State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

May 31, 2013

Gloria Nagle, PhD, MPA
Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT (SPA) 13-005

Dear Ms. Nagle:

California passed Assembly Bill (AB) 1494 (Chapter 28, Statutes of 2012) on June 27, 2012 and September 22, 2012, AB 1468 (Chapter 438, Statutes of 2012) to approve Medicaid expansion in California for targeted low-income children, include premium payments, and transition children from California's Children's Health Insurance Program, known as the Healthy Families Program (HFP) to Medi-Cal. The expected completion date of the transition is September 2013. During the transition, the coverage group, consisting of both HFP transition children and new applicants to Medi-Cal determined eligible as Optional Targeted Low Income Children (OTLIC), operate under an amendment to California's 1115 Bridge to Reform waiver. Once the transition of HFP children completes, these children shall fall under the state plan through this state plan amendment. New applicants, who would otherwise have eligibility for healthcare coverage under the HFP, now have eligibility through Medi-Cal as OTLIC.

To accomplish expanding the Medi-Cal Program, the Department of Health Care Services (DHCS) submits SPA 13-005 to update the portions of the state plan that affect treatment of income and resources, and imposing premiums.

Income Limits and Exempted Resources

Welfare and Institutions Code 14005.26 and 14005.27 now allows Medi-Cal to exempt all resources and disregard income above 200 percent of Federal Poverty Level (FPL) up to and including 250 percent of FPL, for this group of children in preparation to accept these targeted low-income children into this optional program.

Premiums

DHCS chooses to use the federal option under section 1916A of the Social Security Act and 42 CFR 447.50 and 447.62 – 447.82, that allows states to apply premiums. The expansion of the Medi-Cal Program allows no monthly premium payments for parents/guardians of children in a family where the family income is at or below 150 percent of the federal poverty level FPL. Parents/guardians of children in a family where the family income is above 150 percent, up to and including 250 percent of the FPL, pay a minimum monthly premium of $13 per child up to a maximum monthly premium of $39 per family. DHCS submits the following pages to the State Plan for implementation of the OTLIC Program:

- Attachment 2.2-A, pages 23b and 23c Groups Covered and Agencies Responsible
- Supplement 8a to Attachment 2.6-A, page 14 Methodologies for Treatment of Income
- Supplement 8b to Attachment 2.6-A, page 15 Methodologies for Treatment of Resources and
- Attachment 4.18 F, pages1-11 Premiums Imposed on Targeted Low-Income Children
- Title of Attachments, page 4: The inclusion of Attachment 4.18-F, Premiums Imposed on Optional Targeted Low-Income Children

If you have any questions, or if we can provide further information, please contact Ms. Tara Naisbitt, Chief, Medi-Cal Eligibility Division, at (916) 552-9450 or by email at tara.naisbitt@dhcs.ca.gov

Sincerely,

Originally Signed by Toby Douglas

Toby Douglas
Director

Enclosure (if applicable)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **13-005**

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1902(a)(10)(A)(ii)(XIV), Section 1902(r)(2), 1905(u)(2)(B) and 1916A, of the Social Security Act.

7. FEDERAL BUDGET IMPACT:
a. **FFY 2012** 9/1-30/2013 **$53,749,000**
b. **FFY 2013** **$644,980,000**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.2-A pages 23b and 23c
Supplement 8a to Attachment 2.6-A. page 14
Supplement 8b to Attachment 2.6-A, page 15
Attachment 4.18-F, pages 1-9
Title of Attachment, page 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 2.2-A pages 23b and 23c
Title of Attachment page 4

10. SUBJECT OF AMENDMENT:
Implementation of targeted low-income children with family incomes up to and including 200 percent of the federal poverty level; less restrictive income and resource methodologies; and the option to impose premiums

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Originally signed by Toby Douglas

