

**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 (CHIP). 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.

Form CMS-R-211

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

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

State/Territory: The State of Utah

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

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

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

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(e)):

Name: Michael Hales	Position/Title: Director
Name:	Position/Title:
Name:	Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

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

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

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

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

1.1.3. A combination of both of the above.

1.2 Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

The State assures that expenditures for child health assistance will not be claimed prior to the time the State has legislative authority to operate the State plan or plan amendment as approved by CMS.

1.3 Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

The state assures that it will comply with all applicable civil rights requirements.

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

Original start date: August 1, 1998

Effective date: July 1, 2002

Implementation date: July 1, 2002

Enrollment and dental change: July 1, 2003

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))

The following table presents Utah's estimates (as of 2001) on the number of children 0-18 years of age in the state population, the number uninsured, the total number insured, the number insured by public means (Medicaid), and the number insured by private plans. The population estimates are based on the *Health Status Survey*, conducted by the Department of Health, Office of Public Health Data.

Insured and Uninsured Utah Children by Poverty Level, Age, Race/Ethnicity, and Wasatch Front Residence Utah Residents Age 0-18, 2001					
Demographic Subgroup	Population Distribution ¹	Number of Uninsured Children ^{2,3}	Number of Insured Children ^{2,3}	Number Insured by Medicaid ^{2,3,4}	Number Insured by Private Plans ^{2,3,5}
2001 Utah Population, Age 0-18	777,844	54,800	723,100	63,900	622,700
Household Poverty Level					
<100%	84,241	13,400	70,800	31,200	33,800
100%-133%	46,282	5,500	40,800	5,600	26,700
133%-200%	168,014	16,800	151,200	13,100	130,400
Over 200%	479,307	15,500	463,800	13,900	440,700
Total, Children <=18	777,844	54,800	723,100	63,900	622,700
Age Group					
Less than 1 year	45,037	700	44,400	10,400	35,100
1 to 5 years	215,929	13,800	202,200	24,800	168,200
6 to 12 years	281,346	21,100	260,200	16,600	229,200
13 to 18 years	235,531	19,300	216,200	12,000	190,200
Total Children <= 18	777,844	54,800	723,100	63,900	622,700

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Race⁶					
Am Indian/AK Native	20,691	2,100	18,500	3,800	13,200
Asian	14,857	800	14,100	1,200	13,400
Native Hawaiian/Pac. Islndr	9,334	200	9,200	2,000	6,800
Black/African American	9,879	200	9,700	1,100	9,300
White	702,782	40,600	662,200	51,500	585,100
Hispanic	82,296	18,000	64,300	13,000	40,300
Total Children <= 18	777,844	54,800	723,100	63,900	622,700
Urban/Rural Residence					
Wasatch Front (Urban) ⁷	585,950	40,200	545,800	43,900	476,800
Non-Wasatch Front (Rural)	191,894	14,500	177,300	19,900	146,000
Total, Children <= 18	777,844	54,800	723,100	63,900	622,700

1 Estimates based on Utah Process Economic and Demographic (UPED) model published in January 2002 by the Utah Governor's Office of Planning and Budget.

2 Rounded to the nearest 100 persons.

3 Figures in these columns do not sum to the total because of missing values on the grouping variables.

4 Medicaid does not include CHIP.

5 "Private Plan" consists of insurance through current or former employer or union, insurance purchased directly from an insurance company, and insurance through someone who does not live in the household.

6 An individual may have indicated multiple race/ethnic categories.

7 Urban Residence is defined as One hundred or more persons per square mile.

Source: 2001 Utah Health Status Survey.

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))

It is important to understand the backdrop to CHIP; the state's undertaking to provide the state legislature, at the request of Governor, Michael O. Leavitt, created the Health Policy Commission (HPC, decommissioned as of January 30, 2000) to direct and oversee health care reform efforts based on the Governor's blueprint for reform: *HealthPrint*. The Governor sat as chairman of the HPC.

One of the primary, and first goals of *HealthPrint* was to expand Medicaid to provide coverage to all children between the ages of 11 and 17 below the federal poverty level. This occurred in 1994. Also in 1994, insurance reforms included coverage for dependents up to the age of 26; guaranteed renewability; and a high-risk pool for coverage of high-risk children and adults having chronic, severe medical problems, but being ineligible for Medicaid.

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In 1995, Medicaid was expanded to cover all aged, blind, and disabled below 100% of the federal poverty level. Insurance reforms during this, and subsequent years included pre-existing conditions waivers, portability, and the establishment of community rating bands.

The state and the HPC made steady progress of providing health care to children, reducing the number of uninsured children in Utah from 10.19% in 1991 to 8.57% in 1996. The implementation of CHIP fits in nicely with the continuing efforts of the state to provide coverage for all children in the state.

Many of the steps discussed in 2.2.1 and 2.2.2 are a result of the states commitment to provide better health coverage for its population and have been propelled by the health care reforms initiated by the Governor.

To ensure coordination of state and private efforts described under subsections 2.2.1 and 2.2.2, the state has made a determination that CHIP needs to, and will be administered by the Department of Health.

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

The Department of Health (DOH), through its (Division of Health Care Financing (DHCF)) has participated for many years in exceptional outreach efforts to reach children eligible for public health insurance. The department views outreach efforts as an opportunity to enhance the overall public health mission of the department. Outreach means not only carrying out an active seeking of Medicaid and CHIP eligible clients, but a different way of treating families once enrolled.

Seeking Medicaid clients:

Since eligibility determination for Medicaid-only clients was transferred to the DHCF in 1996, the division has actively formed relationships with public programs that would be logical places for families to apply for Medicaid and CHIP. The division takes referrals from such public organizations and from division on-site from the following programs:

Maternal and Child Health Block Grant — All local city and county health department clinics are staffed by on-site Medicaid worker(s) who take applications and maintain cases for any person wishing to apply. Offices are clearly marked and clinic front desk staff routinely refers individuals interested in applying for Medicaid to the on-site worker.

WIC — all WIC clinics in urban areas located in city and county health clinics have a Medicaid worker available on site.

Training and presentations to the WIC staff occur on a regular basis in all areas of the state. The WIC offices have Medicaid applications available to clients.

Head Start — All Head Start registrations in the urban areas are staffed with Medicaid workers. In Salt Lake, each Head Start location is assigned to a DOH community administrative unit from which it receives personalized application assistance and training in addition to taking applications at registration.

Community Health Centers — Each center in an urban area has an on-site Medicaid worker who takes applications and maintains all cases for any person who wishes to apply. Offices are clearly marked and clinic front desk staff routinely refers individuals interested in applying for Medicaid to the on-site worker.

Special state programs — On-site Medicaid workers are assigned to the Family Health Services Children's Special Needs Clinic and to the main office in Salt Lake City for the developmentally disabled/mentally retarded waiver clients of the Division of Services for People with Disabilities (DSPD).

Overall, the number of community locations where a client can apply and maintain eligibility for Medicaid has risen from 1994-1998 from zero to over thirty-three locations.

Change in how Medicaid clients are treated:

Medicaid staff is encouraged to view medical assistance as part of a preventative, public health focus. DOH eligibility workers do not stop with an eligibility determination; they are charged with finding clients access to medical care. The practical result of this change in focus is a significant reduction in paperwork for clients, high marks on customer service from clients, and a "de-linking" in family minds of medical assistance from the more traditional welfare programs. DOH staff are medical resource experts for their communities.

In addition, Medicaid and CHIP clients can choose their office, worker, and form of interview (in person, by telephone, by mail) in all areas.

Staff is encouraged to make Medicaid service for eligible clients an easy, friendly process by removing paperwork barriers for continued participation. A telephone interviewing unit with a toll free number, specializing in foreign

languages, is available to any client in Utah. Staff use telephone interviewing extensively to reduce the "hassle" factor of office visits.

The following DOH programs and relationships are in place:

Baby Your Baby (BYB):

Baby Your Baby is a statewide outreach campaign that encourages early prenatal care, well childcare, and promotes awareness of other important maternal and child health issues. Baby Your Baby began in 1988 and is one of the most successful public/private partnerships in the state. Partners include the Utah Department of Health, KUTV—the local CBS affiliate, Intermountain Health Care, and the Williard L. Eccles Charitable Foundation. The campaign consists of broadcast television and radio elements, including public service announcements and news programs, print support materials, and a 1-800 hotline. The Baby Your Baby hotline is an integral part of this outreach campaign. Each year, the hotline answers more than 18,000 calls, refers an average of 7,000 women for prenatal care, and 800 children for well childcare. The hotline number is advertised on television and radio, newspapers, posters, pamphlets, telephone directories/yellow pages, and through various educational and promotional materials. Utah recognizes Baby Your Baby as a highly effective public education and health care referral system. A Dan Jones & Company survey showed that Baby Your Baby enjoys a 92% name recognition throughout the state. Baby Your Baby has received more than 50 awards including the prestigious Healthy Mothers/Healthy Babies National Recognition for the best-sustained public information campaign in America.

Check Your Health:

The Check Your Health campaign began in 1995. The objective of the campaign is to help parents make wise choices about their family's health care and to make families aware that financial assistance is available through Medicaid's Child Health Evaluation and Care Program (CHEC). Public service announcements instruct viewers to call the Check Your Health hotline if they need help getting preventive health and dental care for their family. This campaign currently features a regular rotation of different television and radio public service announcements.

In connection with this campaign, the department recently developed the "CHECK DECK", a set of handy cards that provide information about how to stay healthy and how to make good decisions about health care services. The cards cover preventive health care, managed care, and health promotion topics. Check Decks are advertised on television and are distributed free-of-charge throughout the state.

