent exam and potentially restorative treatment for caries.

  - If the screening results in identifying additional urgent dental needs the parent will be notified to ensure they have access to follow-up care.

  - All students who do not opt out will receive:
    - Individual hands-off visual oral health screening by a qualified dental provider or supervised health technician.
    - Oral health education delivered in a group or classroom setting.
    - A toothbrush, toothpaste, and educational materials/resources to take home.

- Students identified with urgent or routine dental needs will be referred to community dental providers for care. For referrals families are offered the option of calling Community Case Management Corp. (CCMC) which helps locate a local dentist and provides a list of local Federally Qualified Health Centers (FQHCs) and dentists able to serve the student's needs.

- They can assist Medicaid Beneficiaries with finding a local dentist in coordination with Hawaii Dental Service (HDS) to help Medicaid recipients across all islands find participating dentists, understand covered benefits, and schedule appointments. Additionally, the program will provide families with a list of the local FQHCs and dentists that can service these students' needs.

  Call Community Case Management Corp. (CCMC)
- **O'ahu:** (808) 792-1070
- **Neighbor Islands:** 1-888-792-1070 (toll-free)

As part of the referral process a return call to the parents of a student who needed the referral is contacted to confirm that an appointment was made and that the student was provided with the dental services needed.

The program's dental team is a close-knit group with local connections to help ensure all keiki with dental needs are served in a timely manner.

Process for Billing and Reimbursement for Services Covered by the CHIP HSI

Oral Screenings

Collecting insurance information, becoming credentialed as in-network providers, and billing insurers for oral health screenings provided to children in school-based settings poses a substantial administrative burden and diminishes access to oral screenings. As such, Hawaii plans to reimburse qualified providers such as Hawaii Keiki Oral Health Program (University Health Partner) and Project Vision Hawaii for screening exams (which include oral health education) provided to children in targeted schools statewide.

- The qualified provider shall send a monthly invoice to Hawaii's Medicaid agency, the Med-QUEST Division, that reflects all oral health screening services ONLY furnished by the qualified oral health dental providers for children under the age of 19.

- Med-QUEST will reimburse the provider using CHIP HSI funding. This rate includes hands-off oral health screening, follow-up care coordination/referral, and provision of oral health supplies (toothbrush, toothpaste) and educational materials, and follow-up care coordination if a child is referred.

- CHIP HSI funding will be used to reimburse only oral health screenings for all children by the programs' dental providers. If additional services are needed for the child, they are provided with a referral to assist with services needed.

"Qualified provider" refers to the contracted school-based oral health program (e.g., Hawai'i Keiki, Project Vision Hawai'i), not an individual dental provider.

HSI Reimbursement

- The qualified oral health provider will then prepare an invoice describing services (all inclusive oral screenings) provided to children under age 19 enrolled in Medicaid, CHIP or private insurance and send the invoice to the appropriate Med-QUEST/MCO.

- Med-QUEST will reimburse the qualified oral health provider for the bill using CHIP HSI funding.

A budget is included in Section 9.10.

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))**

4.4.5

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.

4.4.6 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)**

The Outreach Subcommittee of the State's Title XXI Planning Committee served as the core for initiating a broad spectrum of outreach strategy recommendations. Subcommittee members will also continue to serve as a coordinating group for continued development of the design, implementation and evaluation of the approaches outlined below. Members of the group include representatives from the:

- Department of Health – Family Health Services Division (the State's Title V agency), the Public Health Nursing Branch, and the State's Immunization Program;

- Department of Human Services, Med-QUEST Division – Public Information Officer and program staff assigned to the State's Title XXI program;

- Catholic Charities Family Services – a private, non-profit agency with a long history of providing a broad range of health and support services for low-income children, families, and the elderly, including mobile van services providing outreach and care to the homeless in rural areas on Oahu and Hawaii; and

- Hawaii Primary Care Association (HPCA) – a private, non-profit organization advocating for: 1) access to quality primary care for persons with barriers to health care, and 2) the community health centers serving these individuals.