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: 5/31/2013

16. RETURN TO:
Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

No.	Title of Attachment
.*4.18-D	Premiums Imposed on Low Income Pregnant Women and Infants
*4.18-E	Premiums Imposed on Qualified Disabled and Working Individuals
4.18-F	Premiums Imposed on Targeted Low-Income Children
4.19-A	Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care
4.19-B	Methods and Standards for Establishing Payment Rates – Other Types of Care • Supplement 1 – Methods and Standards for Establishing Payment Rates for Title XVIII Deductible/Coinsurance
4.19-C	Payments for Reserved Beds
4.19-D	Methods and Standards for Establishing Payment Rates – Skilled Nursing and Intermediate Care Facility Services
4.19-E	Timely-Claim Payment – Definition of Claim
4.20-A	Conditions for Direct Payment for Physicians' and Dentists' Services
4.22-A	Requirements for Third Party Liability – Identifying Liable Resources
4.22-B	Requirements for Third Party Liability – Payment of Claims
*4.22-C	Cost-Effective Methods for Employer-Based Group Health Plans
*4.32-A	Income and Eligibility Verification System Procedures: Requests to Other State Agencies
*4.33-A	Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals
4.34-A	Requirements for Advance Directives Under State Plans for Medical Assistance
4.35-A	Criteria for the Application of Specified Remedies for SNFs
4.35-B	Alternative Remedies to Specified Remedies to Specified Remedies for SNFs
5.3-A	Training Programs; Sub-professional and Volunteer Programs
7.2-A	Methods of Administration – Civil Rights (Title VI)
7.2-B	Methods of Administration – Section 504 Rehabilitation Act

* Forms Provided

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METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI AND AFDC PROGRAM
(Less Restrictive Than SSI and AFDC)

Beginning on September 1, 2013 exempt all resources pursuant to the option in 1902(r)(2) for Optional Targeted Low-Income Children under Section 1902(a)(10)(A)(ii)(XIV) of the Act.

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METHODOLOGIES FOR TREATMENT OF INCOME
THAT DIFFER FROM THOSE OF THE SSI AND AFDC PROGRAM
(Less Restrictive Than SSI and AFDC)

Beginning on September 1, 2013, apply an income disregard pursuant to 1902(r)(2) for income above 200 percent up to and including 250 percent of the federal poverty level to all Optional Targeted Low-Income Children.

The more liberal income methodologies contained in Supplement 8a to Attachment 2.6-A pages 1, 7, 8, and 9 shall apply for all Optional Targeted Low-Income Children under Section 1902(a)(10)(A)(ii)(XIV) of the Act. Those deductions are:

- Title II Social Security cost of living increase,
- Income disregard applicable to MN individuals,
- In-home caregiver wages exemption, and
- Kinship Guardianship Assistance Payments.

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Alternative Premiums and Cost Sharing Changes

The following alternative premiums and cost sharing changes are imposed under section 1916A of the Social Security Act and 42 CFR 447.50 and 447.62 – 447.82. A state may select one or more options for cost sharing (including copayments, coinsurance, and deductibles) and premiums.

A. For groups of individuals with family income at or below 100 percent of the Federal Poverty Level (FPL):

1. Cost Sharing
   a. Amount of Cost Sharing
      i. _X_ / No cost sharing is imposed.
      ii. ___ / Nominal cost sharing is imposed under section 1916 of the Act (see Attachment 4.18-A and/or 4.18-C).

2. Premiums
   a. Amount of Premiums
      No premiums may be imposed for individuals with family income at or below 100 percent of FPL.

B. For groups of individuals with family income above 100 percent, but at or below 150 percent of FPL:

1. Cost Sharing
   a. Amount of Cost Sharing
      i. X / No cost sharing is imposed.
      ii. ___ / Nominal cost sharing is imposed under section 1916 of the Act (See Attachment 4.18-A and/or 4.18-C).
      iii. ___ / Alternative cost sharing is imposed under section 1916A of the Act as follows (specify the amounts of group and services (see below)):

Group of Individuals	Item/Service	Type of Charge			*Method of Determining Family Income if different than for eligibility (including monthly or quarterly period)
		Deductible	Coinsurance	Copayment	

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b. Limitations:

- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a _XX_ monthly or ___ quarterly basis as specified by the State.
- Cost sharing with respect to any item or service may not exceed 10 percent of the cost of the specific item or service.
- Cost sharing may not be imposed for the services, items, and populations specified at section 1916A (b)(3)(B) of the Act and 42 CFR 447.70(a).
- Additional limitations specified by the State: None

c. Enforcement

___/ Providers are permitted to require the payment of any cost sharing as a condition for the provision of care, items, or services.

Regardless of whether the State elects the above option to permit providers to enforce the collection of cost sharing payments, providers are permitted to reduce or waive cost sharing on a case-by-case basis. However, the State's payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider collects the full cost sharing amount.

2. Premiums

a. Amount of Premiums

No premiums may be imposed for individuals with family income above 100 percent of the FPL, but at or below 150 percent.