Health Resource Hotline Staffing:

A staff of seven individuals; one coordinator and six "resource specialists," answer calls from the Baby Your Baby and Check Your Health hotlines. These health department employees are not medically trained, but possess excellent telephone and communication skills. The majority of calls received through the hotlines are resource and referral in nature. However, when calls of a more medical nature are received, medical professionals within the health department act as backup. The hotline use AT&T's Language Line when translation services are needed.

Every Child by Two:

The *Every Child by Two* statewide Task Force was formed in 1993, to address the low immunization levels among two year olds in Utah. Using an immunization mobile clinic called the Care -A-Van, and a statewide media campaign, Every Child by Two educates parents about immunizations, reminds them to immunize their children, and has a hotline for further information.

Women Infants and Children's Program (WIC):

WIC has clinics located statewide that serve 46,462 children ages 0-5 years who are at or below 185% of poverty. Only half of the WIC clients are currently on Medicaid. All WIC clinics in urban areas located in City/County Health clinics have a Medicaid worker available on site. Training and presentations to WIC staff occur on a regular basis in all areas of the state. WIC offices have Medicaid applications available to all clients.

Maternal and Child Health Block Grants (MCH) to Local Health Departments:

MCH funded well child clinics, offered in 51 sites statewide, identify and refer Medicaid eligible children to eligibility workers. All urban City/County Health Department clinics are staffed by on-site workers who take applications and maintain cases for persons who wish to apply.

Early Intervention Programs:

Early Intervention Programs, providing services in 19 sites statewide, identify and refer Medicaid and CHIP eligible children to eligibility workers.

Children With Special Health Care Needs Clinics (CSHCN):

CSHCN clinics identify and refer Medicaid and CHIP eligible children to eligibility workers. These clinics currently serve many uninsured children throughout the state. They also refer children to the High Risk Insurance Pool.

Fostering Healthy Children Program:

Fostering Healthy Children is a program provided under contract to the Department of Human Services for children in foster care and other placements. The program routinely links children with health services and providers.

School and Education Sites:

School sites and school nursing staff routinely link children and families to health services and providers. School based and school linked health centers, at three sites in the state, offer identification and referral of Medicaid and CHIP eligible children. One Medicaid eligibility worker is currently placed in a highly impacted elementary school in an urban area. Medicaid workers staff all Head Start registrations in the urban areas. In Salt Lake, each Head Start location is assigned to a DOH community administrative unit from which it receives personalized application assistance and training in addition to taking applications at registration.

Smile Factory:

The *Smile Factory*, implemented in 1986, is a dental prevention program provided in at risk elementary schools. The program is now associated with the Families Agencies Communities Together (FACT) initiative (See 2.2.2.). The program provides dental screenings by a local dentist or state dental hygienist. Children are provided with fluoride prescriptions as needed and FACT or school nurse's link children needing care to local dental providers. The program links children with Medicaid as needed.

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

The Utah Department of Health has many public private partnership initiatives currently in place to identify and offer enrollment to all uncovered children who are eligible to participate in public health insurance programs. The following Department of Health public private partnership initiatives are currently in place:

Hospital Sites:

All of the major hospitals serving low-income persons have on-site Medicaid eligibility workers. Small facilities have itinerant services available to their clients.

Blue Cross/Blue Shield Caring Program:

The *Caring Program* currently seeks to provide basic dental insurance coverage to children not eligible for Medicaid in Utah. It covers the cost through private donations.

School Based/Linked Health Centers:

Utah currently has centers that are funded through public private partnerships. School based and school linked health centers, at three sites in the state, offer identification and referral of Medicaid eligible children.

Families Agencies and Communities Together Initiative (FACT):

FACT is a statewide interagency initiative that provides comprehensive wrap around services to children and families through school based programs and 29 county Local Interagency Councils. The site-based teams are in 107 Chapter I elementary schools and identify children who are eligible for Medicaid and refer to eligibility workers. Medicaid eligibility workers are currently located in two of these low-income schools. The sites at the local level bring together many unique public private partnerships that serve to outreach to children and families.

Conferences and Community Events:

Each year many are reached in unique public private partnerships with community advocacy groups. The Utah Issues Annual Conference and the Care Fair implemented by the Junior League are two examples of this. The programs routinely link children and their families with health services and providers.

- 2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.)**

Model Application Template for the State Children's Health Insurance Program

(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Please see section 2.2 and section 5.1. These sections discuss various outreach efforts, community awareness efforts, and partnerships with private health care providers.

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 states 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))

CHIP contracts with two managed care organizations (MCO) to provide medical care for children enrolled in CHIP, and residing in urban areas: i.e., the Wasatch Front, which includes Davis, Salt Lake, Utah and Weber counties. This list includes:

Public Employees Health Program
Molina Healthy Kids

These managed care organizations have extensive provider networks that operate in the four urban counties and include all the major hospitals, physician groups and clinics (both primary care and specialists), and specialty providers such as home health, physical therapy, and hospice. The experience of CHIP, in contracting with multiple managed care organizations demonstrates an ability to develop and maintain provider networks. The availability of these extensive networks within the managed care organizations improves access and continuity of care provided to CHIP enrollees.

In the rural areas of the state—outside Weber, Davis, Salt Lake and Utah Counties—CHIP contracts with Public Employees Health Program. Molina will be expanding into the rural areas at the end of calendar year 2003.

As the agency designated to implement the Utah Children's Health Insurance Program, CHIP and the DOH will offer its long-time experience in working with managed care organizations and negotiate contracts with any willing provider to serve CHIP enrollees in both urban and rural areas of the state. Offering services through more than one network of providers will give CHIP enrollee's greater access and continuity of care through a greater choice of health care providers.

The issues of language and hours of service barriers will be critical in serving CHIP enrollees. CHIP contracts require interpretive services to be provided. For example, current contracts state:

Health Plans shall provide interpretive services for languages on an as needed basis at no cost to the enrollees. These requirements shall extend to both in-person and telephone communications to ensure that enrollees are able to communicate with the Health Plan and Health Plan providers and receive covered benefits. Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend, as interpreter is inappropriate. Family members may be used as interpreters at the enrollee's request only after enrollee has been notified that professional interpreters are available at no cost. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical...

Materials written in a language other than English are a contract requirement of HMOs/MCOs when the non-English speaking population represents 5% of the total population.

Hours of service barriers are a general problem of the health delivery system—public or private. CHIP and its contracting HMO/MCO's use Community Health Centers, extended hour clinics, and urgent care centers to partially address this systemic problem. In addition, divisional contracts hold the HMOs/MCOs responsible for all covered emergency services 24 hours a day and 7 days a week, whether services were provided in or out of the respective managed care organization.

Standards for waiting times for appointments and office waiting times have been established with all contracting HMO's/MCOs. These standards are monitored.

The described requirements and standards are part of the contracts the Department has developed with participating MCO's/HMO's to serve the Children's Health Insurance Program.

All of the above areas are part of the state's HMO Quality Assurance Monitoring Plan and are monitored during annual on-site reviews. CHIP will be included in this monitoring.

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))

Quality care is cost-effective care. CHIP established internal procedures to ensure that quality care is delivered in a cost-effective manner. Two of the most important procedures are outlined in the HMO/MCO contracts, and are overseen through contract monitoring. CHIP contracts require each HMO/MCO to have a utilization plan. The plan must include aspects that guard against the unnecessary use of services, as well as to ensure that services are provided, when necessary. Careful and close monitoring by the DOH is essential for the fair implementation and operation of HMO/MCO plans. Each contracting HMO/MCO has a utilization management department that conducts prior authorizations, concurrent review, prospective review and retrospective review. The health plans conduct quality assurance activities to identify both over utilization and underutilization of services.

Evaluation of the utilization review activities are part of the quality assurance monitoring of the DOH, conducted in several ways.

First, an annual on-site review is conducted following the Utah State HMO Quality Assurance Monitoring Plan. During these reviews, the utilization management activities are evaluated by examining processes, studies, and quality improvement activities resulting from studies and grievance reports. Along with staff from the DHCF, staff from the Division of Community and Family Health Services—with expertise in maternal and child health, children's health, and children with special health care needs—address quality and utilization issues concerning maternal and child populations, as well as others, during the on-site reviews. Staff identifies deficiencies and offers suggestions for improvement following the on-site review.

Secondly, the DHCF health program representatives (HPRs) located at various family support offices serve as patient advocates to assist clients in accessing services. HPRs keep a list of providers who contract with the various HMOs and the HPRs may contact the HMO on the client's behalf.

Lastly, the DHCF has a complaint/grievance program that allows clients and providers to call and voice their problems. The DHCF staff works with the HMO/MCO's to resolve the problems and issues where a client may not be getting home health services or other services directly affecting the client's

care are usually resolved within 24 hours. These existing monitoring procedures are extended to CHIP.

Other procedures and methods are employed to foster proper utilization. These include, but are not limited to, referrals and coordination with the Utah Division of Investigations, Medicaid Fraud and Abuse (DIMFA). When negotiation and education are used with no effect on chronic and persistent patterns of abuse, the DHCF coordinates with the DIMFA. Should circumstances within CHIP require actions concerning fraud and abuse, the lines of communication, cooperation and coordination are well established and functional. Since CHIP is funded through state and federal dollars, and since medical programs have seen some problems with illegal behavior, this existing arrangement with the DIMFA is definitely an advantage to CHIP.

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. X Geographic area served by the Plan:

CHIP assistance will be available statewide.

4.1.2. X Age:

Children under the age of 19 will be eligible for CHIP assistance. The month a child turns 19 years old will be the last month of eligibility.