  The HPCA, acting as the State's lead agency, recently-received a grant from the Robert Wood Johnson Foundation for the "Covering Kids" program –- a national health access initiative for low-income, uninsured children. This three-year-initiative will facilitate state efforts to: 1) design and conduct outreach programs that identify and enroll eligible children into Medicaid and other coverage programs; 2) simplify enrollment processes; and 3) coordinate existing coverage programs for low-income children. Many Title XXI Outreach Subcommittee members were also involved in the development of the HPCA proposal and care was exercised to insure that outreach strategies were complementary.

  Selection of Hawaii as a RWJ demonstration site will allow for:
  1) The initiation of new activities, such as: a) a pilot program using

telecommunication and mobile outreach vans to improve enrollment in isolated rural communities; b) a pilot program to pre-test presumptive eligibility in a specified geographic area; c) establishment of an electronic link between the State's Department of Health and Department of Human Services to eliminate the need for parents of Hawaii-born children to produce hard copy birth certificates; d) c) training of WIC staff from the state's 37 clinic as QUEST outreach eligibility workers; and

2) The expansion of outreach activities that the State will have initiated such as: a) the Train-the-Trainer program; b) a media campaign; c) working with community-based organizations and state agencies to assist with information dissemination; d) expansion of a public informational hotline to allow for initial screening for eligibility; and e) working on developing partnerships with schools, WIC, Head Start, and the Native Hawaiian Health Care Systems to incorporate QUEST enrollment screening into routine intake procedures for other benefits.

The sections below outline the primary avenues of the State's proposed outreach campaign aimed at informing, and assisting with enrolling children who are likely to be eligible for either Medicaid's FFS or QUEST programs or the Title XXI's Medicaid expansion. Given the State's limitations in financial and human resources, prioritization of these approaches is still under discussion.

Preschools and Child Care Centers

- Hawaii Association for the Education of Young Children (HAEYC) is the Hawaii Chapter of the national organization, with sub-chapters on each island (7). Its membership of approximately 800 includes the majority of Hawaii's pre-schools, family child centers, as well as State Department of Education teachers.

- *Alu Like* is a private, non-profit organization providing services to Hawaiian/Part Hawaiian families. One of their programs, *Pulama I Na Keiki* (Cherish the Children) is a parent education program for families with children (newborns to age 3), implemented by parent (peer) educators. This program, based on a home visit model, is federally funded through the Native Hawaiian Education Grant. A new "back to work" voucher program assists low-income Oahu families who have children ages 3 - 5 years with finding and paying for preschool services.

- Kamehameha School Bishop Estate operates between 30 – 40 preschools in specific geographical locations throughout the state. These preschools serve up to 1,000 four year-olds of Hawaiian/Part Hawaiian ancestry who are randomly selected for admission by a lottery. While income level is not one of the admission criteria, many children receive financial assistance or tuition waivers.

- Good Beginnings Alliance is a private, non-profit agency playing a multifaceted role as an umbrella network. Its efforts are aimed at promoting quality early childhood care/services for children ages 0 - 5 in targeted areas throughout the State.

  One facet of its work is funded by the Child Development Block Grant administered by the State's Department of Human Services. These monies fund coordinators in each county who provide oversight for the development and the implementation of county-specific plans crafted by Good Beginnings Community Councils.

  Good Beginnings *Keiki* (Children's) Contacts Project, one of the Alliance's ongoing services, has recently been awarded a $45,000 grant from the HMSA Foundation. This service is unique in that, *Keiki* Contactors provide education about topics such as parenting skills wherever parents and their children gather -- in their homes, in parks or in preschool settings. The recent HMSA grant award, in conjunction with State funds, will allow for the expansion of outreach activities to families regarding information about child health and development issues. As the Alliance initiates this program, it is enthusiastic about coordinating with the Med-QUEST Division to insure that Medicaid program eligibility and enrollment information is also provided.

- Other preschools and child care centers throughout the State through programs such as PATCH (Parents Attentive to Children) – PATCH is an information and referral source for parents seeking pre-school or child care services. Members include PATCH child care and center-based providers as well as interested members of the community who are kept apprised through a newsletter. PATCH also sends newsletters to parents, and maintains a resource data base used to provide parents with service-related information.

- Child Care Connection, Department of Human Services – In addition to licensing preschools, child care centers, after-school programs, and infant and toddler programs throughout the State, these State offices on each island also administer a preschool/child care subsidy program for low-income families with children ages 0 – 13 years old.