C. For groups of individuals with family income above 150 percent of the FPL:

1. Cost Sharing

a. Amount of Cost Sharing

i. X/ No cost sharing is imposed.

ii. __/ Nominal cost sharing is imposed under section 1916 of the Act (see Attachment 4.18-A page 1 and/or 4.18-C page 1.

iii. __/ Alternative cost sharing is imposed under section 1916A of the Act as follows (specify the amounts of group and services (see below)):

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Group of Individuals	Item/Service	Type of Charge			*Method of Determining Family Income if different than for eligibility (including monthly or quarterly period)
		Deductible	Coinsurance	Copayment	

b. Limitations:

- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a _X_ monthly or ___ quarterly basis as specified by the State.
- Cost sharing with respect to any item or service may not exceed 20 percent of the cost of the specific item or service.
- Cost sharing may not be imposed for the services, items, and populations specified at section 1916A(b)(3)(B) of the Act and 42 CFR 447.70(a).
- Additional limitations specified by the State: None

c. Enforcement

___/ Providers are permitted to require the payment of any cost sharing as a condition for the provision of care, items, or services.

Regardless of whether the State elects the above option, providers are permitted to reduce or waive cost sharing on a case-by-case basis. However, the State's payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider collects the full cost sharing amount.

2. Premiums

a. Amount of Premiums

i. ___/ No premiums are imposed.

ii. _X / Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

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Group of Individuals including income level	Premium	*Method of Determining Family Income, if different than for eligibility (including monthly or quarterly period)
Optional targeted low-income children (OTLIC) ages 1 up to the month of their 19th birthday, who have family incomes above150 percent and up to and including 200 percent.	$13 per month 1 child $26 per month 2 children $39 per month 3 or more children	The methodology used for determining eligibility, includes, a disregard of income between 200 percent of the federal poverty level up to and including 250 percent of the federal poverty level.

b. Limitation:

- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a X monthly or __ quarterly basis as specified by the State.
  - Premiums may not be imposed for the populations specified at section 1916A(b)(3)(A) of the Act and 42 CFR 447.66(a).
  - Additional limitations specified by the State:

Section 5006(a) of the American Recovery and Reinvestment Act and 42 CFR Part 447 exempts American Indian/Alaskan Native (AI/ANs) from premiums and enrollment fees, if they are eligible to receive or have received an item or service from an Indian Health Service (IHS)/Tribal 638/Urban Indian Health Program (UIHP) (I/T/U) or through a referral under contract health services.

The State is in the process of developing a means for exempting AI/ANs. If the parent/guardian self attests that the AI/AN applying is eligible to receive or has received a service from an Indian Health Service (IHS)/Tribal 638/Urban Indian Health Program (UIHP) (I/T/U) or through a referral under contract health services, the AI/AN will not have to pay premium payments. If the parent/guardian does not provide self-attestation, then the parent/guardian must submit a letter to the county on I/T/U letterhead that exempts the AI/AN under section 5006(a) of the American Recovery and Reinvestment Act and 42 CFR Part 447. The county will, upon receipt of the letter or self-attestation, submit a transaction with an indicator to identify AI/ANs on the State's Medi-Cal Eligibility Data System (MEDS). This indicator along with the premium aid code identifies the AI/AN as exempt from paying premiums. The state's premium payment processor receives monthly files from MEDS that display the indicator with the premium aid code and exempts the AI/AN and will not bill for premiums.

Until the State has this new process in place as per discussions with CMS on November 29 and December 4, 2012, the State will temporarily use the existing process under the Healthy Families Program to exempt AI/ANs from cost sharing under Medi-Cal.

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c. Enforcement

i. __/ Prepayment is required for the following groups of applicants when they apply for Medicaid:

ii. __/ Prepayment is required for the following groups of beneficiaries as a condition for receiving Medicaid services for the premium period:

iii. X / Eligibility is terminated for failure to pay premiums after a grace period of 90/120 days after the premium due date (at least 60 days) for the following groups of Medicaid beneficiaries:

Beneficiaries in the following age categories will terminate after a grace period of 90/120 days:

- 1-19 years of age, with family income above 150 percent of the FPL and up to and including 200 percent of the FPL (with an income disregard up to and including 250 percent of the FPL) will terminate after 90 days from age 1 - 19 years of age.
- Ages 0-2, Access for Infants and Mothers Program (AIM) linked infants, with incomes above 200 percent up to and including 250 percent FPL will terminate after a grace period of 120 days.

iv. __/ Payment will be waived by the state on a case-by-case basis, if payment would create an undue hardship for the individual.