4.1.3. X Income:

Except as specifically excluded in this section, all gross earned income of any household members will be counted as family income for determining CHIP eligibility including, but not limited to, wages, salaries, commissions, self-employment income, and income paid

under a contract.

Except as specifically excluded in this section, all gross unearned income of any household member will be counted as family income for determining CHIP eligibility including, but not limited to, public assistance payments, alimony, Social Security benefits, pensions, unemployment compensation, workers compensation, and interest.

The following income is excluded from family income:

1. Income which is required to be excluded from income under other Federal statutes;
2. Unearned income paid in-kind to a household member such as payments made to third party for food, shelter, clothing, or other needs;
3. Bona fide loans;
4. Death benefits to the extent the funds are spent on the deceased person's last illness, funeral or burial expenses;
5. Reimbursements of Medicare premiums made by the Social Security Administration or by the state Department of Health;
6. Educational income such as grants, scholarships, fellowships, educational loans, and work-study income provided the individual is enrolled in an educational program;
7. Needs-based veteran's pensions;
8. Reimbursements for expenses incurred by the individual;
9. Childcare assistance paid under Title XX of the Social Security Act;
10. The income of a child, earned or unearned, who is under the age of 19 unless the child is the head of household; and
11. The income of an alien sponsor.

The following income will be counted as family income:

1. Rental income except that the following expenses may be Deducted:
 - a) taxes and attorney fees needed to make the income available,
 - b) upkeep and repair costs necessary to maintain the current value of the property,
 - c) interest only on a loan or mortgage secured by the rental property; and
2. The value of income paid in-kind for which the individual performed a service or which is provided as part of the individual's wages from employment.

Income Standards:

Gross countable family income must be equal to or less than 200% of the federal poverty guideline for a family of the size involved.

Budgeting:

The department shall determine family income prospectively for the upcoming certification period at the time of application and at each renewal for continuing eligibility. Gross income of all household members, which is not excluded, is counted as family income. The department shall determine the household's average monthly income for the upcoming 12-month certification period based on last year's income, or an estimate of the average monthly income the household expects to receive. Income that is received less often than monthly will be prorated over the certification period to determine an average monthly income. The best estimate may be a monthly amount that is expected to be received each month of the certification period, or an annual amount that is prorated over the certification period.

If income is received weekly, the average weekly amount is multiplied by 4.3 to obtain a monthly amount. If income is received every other week, the average bi-weekly amount is multiplied by 2.15 to obtain a monthly amount.

Farm and self-employment income is determined by using the most

recent period of time for which an individual has records. Expenses will be deducted from the gross income to determine the countable income of the individual. An individual may elect to have 40% of the gross self-employment or farm income deducted for business expenses or they may choose to verify actual expenses. If an individual chooses to verify actual expenses, CHIP will allow any expenses that are allowed by the Internal Revenue Service.

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

There will be no resource test for CHIP eligibility.

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

State Residency:

1. To be eligible to receive CHIP benefits, a child must be a resident of the state of Utah. The definition of residency for CHIP will be based on the residency of the parent(s) of the child. Utah residency for an adult or an emancipated individual is a matter of intent and domiciliary if the individual is residing in Utah and intends to be a resident.

Proof of residency may include the school records of the child, parental items such as utility bills, or a signed declaration by the parent. Any dispute over residency will be settled based on the physical presence of the child at the time of application.

2. An American Indian child in a boarding school and a child in a school for the deaf and blind are residents of the state where their parents or legal guardian reside.
3. An individual is a resident of the state if they are temporarily absent from Utah for purposes of employment, schooling, vacation, medical treatment, or military service.

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

Disability is not a consideration in the determination of eligibility. CHIP benefits are provided to an eligible child regardless of disability or

medical condition.

4.1.7. Access to or coverage under other health coverage:

To qualify for enrollment in CHIP, a child must not be enrolled under a group health plan or other health insurance coverage. This includes coverage under a group health plan or other health insurance coverage as defined by HIPAA; which they have not exhausted their maximum lifetime benefits; have access to health insurance coverage available through an employer where the cost to enroll the child in the plan is less than 5% of the household's countable gross annual income; or be eligible to enroll under a state employee's group health insurance plan.

If a child, custodial parent or legal guardian voluntarily terminates health insurance coverage for the child, the child is not eligible for CHIP enrollment for 90 days after such coverage was terminated. The child may be eligible beginning the 91st day after the date the prior insurance coverage ended if all other elements of eligibility are met and if an open enrollment period is being held.

Exceptions to 90-day ineligibility period:

1. Voluntary termination of COBRA coverage
2. Voluntary termination of coverage by a non-custodial parent
3. Involuntary termination from a group health plan
4. Voluntary termination of the State Health Insurance Pool (HIP).

If a non-custodial parent who lives in another state has enrolled a child in his or her insurance plan, but the plan does not provide coverage or provides only limited coverage in Utah, the child may be enrolled in CHIP.

If an absent parent is court-ordered to provide health insurance for a child and the child is enrolled in a health insurance plan, the child is not eligible for CHIP enrollment.

4.1.8. Duration of eligibility:

The eligibility period will begin with the date of application and will end on the last day of the twelfth calendar month after the month an application is received. The continuing eligibility period will last for twelve calendar months (Refer to "Renewal/Termination of Coverage").

Coverage for a child who turns 19 years of age will end on the last day of the month in which the 19th birthday occurs.

4.1.9. Other standards (identify and describe):

Household Composition:

1. The following individuals who reside together must be included in the household for purposes of determining the household size and whose income will be counted, whether or not they are eligible to receive benefits.
 - a. a child, under the age of 19 who does not have access and is not covered by a group health plan, other health insurance, or Medicaid, and will be included in the CHIP coverage;
 - b. The child's spouse;
 - c. The child's siblings, half-siblings, adopted siblings and stepsiblings if they are also under the age of 19;
 - d. The parents and stepparents of any child who is counted in the household size;
 - e. The children of any child counted in the household size;
 - f. The unborn children of any person counted in the household size; and
 - g. The father of any unborn child who is not married to the pregnant woman but has acknowledged paternity.
2. Any individual described in number 1 who is temporarily absent solely by reason of employment, school, training, military service, or medical treatment, or who will return home to live within 30 days of the date of application is part of the household.
3. Household members who do not qualify for CHIP due to their alien status must be included in the household size and their income will be counted.
4. If an individual is caring for a child of his or her former spouse and a divorce has been finalized, the household can choose whether or not to count that child in the household size.

Institutional Status:

Residents of public institutions or of institutes for mental disease are not eligible to receive CHIP benefits.

Citizenship and Alien Status:

A resident is anyone who is: 1) a U.S. citizen; or 2) a qualified alien, as

defined in Public Law 104-193 as amended, who has been in the United States in a qualified alien status for at least five years or is not subject to the five-year bar set forth in section 403 of Public Law 104-193; and 3) a resident of Utah.

The state hereby assures that the DOH will follow all federal laws and guidelines in determining whether a SCHIP eligible child is classified as a citizen of the United States, or a qualified alien.

Social Security Numbers:

Applicants for CHIP are asked to provide their social security number or verification that they have applied for a social security number. However, a child who does not provide a social security number or who has not applied for a social security number will not be denied CHIP coverage.

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. X **These standards do not discriminate on the basis of diagnosis.**

The state hereby makes this assurance.

4.2.2. X **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.**

The state hereby makes this assurance.

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

The state hereby makes this assurance.

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

Enrollment Procedures:

To apply for CHIP benefits, individuals may file an application in person,

through the postal mail, by fax, or online. Applications are accepted during open enrollment periods. Applicants may apply with a CHIP application, a Medicaid or PCN application, or a DWS application. The date of the application shall be the day the signed application form is received, postmarked, or received online. When an emergency or some other circumstance beyond the control of the applicant prevents them from filing a CHIP application, a grace enrollment period beginning no earlier than four days prior to the date an applicant submits a completed and signed application may be allowed as long as the fourth day occurs during an open enrollment period. To receive the coverage, the applicant must inform the eligibility staff that medical services were received during those four days and request the coverage.

After receiving an application, eligibility workers will contact the applicant in person, through the mail, or by telephone. The eligibility worker will request any information necessary to determine eligibility. Such information must be provided by the applicant within thirty (30) calendar days of the application. The application is complete on the date that all required information is received. Eligibility workers will screen for eligibility for Medicaid first. If the applicant is not eligible for Medicaid, a determination of CHIP eligibility will be made.

A determination of eligibility must be made within 45 days of the date of application.

Eligibility Renewal/Termination of Coverage:

A renewal is a re-evaluation of the CHIP eligibility factors to determine if a child is still eligible. A renewal must be completed every 12 months. Renewal forms are computer-mailed and are due within 10 days following the mail date. If the child continues to be eligible, coverage will continue for an additional 12 months. Enrollees are sent a pre-printed enrollment form where changes and updates can be made. Families are not required to return information; they can do their renewal over the telephone. The family has to confirm that no changes have taken place within the past 12 months. If the enrollee states they have changed jobs, a verification of their current income is required.

CHIP coverage will terminate for the following reasons:

- a) the child reaches the age of 19;
- b) the child becomes eligible for Medicaid;
- c) the child is deceased;
- d) the child no longer resides in the state and is not expected to return;
- e) the child has coverage under a group health plan or other health insurance coverage except as provided in section 4.1.7; and

- f) the child has entered a public institution or an institute for mental disease.

In addition, eligibility will not be renewed upon annual renewal for all of the above reasons; the family's gross countable income exceeds the eligibility criteria; or the child has access to insurance through an employer where the cost of coverage is less than 5% of the household gross income.