- Head Start Programs – Like programs across the nation, Hawaii's federally-funded Head Start Program provides comprehensive educational and health services (including dental services and behavioral health consultations) to low-income children throughout the State.

Collaboration with the Department of Education and Department of Health

- The Med-QUEST Division will initiate efforts to collaborate with the State's Department of Education, and the School Health Nurses and Health Aides of the Department of Health. This outreach effort will initially be aimed at providing Medicaid program information and follow-up to grade school students: 1) who are enrolled in the National School Lunch Program, and 2) whose emergency contact cards indicate that they have limited or no health coverage.

Community-based organizations will be asked to disseminate information about the program and the referral process to potentially eligible families. These organizations include, but are not limited to:

- Places of worship/churches such as, the Hawaii Ecumenical Council, and the "Faith in Action" (FACE) program. FACE is composed of 18 churches working together to identify and assist congregation members with social issues, providing home visits and care through parish nurses;
- Activity-based organizations – For example, athletic/sports-related organizations such as: American Youth Soccer Organization (AYSO), Police Athletic League-sponsored sports (youth baseball, football, and basketball teams); scouting organizations; and *Hula Halau* (schools of hula);
- Public housing community associations, and community-based organizations providing social, educational, and recreational services to youth such as: Palama Settlement; the Suzannah Wesley Center; and the YMCA and YWCA.

Developing and/or continuing ongoing coordination with existing organizations and State agencies including, but not limited to:

- Service provider networks such as:
    - Catholic Social Services, the organization providing outreach and care to the homeless population through mobile van services;
    - AIDS Community Care Team – a statewide consortium of organizations providing services to persons with HIV/AIDS that also administers the State's Ryan White service funds;
    - The substance abuse provider network;
- Advocacy organizations such as the Developmental Disabilities Council; the Alliance for Mental Illness; State Children's Council; *Papa Ola Lokahi (*Hawaiian health advocacy organization) as well as other organizations in the Native Hawaiian Health System; and the Homeless Coalition;
- QUEST health and dental plans;
- Healthcare provider organizations such as, the Hawaii Medical Association; the American Academy of Pediatrics – Hawaii Chapter; the Hawaii Nurses Association; the Hawaii Dental Association; the

Healthcare Association of Hawaii; ER Physicians' organization; Discharge Planners Association, and the Case Management Association;
- The State's Unemployment Office; Office of Youth Services; and the Judiciary;
- The Department of Health's Dental Health Division, servicing low-income persons and/or persons with disabilities. This Division currently provides Medicaid benefits information and assistance with completion of the application for persons accessing their services, and
- Shriners Hospital, the pediatric orthopedic facility that has provided since 1923, free surgical and rehabilitative orthopedic care to more than 17,000 children from Hawaii and the Pacific Basin.

State's Title V Agency - Family Health Services Division, Department of Health (DOH)

Specific emphasis will be placed on strengthening the partnership between the State's Medicaid and the Title V agencies. The numerous Family Health Services Division programs currently serving low-income pregnant women, women at-risk, young children at-risk or those with special needs, have been proactive about ensuring that clients, appropriate for Medicaid, are enrolled into either the fee-for-service program or QUEST. To enhance current efforts, discussions with the Family Health Services Division have resulted in a mutual commitment to intensify and expand a jointly coordinated outreach plan.

Improving current efforts

Many agencies in the Title V network receiving Maternal/Child Health Block Grant monies are currently providing Medicaid information and/or enrollment assistance to their clients. For example:
- Mother's Care, a statewide prenatal education and awareness program includes QUEST and Medicaid Title XIX informational brochures in packets provided to pregnant moms;
- The Perinatal Support Clinics throughout the State also provide Medicaid information and, many on Oahu, operating out of the community health centers, have staff reimbursed by Medicaid who perform initial application processing functions;
- Case managers with the Children with Special Health Needs Program, Zero-To-Three Program, and Healthy Start also provide benefits counseling and application assistance.

Expanding outreach efforts within the Family Health Services Division

At a minimum, Medicaid program information will be made available on a statewide basis in the clinical and services sites of the following programs:

- WIC Services Branch – In addition to Medicaid informational brochures, HPCA will pursue its recommendation to work with DHS, Med-QUEST Division to train WIC staff to serve as outstationed eligibility workers at WIC clinic sites.