D. Period of determining 5 percent aggregate family limit for premiums and cost sharing:

Specify the period for which the 5 percent maximum will be applied.

__/ Quarterly
X/ Monthly

E. Method for tracking beneficiaries' liability for premiums and cost sharing:

1. Describe the methodology used by the State to identify beneficiaries, who are subject to premiums or to cost sharing for specific items or services.

   RESPONSE: California will use aid codes to identify beneficiaries with family incomes above 150 percent FPL. These individuals will have premium payments and will require cost sharing tracking. Family incomes at or below 150 percent of the FPL do not require cost sharing tracking.

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Income Level	**Proposed Premiums and copayments* by service type in Medicaid**
Optional targeted low-income children ages 1 up to the month of their 19th birthday, who have family incomes above150 percent up to and including 200 percent with disregards to 250 percent.	$13 per month 1 child $26 per month 2 children $39 per month 3 or more children

2. Describe how the State identifies for providers, ideally through the use of automated systems, whether cost sharing for a specific item or service may be imposed on an individual beneficiary and whether the provider may require the beneficiary, as a condition for receiving the item or service, to pay the cost sharing charge.

   RESPONSE
   Cost sharing in the form of a copayment is primarily a fee-for-service charge. Please refer to Attachment 4.18-A and 4.18-C of California's State Plan for copayments by service. As copayments are not enforceable, California does not instruct its Managed Care providers to collect copayments. Copayments do not affect the receipt of services through Managed Care or California Children's Services.

3. Describe the State's processes (that do not rely on beneficiaries) used for tracking beneficiaries' incurred premiums and cost sharing under section 1916 and 1916A of the Act if families are at risk of reaching their total aggregate limit for premiums and cost sharing, how the State informs beneficiaries and providers when a beneficiary's family has incurred premiums and cost sharing up to its 5 percent aggregate limit, and how the State assures that the family is no longer subject to further premiums and cost sharing for the remainder of the monthly or quarterly cap period.

   RESPONSE
   California does not anticipate or expect children to reach or exceed the five percent monthly aggregate limit imposed by federal regulations on the assessed premiums. However, to ensure the family does not exceed the monthly aggregate limit imposed, California intends to implement a process that uses the family income reported to the counties to determine the maximum five percent cap and assess that amount against the premiums if any, required of the family each month. This five percent cap displays on the monthly premium statement to inform beneficiaries of the maximum dollar amount incurred each month before they are no longer subject to further cost sharing provisions.

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California will use the state's premium payment processor's billing process to track the cost sharing for the Optional Targeted Low Income Children's Program. Currently, California only charges premiums for children in families with family income above 150 percent FPL and there are no copayments.

AI/AN beneficiaries are exempt from premiums if the parent/guardian of the AI/AN self attests to the county eligibility worker that the AI/AN beneficiary is eligible to receive or has received an item or service from an Indian Health Service (IHS)/Tribal 638/Urban Indian Health Program (UIHP) (I/T/U) or through a referral under contract health services. If the parent/guardian does not provide self-attestation, then the parent/guardian must submit a letter to the county on I/T/U letterhead that exempts the AI/AN beneficiary under section 5006(a) of the American Recovery and Reinvestment Act and 42 CFR Part 447. The county will, upon receipt of the letter or self-attestation, submit a transaction with an indicator to identify AI/AN beneficiaries on California's Medi-Cal Eligibility Data System (MEDS). This indicator along with the premium aid code identifies the AI/AN beneficiary as exempt from cost sharing and premiums. The state's premium payment processor receives monthly files from MEDS that display the indicator with the premium aid code. The premium payment processor then posts on the individual's premium statement "exempt from premium payments and/or copays." This information "exempt from premium payments and/or copays and deductibles" will also display as a message on California's automated eligibility verification system and point of service devices.

If DHCS is ever approved for enforceable copayments, then this process will be reviewed and revised accordingly.

4. Describe the process through which beneficiaries may request that the State reassess the family's aggregate limit for premiums and cost sharing when the family's income has changed or if a family member's Medicaid enrollment is being terminated due to nonpayment of a premium.

RESPONSE

To request a reassessment of premiums levels, beneficiaries need to contact their county eligibility worker (EW). The EW requests information pertinent to the change in order to conduct a redetermination based on a change in circumstance in accordance with current policy and then either finds the beneficiary eligible to a full scope, no share-of-cost Medi-Cal program or reassesses the family premium accordingly.

Beneficiaries terminated due to nonpayment of a premium may request a fair hearing to review and reassess the family's premiums when they object to the termination. The beneficiary may at any time there is a change in circumstance, contact their county EW for a reassessment of income.