During the 12-month CHIP eligibility period, recipients of CHIP benefits are required to notify the agency if any of the above mentioned circumstances change, except a change in income. These changes must be reported within 10 days of the date the client learns about the change. If these changes occur during the 12-month CHIP eligibility period, CHIP eligibility will end on the last day of the month in which it is determined that the child no longer qualifies for CHIP. For children who turn 19 during the 12-month certification period, their eligibility will end on the last day of the month in which their 19th birthday occurs.

Case Closure or Withdrawal:

CHIP benefits will be terminated upon recipient request or when the recipient is no longer eligible. An applicant may withdraw an application for CHIP benefits any time prior to approval of the application.

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 your state.

The Department accepts applications for enrollment at times when sufficient funding is available to justify enrolling more individuals. The Department limits the number it enrolls according to the funds available for the program.

CHIP enrollment is limited based on the cost per enrollee. Open enrollment periods will be held throughout the year in order to enroll a sufficient number of children so the average annual enrollment for CHIP is ~~24,000~~ **28,000**. The Department will notify the public of the open enrollment period 10 days in advance through a newspaper of general circulation, television and/or radio ads. The enrollment cap will not affect current CHIP enrollees.

Due to budgetary concerns, an enrollment cap was required to meet fiscal projections. The administration of the enrollment cap was handled by giving notification to the Eligibility Workers throughout the state that an enrollment cap was being implemented. These workers then notified applicants that an enrollment cap had been set. This information was published in the

newspaper and aired on television based on the Department's news release. No waiting list will be maintained for interested CHIP applicants.

(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:

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

Applications for CHIP benefits are taken and processed by DHCF eligibility staff who also determine Medicaid. The application will request information about health insurance coverage for the children in the household, including information about available coverage and whether or not the applicant has elected such coverage. Workers will interview applicants to determine if there is any available health insurance coverage for any of the children. The first step of the eligibility determination process will be to screen if any of the children qualify for Medicaid. Since Medicaid eligibility workers will be processing all CHIP applications, they are qualified to make the Medicaid determinations. Any child who is eligible for a Medicaid program (except for the Medically Needy program with an unmet spenddown) will be enrolled in Medicaid.

Any child who is found to have insurance coverage available through an employer and the cost to enroll is less than 5% of the household's countable income, or who is already covered by a group health plan or other health insurance coverage will be determined ineligible for CHIP. The eligibility worker will still screen Medicaid for such children.

The department will exchange information with other state agencies which may have information about the availability of insurance coverage for children applying for or determined eligible for CHIP. This exchange of information will help identify possible coverage which may not have been disclosed during the application process, or which may become available at some later time during the certification period. Information exchanges may include exchanging information with the Office of Recovery Services, the Department of Workforce Services, and the Department of Human Services. The agency may also

contact the parents' employers to request information about the availability of health insurance coverage for the children. During eligibility determination and redetermination, the eligibility worker verifies who the client's employer is and they verify wages. This information will allow the eligibility worker to determine if the client has access to a state health benefit plan.

Clients are required to report to the department any time an eligible child begins to be covered under a health insurance plan and if insurance coverage becomes available. At each renewal, the client will be asked if any of the children now have access to or are covered by a group health plan or other health insurance coverage.

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

As explained above in 4.4.1, DHCF eligibility workers process Medicaid and CHIP applications. The first step in determining eligibility for CHIP is to screen if any of the children in a household are eligible for a Medicaid program.

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))

Applications received outside of a CHIP open enrollment period are screened for Medicaid eligibility.

Medicaid eligibility workers also take and process applications for CHIP enrollment. If a child has applied for Medicaid during a CHIP open enrollment period and the child is ineligible for Medicaid but meets CHIP eligibility, the child is enrolled in CHIP. At any time during an open enrollment period, if a child who has been receiving Medicaid becomes ineligible, or if the household is aware that a child will become ineligible in the month immediately following the open enrollment period, the household is encouraged to apply during open enrollment to be effective after Medicaid terminates.

**4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box.
(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. X Coverage provided to children in families at or below 200% FPL:

describe the methods of monitoring substitution.

The CHIP application will ask whether the applicant has been covered either under individual coverage, or under an employer-sponsored coverage, during the three months prior to application for CHIP. An applicant will be ineligible for CHIP if the applicant has voluntarily terminated either employer-sponsored, or individual coverage within the three months prior to the application date for coverage under CHIP. However, an applicant who is involuntarily terminated from employer coverage is eligible for CHIP without a three-month waiting period.

Both the CHIP application, and the eligibility worker, will inform the applicant that any concurrent coverage under a health benefit plan (including group or individual coverage) will deem the applicant ineligible for CHIP. The eligibility workers will verify this information with the families' employers, if necessary.

During open enrollment periods, the number of CHIP applicants who are denied eligibility due to coverage under a group health plan is reported. In addition, the State monitors the number of CHIP applicants who are closed due to existing health insurance. The State also reviews a monthly report that has information on CHIP clients who are covered by private health insurance. This report is researched to determine if the client is still eligible for CHIP.

- 4.4.4.2. Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.
- 4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.
- 4.4.4.4. If the state provides coverage under a premium assistance program, describe:

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

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who

are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Children who are covered by Indian Health Services will be eligible for CHIP coverage. CHIP policies will specify that such children are eligible. Outreach efforts discussed in sections 5.1 will help identify and reach the Indian populations in the state so they are informed about CHIP and have access to apply.

Applications for CHIP enrollment are taken at various sites throughout the state, including areas on or near American Indian reservations. The eligibility workers in these areas are Native Americans and speak the language. When advertising is done for open enrollment, flyers are sent to Indian Health Centers and are posted in chapter houses, schools, and local post offices. Advertising is also done on the tribal radio stations and in Tribal newspapers.

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)**

Due to limited funding and high enrollment, CHIP enrollment was frozen in December of 2001. CHIP now holds periodic open enrollment periods; the first was held in June 2002. This change has affected the way outreach is conducted. Statewide outreach and enrollment campaigns are now conducted only periodically.

The CHIP open enrollment outreach strategy consists of the following components:

- Utah CHIP brand
- TV and Radio Mass Media
- Public Relations
- Grassroots outreach to community partners
- Evaluation

Utah CHIP Brand

In conjunction with open enrollment sessions, CHIP has begun a branding campaign with the tagline "CHIP. . . A Good Call for Kids." The brand has been applied to TV, radio, and collateral materials. Utah CHIP kids are featured in TV and collateral materials, and a similar look and feel are used. In the radio ads, CHIP parent's voices are used, along with the music used in the TV ads. Branded materials are available in Spanish.

TV and Radio Mass Media

Beginning two weeks before CHIP open enrollment, radio and TV ads begin airing statewide on many stations that appeal to the appropriate demographic. The ads feature both the hotline phone number, 1-877-KIDS-NOW, and the CHIP website, where families can apply online. A strength of the TV ads is that the phone number and website are visible for about ½ the length of the ad, allowing plenty of time for families to get the numbers.

Public Relations

Prior to open enrollment, a press release is issued to announce the dates. Immediately prior to the first day of open enrollment, the release is reissued, and interviews provided. This strategy may vary based on other current events. Various strategies to maximize the PR aspect of the outreach

campaign are used.

Grassroots Outreach to Community Partners

CHIP's efforts to work with community partners were modified to suit the new open enrollment system. A list of partners who interact with the intended population is being maintained including, but not limited to, WIC Clinics, Head Start, high-risk schools, school nurses, local health departments, non-profit, ethnic groups, pediatricians, eligibility offices, and other groups. These partners receive an announcement that enrollment would be opened and CHIP materials to distribute, including brochures, applications, and other promotional items. In addition, ongoing efforts were conducted to expand partnerships with community organizations to improve the grassroots aspect of CHIP outreach.

The Department of Health views the outreach effort as an opportunity to enhance the overall public health mission of the department. The department will work to insure that transportation, language, and hours of service barriers do not prevent access. The department will use existing relationships to help identify potentially eligible children by inviting agencies to help design an outreach process that is tailored to their constituency's needs with the objective to reach all children who Medicaid cannot cover.

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.**

Attachment B provides the plan coverage, amount, scope and durations of Services.

Attachment C provides the signed actuarial report.

- 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**

- 6.1.4.3. 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. X Inpatient services **(Section 2110(a)(1))**

Scope of Coverage

Inpatient hospital medical and surgical care will be considered a covered benefit for a registered bed patient for treatment of an illness, injury or condition, which cannot be treated on an outpatient basis. The hospital must be a short-term, acute care facility licensed and certified by the state of Utah.

Level of Coverage

For enrollees up to 150% of the federal poverty level:

\$3.00 co-payment for inpatient hospital services.

For enrollees 151% through 200% of the federal poverty level:

Inpatient hospital services require co-insurance of 10% of the allowed amount.

Exclusions

Hospital charges in conjunction with ineligible surgical procedures or related complications.

Charges for treatment programs for enuresis (bed wetting) or encopresis.

Convenience items such as guest trays, cots, and telephone calls.
Occupational therapy and recreational therapy.
Whole blood, autologous (self) blood storage for future use.
Hospital charges while on leave-of-absence.
Charges incurred as an organ or tissue donor.
Charges for custodial care, nutritional counseling, care, confinement, or services in a transitional living facility, community reintegration program, vocational rehabilitation, or services to re-train self care or activities of daily living.

6.2.2. X Outpatient services **(Section 2110(a)(2))**

Scope of Coverage

Outpatient services are provided to enrollees at a licensed, certified hospital who are not admitted to the hospital. Services provided by a covered provider for medically necessary diagnosis and treatment or sickness, injury and other conditions. All services related to outpatient visits are covered, including physician services.