- Children with Special Health Needs Branch – In addition to the Children with Special Health Needs Program and the Zero-To-Three Program where information is currently available through special services such as the Hawaii Keiki Information Service (H-KISS), brochures will also be placed in the Infant and Toddler Section:
    - Infant and Toddler Development Program that provides direct therapeutic services (OT, PT and Speech) for children with developmental delays; and the
    - Preschool Developmental Screening Program providing services to children ages 3 - 5.

- Maternal and Child Health Branch, including the
    - Child Health Services Section that implements the State's Lead Screening program;
    - Early Head Start Program that provides psychosocial support services; and
    - Family Planning Services Section.

In addition to the family planning clinics operating out of the primary care clinics/community health centers, informational brochures will be placed in the offices of physicians who have been contracted with to provide family planning services.

Developing ongoing coordination with programs such as the:

- Department of Education's High School *Hapai* (Pregnancy) Coordinators, who provide supportive services to pregnant teens; and
- Kapiolani's Teen Intervention Program administered by the medical center for women and children in the state.

Developing and implementing "Train the Trainer" sessions aimed at training staff from both the public and private sectors who will train others involved in outreach efforts about, at a minimum, the:

- Medicaid programs' eligibility criteria and the application process;
- How to assist applicants with completing the Medicaid application;
- Documentation requirements for eligibility determination;
- Medicaid program benefits;
- The QUEST program and managed care.

Developing easy-to-understand instructions (at the 5th grade level and printed in English, Ilocano/Tagalog, Chinese, Samoan, Vietnamese, and Korean) to assist

applicants with completing the Medicaid application form.

Establishing an 800 hotline, accessible on a statewide basis for enrollment information, including-Medicaid program information, eligibility criteria, assistance with completing the application form, and contact number(s) for more information. The State is also intending to link up with the National Governor's Association's "Insure Kids Now" toll-free hotline services that will be connecting families nationwide to the appropriate agency/persons in their own state.

Developing a Medicaid program website to provide information about Medicaid programs.

Developing a media campaign, that will include:

- Conducting a contest to name-the-program and develop a logo;
- Seeking a celebrity spokesperson;
- Initiating press releases and feature articles for major, local and ethnic newspapers;
- Distributing public service announcements for radio and TV;
- Arranging for bus advertising cards;
- Submitting an application to the Ad Council for the "Ad2" program (The Ad Council develops a media campaign for one selected program each year).

Developing links with the business community and foundations to enlist their support with activities such as information dissemination and the media campaign.

The outreach efforts described above apply to each Medicaid program – the fee-for-service program, QUEST, and the Title XXI Medicaid expansion. Additionally, staff stationed in the FQHC and the disproportionate share hospital on Oahu will be performing application processing activities for children eligible for Title XXI as well as Medicaid's Title XIX and Section 1115 waiver programs.

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. ☐ Pre-natal care and pre-pregnancy family services and supplies **(Section 2110(a)(9))**

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

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

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

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

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))**

Please refer to matrix located in Appendix 1

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

Please refer to matrix located in Appendix 1

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))**

Please refer to matrix located in Appendix 1

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-child care
- 9.3.7.3. ☐ Adolescent well visits
- 9.3.7.4. ☒ Satisfaction with care
- 9.3.7.5. ☒ Mental health
- 9.3.7.6. ☒ Dental care
- 9.3.7.7. ☒ Other, please list:
  - ☒ Utilization of Primary Care Providers
  - ☒ Appointment Wait Times

☒ EPSDT Periodicity Screens

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's Annual Reports on the progress made in reducing the number of uncovered low-income children will be primarily based on the findings and analysis of the annual Hawaii Health Survey conducted in the last three years by the State's Department of Health. This annual survey, being refined with use, has focused on gathering data about the health coverage status of Hawaii's children by income, age, and employment status of the child's family. The State intends to continue using this data to: 1) calculate the baseline number of uncovered low-income children; and 2) analyze the extent of progress made, in the context of the factors affecting the provision of accessible, affordable, quality health insurance and health care for children in Hawaii.