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F. Public Notice Requirements:

Explain how the State meets the following public notice requirements at 42 CFR 447.76.

1. The requirement at 42 CFR 447.76(a) and (b) for making available certain information about the State's premiums and cost sharing policies and procedures to the general public, applicant, beneficiaries, and providers:

   RESPONSE
   California began notifying the public of its premium policy, including differences based on income, through an established venue of public forums, departmental web pages, program notices, legislation and regulations, and stakeholder meetings and webinars in late 2012 and continues to work with stakeholders and the public on outreach concerning this policy.

   Applicants and beneficiaries receive information from county agencies in the following forms: the Medi-Cal brochure, application and evidence of coverage documentation, enrollment materials, and program regulations at the time of eligibility determination and redetermination.

   Through outreach and training, individuals such as certified application assistors, who help families with their application, will also be familiar with the program's requirements and be able to communicate them to families when discussing the program. Any changes to the premiums would be presented in public forums.

2. The requirement at 42 CFR 447.76(c) to provide the public with advance notice and the opportunity to comment prior to submitting a State plan amendment (SPA) to establish or substantially modify alternative premiums and/or cost sharing under section 1916A of the Act.

   (Note: The State must submit documentation with the SPA to demonstrate that this requirement was met.)

   RESPONSE
   On October 31, 2012, the State distributed draft pages in the State Plan Amendment (SPA) 12-018 to various stakeholder groups and posted all documents publicly on the department's website at http://www.dhcs.ca.gov/services/Pages/HealthyFamiliesTransition.aspx with a request for feedback by 3p.m. on November 9, 2012. All interested parties were encouraged to send their questions and feedback in writing to the email inbox dhcshealthyfamiliestransition@dhcs.ca.gov. The State also conducted public webinars on September 13, 2012 and October 23, 2012 in which proposed amendments in SPA 12-018 were presented to stakeholders and interested parties in person and over the Internet.

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On December 4, 2012, the State forwarded copies of emails to CMS that the State had sent to stakeholders requesting comments on the waiver amendment and draft SPA, and copies of webinar presentations.

In addition, the State distributed a Tribal Notice to the California IHS/UIHP on August 24, 2012. The tribal notice informed tribal organizations of the proposed amendments in SPA 12-018 and the potential impact on the tribal organizations and its beneficiaries. The provisions in SPA 12-018 were also presented at the quarterly webinar held for tribal organizations on August 30, 2012. Subsequent to this the State distributed a follow-up Tribal Notice to the California HIS/UIHP on April 26, 2013 updating the change in SPA number to 13-005 and reemphasizing the Medicaid expansion OTLIC Program. In addition, DHCS presented this information at the Indian Health Conference held on March 6, 2013.

State Plan Under Title XIX Of The Social Security Act
State: California

Citation	Groups Covered
	Optional Coverage Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(XIV) of the Act	X 21. Optional Targeted Low Income Children who: a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability); b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on March 31, 1997, (other than because of the age expansion provided for in §1902(l)(1)(D)); c. are not covered under a group health plan or other group health insurance (as such terms are defined in §2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997, offered by a State which receives no Federal funds for the program; d. have family income at or below: 200 percent of the Federal Poverty Level (FPL) for the size family involved, as revised annually in the Federal Register; or a percentage of the FPL, which is in excess of the "Medicaid applicable income level" (as defined in §2110(b)(4) of the Act), but by no more than 50 percentage points.

State Plan Under Title XIX Of The Social Security Act
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Citation		Groups Covered
		B. Optional Coverage Other Than the Medically Needy (Continued) The State covers: _X_ All children described above, who are under age _19_ (18, 19), with family income at or below 250 percent of the Federal poverty level (FPL). The following reasonable classifications of children described above, who are under age 19 (18, 19), with family income at or below the percent of the FPL specified for the classification: (ADD NARRATIVE DESCRIPTION(S) OF THE REASONABLE CLASSIFICATION(S) AND THE PERCENT OF THE FPL USED TO ESTABLISH ELIGILBILITY FOR EACH CLASSIFICATION.)
1902(e)(12) of the Act	_X_	22. A child under age 19 (not to exceed age 19), who has been determined eligible, is deemed to be eligible for a total of 12 months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.
1920A of the Act	_X_	23. Children under age 19, who are determined by a "qualified entity" (as defined in 1920A(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan. The Single Point of Entry Clearinghouse