Level of Coverage

For enrollees up to 150% of the federal poverty level:

\$3.00 co-payment due for outpatient hospital services and emergency room visits.

For enrollees 151% through 200% of the federal poverty level:

Co-insurance, 10% of the allowed amount. The allowed amount is the billed charge less 25%.

\$35.00 co-payment for each emergency room visit.

Exclusions

Same exclusions as in-patient services above.

6.2.3. X Physician services **(Section 2110(a)(3))**

Scope of Coverage

Physician, physician-related, chiropractic and podiatry services

provided to enrollees by a covered, licensed provider, for medically necessary and preventative services. Services provided directly by licensed physicians, or osteopaths, or by other licensed professional such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision. Includes surgery and anesthesia.

The Health Plan shall provide to CHIP enrollees preventive screening services, including routine physical examinations and immunizations to all eligible children up to age 19, in accordance with the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP) periodicity schedules covered in full, with no co-payment or co-insurance required. The Health Plan will educate and encourage compliance with AAP periodicity schedules.

Level of Coverage

For enrollees up to 150% of the federal poverty level:

\$3.00 co-payment per medical visit, including hospital inpatient and outpatient physician visits.

For enrollees 151% through 200% of the federal poverty level:

\$15.00 co-payment per medical visit, including hospital inpatient and outpatient physician visits.

Exclusions

Eyeglasses and contact lenses (with exception of one lens immediately following corneal transplant surgery or the contact lens necessary to treat keratoconus).

Examinations made in connection with a hearing aid.

Hormone injections or pellet implants (an allowance up to \$300 may be approved for injections when oral medication cannot be used).

Office visits in conjunction with hormone injections.

Charges for weight loss or in conjunction with weight loss programs.

Charges for medical hospital visits the same day of following a surgical procedure.

A charge for office visits in conjunction with allergy injection.

Health screening or services to rule out familial diseases or conditions without manifest symptoms.

Genetic counseling and testing except prenatal amniocentesis or chronic villi sampling for high-risk pregnancy.

Charges for nutritional counseling or analysis.
Charges for any injection when the material used is not identified.
Hypnotherapy or biofeedback.
Chiropractic or physical therapy primarily for maintenance care.
Injectable vitamins or their administration.
Experimental, investigational, or unproven medical practices.
Vision therapy.
Tobacco abuse.
Take-home medications from a provider's office.
Treatment therapies for developmental delay or child developmental programs.
Sublingual antigens.
Rolfing or massage therapy.
Hair transplants or other treatment for hair loss or restoration.
Study models, panorex, eruption buttons, orthodontics, occlusal adjustments or equilibration, crowns, photos, and mandibular kinesiograph are some, but not necessarily all, ineligible services for the treatment of TMJ/TMD, or myofacial pain.
Care, treatment, or services for diagnosis of illness limited to multiple environmental chemicals, food, holistic or homeopathic treatment, including drugs.
Charges for prolotherapy or chelation therapy. Office calls in conjunction with repetitive therapeutic injections.
Functional or work capacity evaluations, impairment ratings, work hardening programs, or back to school.
Medical or psychological evaluations for legal purposes such as custodial rights, paternity suits, disability ratings, etc., or for insurance or employment examinations.
Charges for special medical equipment, machines, or devices in the provider's office used to enhance diagnostic or therapeutic services in a provider's practice.
Cardiac and/or pulmonary rehabilitation, phases 3 and 4, or other maintenance therapy or exercise program.
Charges for sublingual or colorimetric testing.
Charges which are dental in origin including care and treatment of the teeth, gums or alveolar process, endodontia, periodontia, orthodontia, prosthetics, dental implants, or anesthesia or supplies used in such care.
Charges for pre-natal classes.
Charges for the treatment of weak, strained, flat, or unstable feet; visits in connection with orthotics; palliative care or metatarsalgia or bunions; treatment for corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease.

6.2.4. X Surgical services **(Section 2110(a)(4))**

Scope of Coverage

All tests (laboratory, x-ray, etc.) necessary prior to inpatient or outpatient surgery. Inpatient and outpatient surgical procedures. Anesthesia services and supplies.

Level of Coverage

0% co-insurance. Includes all services related to covered surgical procedures (i.e., physician services, anesthesia services and supplies, pre-surgical testing, surgical services and supplies, inpatient and outpatient facility services, etc.). Pre-surgical tests are covered if physician orders the tests; proper diagnosis and treatment require the tests; and surgery takes place within 7 days of testing. If surgery is canceled because of pre-surgical test findings or as a result of a second opinion on surgery, the cost of the test will be covered.

Exclusions

Charges for care, treatment or surgery performed primarily for cosmetic purposes, except for expenses incurred as a result of an injury suffered in the preceding five years.

Breast reconstruction, augmentation, or implant; except initial restoration made necessary as a result of cancer surgery performed in the preceding five years.

Capsulotomy, replacement, or repair of breast implant originally placed for cosmetic purposes, or any other complication of cosmetic or non-covered breast surgery.

Simple/subcutaneous mastectomy for benign disease or mastectomy for anything other than cancer, including reconstruction or complications.

Obesity surgery, such as gastric bypass, stomach stapling etc., including any present or future complications.

Cosmetic surgery.

Assisted Reproductive Technologies (ART's) including but not limited to In vitro Fertilization, Gamete Intra Fallopian Tube Transfer (GIFT), Embryo Transfer (ET), Zygote Intra Fallopian Transfer (ZIFT), or the storing of frozen sperm, eggs, or gametes for future use. Radial keratotomy, astigmatic keratotomy or other surgical treatment for correction of refractive errors.

Charges incurred as an organ or tissue donor.
Organ or tissue transplant (except cornea, kidney, kidney/pancreas, liver, bone marrow, stem cell, lung and heart, which may be considered with written pre-authorization).
Reversal of sterilization.
Trans-sexual operations.
Rhytidectomy (excision of wrinkles around the eyes).
Charges that are dental in origin: extraction of teeth, dental implants and crowns or pontics over implants, reimplantation or splinting, endodontia, periodontia, or orthodontia, including anesthesia or supplies used in such care.
Complications as a result of other non-covered or ineligible surgery.
Injection of collagen. Lipectomy, abdominoplasty, pannulectomy.
Repair of diastasis recti. Non-FDA approved, experimental, or investigational procedures, drugs, and devices.
Pellet implantation; Liposuction; Chemical peel.
Charges for the treatment of weak, strained, flat, unstable or unbalanced feet; visits in connection with orthotics; palliative care of metatarsalgia or bunions, corns, calluses, or toenails, except removing nail roots and care prescribed by a licensed physician treating metabolic or peripheral vascular disease.
Orthodontic treatment or expansion appliance in conjunction with jaw surgery.
Chin implant, genioplasty or horizontal symphyseal osteotomy.
Unbundling or fragmentation of surgical codes.
Injections of sclerosing solution for spider veins.
Rhinoplasty, except as a result of accidental injury in the preceding five years.
Laser assisted uvulopalatoplasty (LAUP).
Additional surgical fees are not eligible when a laser is used.
Anesthesia charges in conjunction with ineligible surgery.
Anesthesia administered by the primary surgeon.
Monitored anesthesia care (standby) except in conjunction with procedure 92982, angioplasty.

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))**

Scope of Coverage

Prescribed drugs and preparations provided by a licensed pharmacy.

Prescription medications must be authorized by a professional licensed to write prescriptions. Prescriptions must be medically necessary. May be limited to generic medications where medically acceptable. Includes family planning or contraceptive medications or devices, except Norplant and infertility drugs.

Level of Coverage

For enrollees up to 150% of the federal poverty level:

\$1.00 co-payment for generics and brand name drugs on the approved list.

\$3.00 co-payment for drugs not on the approved list.

Note: a prior authorization will be required to use any drugs not on the approved list.

For enrollees 151% through 200% of the federal poverty level:

\$5.00 co-payment for generics and brand name drugs on the approved list.

50% co-insurance for drugs not on the approved list.

Note: a prior authorization will be required to use any drugs not on the approved list.

Exclusions

The fact that a provider may prescribe, order, recommend, or approve a prescription drug, service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition.

Drugs that are not medically necessary for condition.

Charges for the treatment of hair loss or restoration (Rogaine). Experimental or investigational drugs.

Anorexiant/diet aids (with the exception of Dexedrine/Desoxyn/Obetrol for documented treatment of Attention Deficient Disorder in children under age 18).

Any over-the-counter (OTC) drugs or drugs that do not require a prescription, except insulin.

Any drug not FDA approved.

Therapeutic devices or appliances.

Diagnostic agents.

Immunization agents, biological serum, blood, or blood plasma.
Prescriptions that an eligible person is entitled to receive from any governmental plan or medication prescribed as a result of an industrial injury or illness payable under Workers Compensation or employers liability laws.
Medications taken by insured or dependents of the insured while in an institution that operates on its premises a facility for dispensing pharmaceuticals.
Any drug used for cosmetic purposes.
Drugs used by a second party.
Compounded drugs (a procedure that alters the FDA approved form of a legend drug.)
Replacement prescriptions resulting from loss, theft or breakage. Delivery or shipping charges.
Medication furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.
Vitamins, minerals, food supplements, or homeopathic medicine. Mother's milk or special infant formulas.
Anabolic steroids (used for muscle building).
Medication prescribed as a result of an industrial (on the job) injury or illness payable under Worker's Compensation or employer's liability laws.
Charges for unproven medical practices or care, treatment or drugs which are experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.
Charges that the insured is not, in the absence of coverage, legally obligated to pay.
Norplant and infertility drugs.