The State's Evaluation of the effectiveness of the state plan will address the elements outlined in Section 10.2. The information and other sources to be used in the analysis of the plan's effectiveness in meeting performance measures will include:

1. The following information systems:*
   - the Hawaii Automated Welfare Information (HAWI) system that tracks Medicaid ABD and QUEST program eligibility and demographics;
   - the Hawaii Prepaid Medical Management Information System (HPMMIS) tracks service utilization and expenditure data as well as demographic information of Medicaid's fee-for-service program
   - HPMMIS also tracks Medicaid FFS and QUEST program enrollment and disenrollment activity and encounter data, including sub-systems for reference files and the QUEST provider registry.

   The Division implemented the Hawaii Prepaid Medical Management Information System (HPMMIS) that provides:
   - Fiscal Agent services;
   - Certified/Certifiable MMIS;

- Health Plan Enrollment/Disenrollment information;
- Encounter Data Processing;
- Data Warehouse capacity;
- Predefined Reports;
- Decision Support/Executive Information System;
- Capitation Payment activities; and
- Premium Share Billing and Collection

*An option that is also currently being explored is the possibility of using some components of Arizona's Information System. Discussions have been initiated about areas such as eligibility, enrollment, encounter data and provider files, and a feasibility study is now being conducted to assess the potential compatibility of Arizona's system in meeting Hawaii's informational system needs.

2. Quality improvement/quality control mechanisms currently in place to monitor and assure quality and appropriateness of health, dental, and behavioral health services will also be used. As an expansion of Medicaid, the provision of services to the Title XXI targeted groups will be fully integrated in all current mechanisms including, but not limited to:

    - The requirement for QUEST plans to develop and operationalize an internal Quality Assurance Program (QAP) meeting stipulated standards;
    - Compliance with QAP reporting requirements, including quality of care studies, QAP evaluation reviews, and reports on complaints and grievances from members and providers, with additional information about the number of adverse actions/decisions made, the number of appeals and the outcomes of the appeals;
    - Submittal of HEDIS reports addressing the health plans' performance in the areas of membership, utilization, quality of care, and access to care;
    - Submittal of encounter data;
    - External monitoring by an External Quality Review Organization (EQRO) responsible for conducting an independent medical review or audit of the quality of services provided by the health plans;
    - Case study interviews; and
    - Surveys of members and providers conducted by the Med-QUEST Division to: 1) determine overall satisfaction with QUEST, QUEST-Net and the health plan; 2) the quality of care received; and 3) the overall health status of members.

3. The Policy and Program Development Office of the Med-QUEST Division will be responsible for monitoring progress and preparing the annual assessment and the evaluations, and will also ensure that input is received from the State Title XXI Planning Committee.

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))**

In fall 1997, the State initiated efforts for public involvement through an informational meeting at which the Director of the Department of Human Services and the Administrator of the Med-QUEST Division presented information about Title XXI and highlighted its potential opportunities. The invitation they extended to all interested parties to participate in the Title XXI planning process was enthusiastically received by consumer/advocacy organizations, legislators, public sector and community-based service providers, and professional health organizations.

While there was an initial concern that Hawaii might be precluded from participating because of the maintenance of effort provision, the Department of Human Services in conjunction with the Department of Health decided to proceed with the Title XXI planning process to ensure that the State would meet the June 20, 1998 deadline for submittal of the State's plan. The State subsequently received HCFA's provisional approval to access Hawaii's Title XXI allotment.

Between January and April 1998, four (4) State Title XXI Planning Committee meetings were held to review, discuss, revise, and accept or reject proposals generated by the Eligibility, Benefits, and Outreach sub-committees established by the statewide Planning Committee. All final recommendations from the Committee were carefully considered by the Med-QUEST Division in development of this proposed state plan. During the implementation phase of the Title XXI Medicaid expansion, the State will continue to request the Committee's input.