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

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

Scope of Coverage

Professional and technical laboratory and x-ray services furnished by licensed and certified providers. All laboratory testing sites providing services under this contract must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

Level of coverage, Laboratory

For enrollees up to 150% of the federal poverty level:

\$1.00 co-payment for laboratory services under \$50.00

\$2.00 co-payment for laboratory services over \$50.00

For enrollees 151% through 200% of the federal poverty level:

\$5.00 co-payment for laboratory services under \$50.00

Co-insurance, 10% of allowed amount for laboratory services over \$50.00

Level of coverage, X-Ray

For enrollees up to 150% of federal poverty level:

\$1.00 co-payment for x-ray services under \$100.00

\$3.00 co-payment for x-ray services over \$100.00

For enrollees 151% through 200% of the federal poverty level:

\$5.00 co-payment for x-ray services under \$100.00

Co-insurance, 10% of allowed amount for x-ray services over \$100.00

Exclusions

Charges in connection with weight loss programs.

Health screening or services to rule out familial diseases or conditions without manifest symptoms are considered routine and are excluded from coverage.

Genetic screening except prenatal amniocentesis or chronic villi sampling or as described in the Pre-Authorization Section above.

Charges incurred as an organ or tissue donor. Charges for sublingual or colorimetric testing.

Lab, x-ray, or diagnostic services which are unproven, experimental, or investigational.

Charges for hair analysis, trace elements, or dental filling toxicity.

Charges in conjunction with ineligible procedures, including pre- or post-operative evaluation.

Routine drug screening.

Routine HIV/AIDS testing.

Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment

examinations.

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

Scope of Coverage

Family planning (including sterilization) and prenatal (including high-risk) services include disseminating information, counseling and treatment.

All family planning and prenatal services must be provided by or authorized by a physician, certified nurse midwife or nurse practitioner. Sterilizations are covered to the extent permitted by federal and state law and must meet the documentation requirements of 42 CFR 441, Subparts E & F. All services must be provided in concert with Utah Law. Prenatal services - see Section 6.2.1, 6.2.2, 6.2.3, 6.2.4, 6.2.6, and 6.2.8. Services for high-risk prenatal services.

Exclusions

Norplant, infertility drugs, in-vitro fertilization, genetic counseling. Charges for unproven medical practices or care, treatment or drugs, which are experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.

6.2.10. X 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))**

Scope of Coverage

Inpatient mental health services are covered for a maximum 30 days per year. Residential treatment may be provided in lieu of inpatient care.

Level of Coverage

For enrollees up to 150% of the federal poverty level:

\$3.00 co-payment for each visit, 30 days per plan year, per child limit.

For enrollees 151% through 200% of the federal poverty level:

Co-insurance, 10% of allowed amount for first 10 days, 50% of allowed amount for next 20 days.

30 day per child per plan year limit.

Residential treatment in lieu of inpatient care may be substituted at same co-insurance.

Exclusions

Charges for marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances such as everyday stress and strain, financial, marital, and environmental disturbances.

Charges for mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.

Office calls in conjunction with repetitive therapeutic injections.

Charges in conjunction with wilderness programs.

Inpatient charges for behavior modification, enuresis, or encopresis.

Psychological evaluations for legal purposes such as custodial rights, etc.

Occupational or recreational therapy.

Hospital charges while on leave of absence.

- 6.2.11. X 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))**

Scope of Coverage

Outpatient mental health services are covered for a maximum 30 visits per year.

Level of Coverage

For enrollees up to 150% of the federal poverty level.

\$3.00 co-payment per office visit.

For enrollees 151% through 200% of the federal poverty level:

Co-insurance, 50% of allowed amount.

Exclusions

Charges for marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances such as everyday stress and strain, financial, marital, and environmental disturbances.

Charges for mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.

Office calls in conjunction with repetitive therapeutic injections.

Charges in conjunction with wilderness programs.

Inpatient charges for behavior modification, enuresis, or encopresis.

Psychological evaluations for legal purposes such as custodial rights, etc.

Occupational or recreational therapy.

Hospital charges while on leave of absence.

- 6.2.12. X 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))**

Scope of Coverage

Equipment and appliances used to assist the patient's medical recovery, including both durable and non-durable medical supplies and equipment. Durable equipment includes, but is not limited to prosthetic devices.

Level of Coverage

For enrollees up to 150% of the federal poverty level:

No co-insurance.

For enrollees 151% through 200% of the federal poverty level:

Co-insurance, 20% of allowed amount.

Exclusions

The fact that a provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion. The following are some, but not necessarily all, items not covered as a benefit, regardless of the relief they may provide for a medical condition:

Routine maintenance and care, cleaning solutions, batteries, tires, upholstery repair, etc., of Durable Medical Equipment (DME) or prosthetics.

Maintenance, warranty, or service contracts.
Motor vehicles or motor vehicle devices or accessories such as hand controls, van lifts, car seats, or vehicle alterations.
Air conditioning.
Home physical therapy kits.
Whirlpool baths and other multipurpose equipment or facilities, health spas, swimming pools, saunas, or exercise equipment.
Air filtration units, vaporizers, humidifiers.
Heating lamps or pads.
Charges for a continuous hypothermia machine, cold therapy, or ice packs.
Lift or contour chairs, vibrating chairs, or adjustable beds.
Dialysis equipment.
Orthotics, arch supports, shoe inserts or wedges, etc. Orthopedic or corrective shoes. (Attachment of a brace or crossbar is eligible).
Hearing aids (except as indicated under Covered Services).
Adaptive devices used to assist with activities of daily living, vocational or life skills.
Communicative equipment or devices, systems, or components.
Computerized assistive devices; communicative boards, etc.
Breast pumps.
Vitamins, minerals, food supplements, special infant formulas, or homeopathic medicine.
Blood pressure monitors, Wrist alarms for diabetics, Enuresis alarm systems.
Spinal pelvic stabilizers, Orthopedic braces solely for sports activities.
More than one breast prosthesis for each affected breast following surgery for breast cancer.
More than one lens for each affected eye following corneal transplant surgery.
More than two pair of support hose for a medical diagnosis per policy year.
Computer systems or components.
Environmental control devices, i.e., light switches, telephones, etc.
Replacement of lost, damaged, or stolen DME or prosthetics.
Eye glasses/contact lenses

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

Level of Coverage

For enrollees up to 150% of the federal poverty level:

No co-insurance.

For enrollees 151% through 200% of the federal poverty level:

Co-insurance, 20% of allowed amount.

Exclusions

The fact that a provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it an eligible benefit, even though it is not specifically listed as an exclusion.

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

Scope of Coverage

Home health services, defined as intermittent nursing care provided by certified professionals (registered nurses, licensed practical nurses and home health aids) in the client's home when the client is homebound or semi-homebound. Hospice services delivered to terminally ill patients (six months life expectancy) who elect palliative versus aggressive care are covered.

Level of Coverage

Home health care is to be rendered by a Medicare-certified Home Health Agency. Hospice care is to be rendered by a Medicare-certified hospice.

Exclusions

Nursing or aide services which are requested for the client's convenience or the convenience of their family, (i.e., bathing, feeding, exercising, homemaking, moving the patient, giving medication, or acting as a companion or sitter) which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services, are not payable. This exclusion applies regardless of whether services were recommended by a provider.

Private duty nursing. Home health aide.

Custodial care.

Respite care.

Travel or transportation expenses, escort services, or food services.

Charges for medical care rendered by an immediate family member are subject to review by CHIP and may be determined by CHIP to be ineligible.

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

See 6.2.14

6.2.16. X 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. X Dental services **(Section 2110(a)(17))**

Scope of Coverage

The following dental services based on American Dental Association (ADA) codes are covered:

0120, 0150 (limit two exams every twelve months), 0140 (exams), 0220, 0230, 0270, 0272, 0274, 0330 (x-rays), 1110, 1120 (cleanings), 1201, 1203, 1205 (fluoride), 1351 (sealants), 1510, 1515, 1520, 1525, 1550 (space maintainers), 2140, 2150, 2160, 2161, 2330, 2331, 2332, 2335, 2391-2394 (fillings), 2751, 2930, 2931, 2933, 2954 (crowns), 3220, 3230, 3240 (pulpotomy/pulpal therapy), 3310 (root canal), 7111, 7140, 7210, 7220, 7230, 7240 (extractions), 7270, 7286, 7510, 7960 (misc.), 9110 (palliative/emergency), 9220, 9221, 9241, 9242 (sedation).

Level of Coverage

For enrollees up to 150% of the federal poverty level:

No co-insurance for cleanings, exams, x-rays, fluoride, and sealants.

\$3 co-pay for all other covered services.

For enrollees 151% through 200% of the federal poverty level:

No co-insurance for cleanings, exams, x-rays, fluoride, and sealants.

Co-insurance, 20% for all other covered services.

Exclusions

Services not listed above (scope of coverage).

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

See 6.2.10 above.

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

See 6.2.11 above.

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

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

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

Scope of Coverage

Treatment and services provided by a licensed physical therapist authorized by a physician. Screening services provided by a licensed medical professional to test for hearing loss. Hearing aids are covered only to improve impairment due to a congenital defect. Services provided by a licensed medical professional in therapy to restore speech loss or to correct impairment if due to a congenital defect or an injury or sickness.

Level of coverage

Up to 16 visits per plan year (this may include occupational therapy for fine motor function).

For enrollees up to 150% of the federal poverty level

\$3.00 co-payment per visit.

For enrollees 151% through 200% of the federal poverty level

\$15.00 co-payment per visit.

Exclusions

Services outside the restrictions listed above.

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

See 6.2.14 above.

6.2.24. X Any other medical, diagnostic, screening, preventive, restorative, remedial,

therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

Vision Care

Scope of Coverage

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice.

Levels of Coverage

100% up to \$30 for 1 examination every 12 months for eye refraction's, examinations.

Hearing Services

Scope of Coverage

Screening services provided by a licensed medical professional to test for hearing loss.

Levels of Coverage

100% up to \$30 for 1 examination every 12 months.

Hearing aids covered only to improve impairment due to congenital defect.

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

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

Scope of Coverage

Ambulance (air and ground) service for medical emergencies only.

Level of Coverage

100%

Exclusions

Charges for common or private aviation services.
Services for the convenience of the patient or family.

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))**

General Exclusions

Charges prior to coverage or after termination of coverage even if illness or injury occurred while the insured is covered by CHIP.

Charges for educational material, literature or charges made by a provider to the extent that they are related to scholastic education, vocational training, learning disabilities, behavior modification, dealing with normal living such as diet, or medication management for illnesses such as diabetes.

Charges for services primarily for convenience, contentment or other non-therapeutic purpose.

Charges for unproven medical practices or care, treatment or drugs which are experimental or investigational in nature or generally considered experimental or investigational by the medical profession or non-FDA approved.

Charges for any service or supply not reasonable or necessary for medical care of the patient's illness or injury.

Charges which the insured is not, in the absence of coverage, legally obligated to pay.

Charges for services, treatments or supplies furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.

Charges for services, treatments or supplies received as a result of an act of war occurring when the insured is covered by CHIP.

Charges for any services received as a result of an industrial (on the job) injury or illness, any portion of which is payable under workman's compensation or employer's liability laws.

Charges for services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony.

Charges made for completion or submission of insurance forms.

Charges for care, treatment, or surgery performed primarily for cosmetic purposes, except for expenses incurred as a result of an injury suffered in the preceding five years.

Shipping, handling, or finance charges.

Charges for medical care rendered by an immediate family member are subject to review by CHIP and may be determined by CHIP to be ineligible.

Charges for expenses in connection with appointments scheduled and not kept.

Charges for telephone calls or consultations.

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)

The state assures that it will not permit the imposition of any pre-existing Medical condition exclusion for covered services.

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

The state assures that it will not permit the imposition of any pre-existing medical condition exclusion for covered services.

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:

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 states 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 childcare, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

The Utah Children's Health Insurance Program will use a combination of quality methods to assure high quality care for CHIP enrollees. Many of the quality initiatives will include the extensive quality assurance and performance measurement reporting requirements currently required in HMO contracts with the Division of Health Care Financing (Medicaid), in addition to quality improvement and measurement activities that emphasize preventive and primary care services and the unique needs of CHIP enrollees and CHIP staff. CHIP will require contractors to meet all state licensing requirements, have a comprehensive quality assurance system in place, participate in internal and community quality improvement activities, and report performance and utilization data to CHIP. The Indian Health Service will be exempt from state licensing requirements. These quality measurement activities will be designed to promote contractor accountability, community-based improvement opportunities, and to guide CHIP policy decisions.

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. X Quality standards

CHIP contractors will be required to have a current Certificate of Authority, issued by the Department of Insurance, or be a health plan approved by the Department of Health, and submit a Quality Assurance Plan description to CHIP that summarizes the contractor's quality assurance system, including (but not limited to) the following standards for the entire range of clinical care and service delivery provided by the contractor:

- detailed quality objectives and a timetable for accomplishment
- description of quality assurance committee structure

- identification of departments/individuals responsible for quality assessment
- description of manner in which network providers participate in quality activities
- credentialing/recredentialing procedures
- standards of clinical care that address preventive services and are based on reasonable scientific evidence and are regularly reviewed by clinicians and disseminated to network providers
- standards of service accessibility
- medical records standards, including medical records confidentiality provisions
- utilization review standards and process
- quality indicator measures and clinical studies
- quality assurance plan documentation methods
- description of how quality improvement activities are integrated with other plan/management functions
- monitoring of the effectiveness of the client grievance process including identification of individuals with specific responsibility to resolve problems

CHIP will require contractors to have in place protocols for the approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory encounters meet pre-defined criteria.

7.1.2. X Performance measurement

Utah's Medicaid program has established a comprehensive quality measurement and accountability system for its HMO Medicaid clients. CHIP has built on these performance reporting initiatives for its enrollees. CHIP requires contractors to be accountable for their performance in meeting children's health needs. This accountability will be implemented through the contractor's implementation of organizational quality assurance and quality improvement initiatives (Sections 7.1.1 and 7.1.4), but also through the reporting, to CHIP and the Office of Health Data Analysis, comparative and independently-verified performance measurement data, participation in standardized member satisfaction surveys conducted by the DOH, and encounter/claims reporting requirements. CHIP will require contractors to annually report specific quality performance data to the Office of Health Data Analysis, consistent with existing Administrative Rules

R428-12 and R428-13 (Enrollee Satisfaction Survey and Reporting of HMO Performance Measures) guiding the reporting of health plan performance measurement data to the DOH. The Office of Health Data Analysis will work with rural and independent providers to design data collection alternatives to meet these reporting requirements. Alternatives may include encounter/claims data collection or DOH-supported abstraction of selected HEDIS measures from the provider's medical records.

The following reporting requirements will be necessary for providers and health plans to participate with CHIP. Requirements include, but are not limited to, the following:

Effectiveness of Care/Quality

- Childhood immunization status
- Adolescent immunization status
- Prenatal care in the first trimester
- Low birth-weight babies
- Treating children's ear infections

Access to Services

- Annual dental visit
- Membership survey questions: usual source of care, unmet needs, after-hours access, provider choice, delay in care

Use of Services

- Well child visits in the first 15 months of life
- Well child visits in the third, fourth, fifth, and sixth year of life
- Adolescent well-care visit
- Frequency of ongoing prenatal care

Access/Availability of Care

- Availability of dentists
- Availability of Interpretation services

Health Plan Stability

- Disenrollment
- Provider turnover
- Years in business/total membership
- Indicators of financial stability

Health Plan Descriptive Information

- Board certification/residency completion
- Provider compensation
- Physicians under capitation
- Case management
- Utilization management
- Risk management
- Quality assessment and improvement (QA plan)
- Recredentialing
- Preventive care and health promotion
- Arrangements with public health, education, and social services entities
- Pediatric mental health services
- Chemical dependency services
- Family Planning Services

Cost of Care

- High occurrence/high-cost DRGs

Membership Satisfaction

For the urban CHIP clients enrolled in Wasatch Front managed care plans, the Office of Health Data Analysis will conduct CHIP member satisfaction surveys from a randomly selected sample of CHIP enrollees. This survey will be conducted by an independent survey research agency using a standardized survey instrument (e.g. Consumer Assessment of Health Plan Survey or CAHPS), modified according to CHIP program needs. The survey is conducted in conjunction with the Annual Medicaid HMO Enrollee Satisfaction Survey in order to derive comparable data for benchmarking and quality improvement efforts.

- Enrollee's overall satisfaction with their health plan

- Enrollee's satisfaction with specific aspects of health plan or services (access to care, quality of health care, coverage, and management of care)
- Enrollee's report of complaints or problems in the past 6 months, waiting times for appointments, actual care, calling for information or advice, delays in approval of treatment, referrals to a specialist
- Assessment of unmet medical needs

For the CHIP clients enrolled with independent community providers modified survey instrument will be adopted, with core questions from the CAHPS, and administered by the survey agency to these enrollees.

HEDIS 3.0 measures relevant to children and adolescents will be supplemented and augmented with patient-level encounter data—or aggregate measures negotiated individually with each provider or health plan—following an assessment of the provider's or health plan's information system capacity. Verified HEDIS data and member satisfaction data will serve several purposes: as the foundation for consumer-oriented reports for members, for CHIP contract negotiations and performance goals, and to target community quality improvement priorities based on need. Encounter data will be compiled by the DOH, Office of Health Data Analysis, validated by each data supplier, and used for analytic purposes, including program quality assessment, quality improvement, and monitoring of patterns of care through linkage with other data sets such as vital records, hospital utilization data bases, and eligibility files. All patient identifiable information will be considered confidential and all data handling and reporting activities will be conducted according to current policies in a secure environment.

7.1.3. X Information strategies

CHIP enrollee education materials will be developed to ensure that CHIP enrollees are informed of their benefits, their rights and responsibilities, comparative performance information about contractors, and other educational material about CHIP and its contractors. The contractors will be required to provide enrollees with provider network structure, grievance procedures and toll-free numbers, policies on referrals and after-hours care, and other information related to the contractor's organization. CHIP will review all of the contractor's written materials prior to distribution to CHIP enrollees and materials will be available in prose that is readable and easily understood, in English and non-English.

7.1.4. X Quality improvement strategies

CHIP provides an opportunity to link providers, public health, and other community organizations to provide preventive, high quality care. CHIP will require contractors to have in place an internal measurement and monitoring system that assures provider and network involvement, emphasizes preventive and coordinated care according to clinical standards and guidelines, and incorporates feedback to providers. A plan for identification, correction, and follow-up monitoring under and over utilization of care by the CHIP enrollees must be specified and will be reviewed at least annually by the CHIP staff. The quality improvement plan should include, but not be limited to, the following components:

- description of the process in place to assure systematic quality assessment, improvement, and feedback
- description of the process by which the organization objectively and systematically monitors and evaluates the quality and appropriateness of care and service to its enrollees
- description of methods and frequency of data collection and how these data are used to identify problems and promote improvement

CHIP will require contractors to participate in community wide quality improvement initiatives and focused studies that are intended to advance children's health in Utah. The contractor must have a contractual arrangement with an external quality review organization for the purposes of focused quality studies and other community and CHIP-based quality studies during each year. Specific areas of study will be identified and required in the CHIP contract. In addition, providers and health plans will submit an annual submission of grievance/complaint information and will be subject to annual review/site visits by CHIP staff.