The State Title XXI Planning Committee reflects broad-based statewide participation, and includes representation from the following :

☐ Consumer/advocacy groups
- Consumers
- AIDS Community CareTeam
- Developmental Disabilities Council
- Easter Seals Society of Hawaii
- Hawaii Advocates for Children and Youth
- Legal Aid Society of Hawaii
- State Children's Council

☐ Community-Based/Private Sector Organizations
- Catholic Charities Family Services
- Family Support Services
- Head Start
- Kapiolani Teen Intervention Program
- Kokua Kalihi Valley Social Services
- Palama Settlement
- Papa Ola Lokahi
- Parents and Children Together (PACT)
- Queen Liliuokalani Children's Center

☐ Health Care Provider Organizations
- American Academy of Pediatrics, Hawaii Chapter
- Hawaii Dental Association
- Hawaii Medical Association
- Hawaii Nurses Association
- Hawaii Primary Care Association
- Healthcare Association of Hawaii

☐ Executive Office - Senior Policy Advisor to the Governor For Children and Families

☐ Legislative Representatives
- House Committee on Health

- House Committee on Human Services and Housing
- Senate Committee on Health and Environment
- Senate Committee on Human Resources Services

☐ QUEST Health Plans
- Aloha Care
- DentiCare, Inc.
- HMSA, including HMSA's Community Relations Office
- Kaiser Permanente
- Kapiolani HealthHawaii
- Queen's Health Plan
- StraubCare Quantum.

☐ Public Sector Agencies
- Department of Education - Kahuku High School
- Department of Health
  - ♦ Administrative Representation by the Deputy Director of DOH
  - ♦ Child and Adolescent Mental Health Division
  - ♦ Dental Health Division
  - ♦ Family Health Services Division (State's Title V Agency)
    - ⇒ Administrative and Program Development Staff
    - ⇒ Children with Special Needs Branch
    - ⇒ Family Planning Services Section
    - ⇒ Healthy Start
    - ⇒ Zero-To-Three Project
    - ⇒ Immunization Program
- Department of Human Services
  - ♦ Med-QUEST Division
    - ⇒ Health Coverage and Management Branch
    - ⇒ Policy and Program Development
  - ♦ Social Service Division
    - ⇒ Administrative Staff
    - ⇒ Child Welfare Services

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))**

We are not aware of any Federally recognized Indian Tribes in the State; however, if we become aware of them, they will be invited to participate in the development and implementation of enrollment procedures for American Indian and Alaska Native children as required in 42 CFR

457.125.

We have not had any organizations come forward to express interest in participating in the development and implementation of the program; however, should an organization come forward, they will be asked to participate in the development and implementation of enrollment procedures for American Indian and Alaska Native children as required in 42 CFR 457.125.

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).

When approval is granted by CMS, the amendments as described in §457.65(b) through (d), cannot take effect until a public hearing is held and administrative rules are adopted. The following text is standard and used for that purpose.

Pursuant to sections 91-3 and 92-41, Hawaii Revised Statutes, a legal notice is published to inform the public of when the Department of Human Services will hold a public hearing to consider proposed amendments to and repeal of existing rules, and the adoption of new rules of the Med-QUEST Division for the purpose of conforming to State and Federal Statutes.

A brief description of the proposed rules, which are based on State and Federal laws, are listed.

All interested parties are invited to attend the hearing and to state their views relative to the proposed rules either orally or in writing. The public is informed of the process should oral or written testimony be presented.

The public is informed that a copy of the proposed rules 1) will be mailed at no cost to any interested person; and 2) are available at the Virtual Rules Center located at the following web site: http://www.hawaii.gov/dhs/main/har.

Lastly, the public is informed that special accommodations (i.e., sign language interpreter, large print, taped materials, or accessible parking) can be made, if requested at least seven working days before the scheduled public hearing.

9.10. Provide a 1-year projected budget that satisfies requirements under Section 2107(d) of the Social Security Act and 42 CFR § 457.140.

STATE: Hawaii	FFY Budget
Federal Fiscal Year	**2024-2025**[vi]
State's enhanced FMAP rate	**71.36%**[vii]
Benefit Costs	
Insurance payments	
Managed care	61,000,000
per member/per month rate	141
Fee for Service	8,000,000
Total Benefit Costs	69,000,000
(Offsetting beneficiary cost sharing payments)	2,000,000
Net Benefit Costs	67,000,000
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	1,200,000
General administration	1,200,000
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	462,000
Other	
Total Administration Costs	2,713,350
10% Administrative Cap	6,971,335
Cost of Proposed SPA Changes	
Federal Share	49,747,447
State Share	19,965,903
Total Costs of Approved CHIP Plan	69,782,000

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: State general funds.

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[i] American Optometric Association. "School-aged Vision: 6 to 18 Years of Age." http://www.aoa.org/patients-and-public/good-vision-throughout-life/childrens-vision/school-aged-vision-6-to-18-years-of-age?sso=y

[ii] Slusser, Wendelin and Dudovitz, Rebecca. Impact Analysis of Vision To Learn. UCLA. http://visiontolearn.org/wp-content/uploads/UCLA-Study-Quantitative-Analysis.pdf

[iii] Project Vision Hawaii. https://www.projectvisionhawaii.org/

[iv] Vision To Learn. https://visiontolearn.org/

9.10. Provide a 1-year projected budget that satisfies requirements under Section 2107(d) of the Social Security Act and 42 CFR § 457.140.

STATE: Hawaii	FFY Budget
Federal Fiscal Year	**2024-2025**[vi]
State's enhanced FMAP rate	**71.36%**[vii]
Benefit Costs	
Insurance payments	
Managed care	61,000,000
per member/per month rate	141
Fee for Service	8,000,000
Total Benefit Costs	69,000,000
(Offsetting beneficiary cost sharing payments)	2,000,000
Net Benefit Costs	67,000,000
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	1,200,000
General administration	1,200,000
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	
Hearing Services	690,000
Vision Services	462,000
Other	
Total Administration Costs	3,552,000
10% Administrative Cap	7,055,200
Cost of Proposed SPA Changes	
Federal Share	50,345,907
State Share	20,206,093
Total Costs of Approved CHIP Plan	70,552,000

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: State General Funds

[vi] The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

[vii] Kaiser Family Foundation. Enhanced FMAP for CHIP (FY 2023). https://www.kff.org/other/state-indicator/enhancedfederal-matching-rate-chip/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

9.10. Provide a 1-year projected budget that satisfies requirements under Section 2107(d) of the Social Security Act and 42 CFR § 457.140.

STATE: Hawaii	FFY Budget
Federal Fiscal Year	**2026-2027**[xi]
State's enhanced FMAP rate	**71.78%**
Benefit Costs	
Insurance payments	
Managed care	61,000,000
per member/per month rate	141
Fee for Service	8,000,000
Total Benefit Costs	69,000,000
(Offsetting beneficiary cost sharing payments)	2,000,000
Net Benefit Costs	67,000,000
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	1,200,000
General administration	1,200,000
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	
Hearing Services	690,000
Vision Services	462,000
Dental Services (K-12)	**Total-778,884**
Other	
Total Administration Costs	4,330,883
10% Administrative Cap	7,133,088
Cost of Proposed SPA Changes	
Federal Share	51,201,308
State Share	20,129,575
Total Costs of Approved CHIP Plan	71,330,883

NOTE: Include the costs associated with the current SPA.

The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

[xi] Federal Register :: Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2025, Through September 30, 2026

The Source of State Share Funds: State General Funds

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**.

Eligibility and Enrollment Matters

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

Health Services Matters

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

Premium Assistance Programs

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

STRATEGIC OBJECT	PERFORMANCE GOALS	PERFORMANCE MEASURES
1. Reduce the number of uninsured children Date Source: pg. 64/84 in FFY 2021 CARTS doc.	1.1 Maintain or increase the new enrollment of children into Medicaid and CHIP. 1.2 Continue information and outreach activities about Medicaid programs, including Title XXI Medicaid expansion, to maintain or increase total CHIP enrollment of children under age 19.	1.1.1 Goal will be measured by dividing the number of unduplicated children newly enrolled in Medicaid and CHIP by the number of unduplicated children enrolled in Medicaid and CHIP in the State of Hawaii during the second to last FFY. 1.2.1. Goal will be measured by dividing the number of unduplicated children enrolled in CHIP in the last FFY by the number of unduplicated children enrolled in CHIP in the second to last FFY.

STRATEGIC OBJECT	PERFORMANCE GOALS	PERFORMANCE MEASURES
2. Increasing the access and use of preventative care. Date Source: pg. 68/84 in FFY 2021 CARTS doc.	2.1 Achieve an annual increase in the prevalence of well-care visits among adolescents until the state achieves a 95% average compliance rate.	2.1.1 Goal will be measured by reviewing the rate of increase from last FFY to the second to last FFY