7.2. Describe the methods used, including monitoring, to assure access to covered services, including: (2102(a)(7)(B)) (42CFR 457.495)

Providers and health plans contracting with CHIP will establish and maintain a sufficient number and mix of providers (primary care and specialty practitioners) in geographically accessible locations for the populations they serve. Each provider

and health plan will submit a provider list to CHIP annually, and more often as network changes are made, for review. The network must contain all of the provider types necessary to administer the prepaid benefit package, including hospitals, physicians, allied health professionals, pharmacies, and DME providers. No practitioner sanctioned by Medicare, Medicaid, or without a valid Utah license or federal equivalent may be included in the network.

Twenty-four hour coverage: The provider and health plan must have a system in place that promotes continuity of care. Providers and health plans must provide coverage to members twenty-four hours a day and seven days a week. This care must be provided either directly by the health plan or through the network primary care providers. Health plans must provide clear instructions to enrollees on how to obtain services after hours and on weekends at the time of enrollment. Providers and health plans must provide a twenty-four hour toll free telephone number for enrollees to call which directly accesses a health care professional.

Providers and health plans must have provisions for emergency care in the network and can not require pre-authorization for life-threatening emergencies or penalties for seeking care outside of the network for life-threatening emergencies.

The network structural information will be reviewed annually and this information will be linked with other measures of enrollee access, such as satisfaction surveys and health care utilization measures such as emergency room visits/1000, inpatient visits/1000, rates of ambulatory sensitive conditions, etc. This information will guide quality assessment, program planning, and targeted interventions.

CAHPS and HEDIS data are both used to assist in monitoring the health plans. In addition to these measures, the health plans submit a year-end report that includes claims cost and utilization data.

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))

Health plans provide CHIP enrollees preventive screening services, including routine physical examinations and immunizations. The health plan provides preventive services to all eligible children and young adults up to age 19 in accordance with the American Academy of Pediatrics (AAP) periodicity schedules. The health plan agrees to educate and encourage compliance with the AAP periodicity schedules. These efforts will include education and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the CHIP

enrollees.

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))**

Health Plans are prohibited from requiring enrollees to seek prior authorization for services in a medical emergency. Health plans inform their members that access to emergency services is not restricted, and that if the enrollee experiences a medical emergency, he or she may obtain services from a non-plan physician or other qualified provider, without penalty.

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 enrollees medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

The health plan ensures there is access to all services to meet the health needs of children with special health care needs. Individuals with special health care needs are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children, generally.

1. The health plan identifies children with special health care needs at the initial contact made by the health plan representative to educate the client and must offer the client care coordination or case management services. Care coordination services are services to assist the client in obtaining needed medical services from the health plan or another entity if the medical service is not covered under the contract.
2. The health plans have a mechanism to inform caregivers and, when appropriate, enrollees with special health care needs about primary care providers who have training in caring for such enrollees (and providers who can verify diagnoses, develop treatment plans, provide services, etc.) so that an informed selection of a provider can be made. If the health plan restricts the number of referrals to specialists, the health plan shall not penalize those providers who make such referrals for such enrollees.
3. The health plan has primary care providers with skills and experience to meet the needs of enrollees with special health care

needs. The health plan allows an appropriate specialist to be the PCP but only if the specialist has the skills to monitor the enrollee's preventive and primary care services.

4. The health plan ensures there is access to appropriate specialty providers to provide evaluation and treatment services for children with special health care needs. If the health plan does not employ or contract with a specialty provider to treat a special health care condition at the time the enrollee needs the specialist's services, the health plan must have a process to allow the enrollee to request services from a qualified specialist who may not be affiliated with the health plan. The process for requesting specialist's care must be clearly described by the health plan and explained to each client upon enrollment.

- 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))**

For services that require immediate prior authorization, the provider may call the Health Plan and receive prior authorization over the phone. For all other authorizations, the provider may submit a written request, which the Health Plan will respond to within 14 days of receipt.

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 states 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:

No premium will be collected for CHIP enrollees at or below 100% of the federal poverty level.

Enrollees 101% through 150% of the federal poverty level will be charged a quarterly premium of \$13.00 per family; 151% through 200% of the federal poverty level will be charged a quarterly premium of \$25.00 per family.

8.2.2. Deductibles:

There will be no deductibles required for participation in CHIP.

8.2.3. Coinsurance or copayments:

The following are the co-payment and co-insurance requirements for participation in CHIP. Levels of co-payments will be limited to the income groups identified in the federal enabling legislation 2103(e)(3)(A) & (B).

Co-Payment requirements for CHIP clients/enrollees up to 150% of the federal poverty level.

Hospital Services (inpatient, outpatient, and emergency department):

\$3.00 co-payment for inpatient, outpatient, and emergency department visit.

Outpatient Office Visits:

\$3.00 co-payment per visit. This includes physician, physician-related, mental health, physical therapy, speech therapy, chiropractic, and podiatry visits.

(No co-payment for well-baby care, well-child care, and immunizations.)

Prescription Drugs:

\$1 co-payment per prescription for generics and brand names on the approved list.

\$3 co-payment per prescription drugs not on the approved list.

*Note: a prior authorization will be required to use any drugs not on the approved list.

Laboratory:

\$1.00 co-payment for laboratory services under \$50.

\$2.00 co-payment for laboratory services over \$50.

X-ray:

\$1.00 co-payment for x-ray services under \$100.

\$3.00 co-payment for x-ray services over \$100.

Vision Screening Services:

100% coverage of allowed amount up to \$30, limit of one exam every 12 months.

Hearing Screening Services:

100% coverage of allowed amount up to \$30, limit of one exam every 12 months.

Dental Services:

Plan pays 100% for cleanings, exams, x-rays, fluoride, and sealants.

\$3.00 co-payment for all other covered services.

Mental Health Services, In-Patient Care:

\$3.00 co-payment for each visit

30 days per plan year, per child limit

Mental Health Services, Out-Patient Care:

\$3.00 co-payment for each visit
30 visits per child, per plan year limit

Out-of Pocket Maximum:

The maximum out of pocket expense is 5% of a family's annual gross income.

Co-Insurance and Co-Payment requirements for CHIP clients/enrollees 151% through 200% of the federal poverty level:

Hospital Services (inpatient, outpatient, and emergency department)

Co-insurance, 10% of allowed amount. The allowed amount is the billed charges less 25%.

\$35.00 co-payment for each emergency department visit.

Inpatient/Outpatient office visits:

\$15.00 co-payment per visit. This includes physician, physician-related, physical therapy, speech therapy, chiropractic, and podiatry visits.

No co-payment for well-baby care, well-child care and immunizations.

Prescription Drugs:

\$5.00 co-payment per prescription for generic and brand name drugs on the approved list.

50% co-insurance per prescription for drugs not on the approved list.

*Note: a prior authorization will be required to use any drugs not on the approved list.

Laboratory and X-Ray Services:

\$5.00 co-payment for laboratory services under \$50.00

Co-insurance, 10% of allowed amount for laboratory services above \$50.

\$5.00 co-payment for x-ray services under \$100.00

Co-insurance, 10% of allowed amount for x-ray services above \$100.

Vision Screening Services:

100% coverage of allowed amount up to \$30.00, limit of one exam every 12 months.

Hearing Screening Services:

100% coverage of allowed amount up to \$30.00, limit of one exam every 12 months.

Durable Medical Equipment and Supplies:

Co-insurance, 20% of allowed amount.

Dental Services:

Plan pays 100% for cleanings, exams, x-rays, fluoride, and sealants.
Plan pays 80% for all other covered services.

Mental Health Services In-Patient

Co-insurance, 10% of allowed amount for first 10 days; 50% of allowed amount for next 20 days. 30 days per child, per plan year limit.

Mental Health Services Out-Patient

Co-insurance, 50% of allowed amount.
30 visits per child, per plan year limit.

Out-of-Pocket Maximum

The maximum out of pocket expense is 5% of a family's annual gross income.

Co-Insurance and Co-payment requirements for CHIP clients/enrollees who are Native American.

No co-payments or premiums are charged to CHIP enrollees who are Native American.

8.2.4. Other: N/A

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))

The department provides this information in brochures that are distributed statewide. In addition, the information is available to the public from the Hotline that is established.

At the time of eligibility determination, cost-sharing information will be provided to the applicants.

Changes to the cost-sharing requirements will be brought forth to the CHIP Advisory Committee for full discussion in public forum.

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. X 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. X 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. X 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))

Through the various information strategies such as the use of eligibility workers to inform the enrollees, enrollees and their families are informed as to the limits of their financial liability for the coverage.

Information brochures are provided to all participating providers for distribution to their clients.

This information does include written requests for the families to inform the

state whenever the 5% maximum is met or exceeded. The family will receive a refund in an amount equal to their excess payments. Once the maximum out of pocket is met, the health plan blocks the cost sharing for the rest of the plan year so the client is not billed any additional co-payments.

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)

American Indian and Alaska Native children are issued a medical card that indicates they have zero cost sharing. This ensures that providers will not charge the client any type of cost sharing.

For premium charges, American Indian and Alaska Native children accounts are flagged to identify them as being exempt from premium payments.

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))

Consequences for an enrollee or applicant who does not pay copayments or coinsurance will be handled between the enrollee or applicant and the health care provider who has rendered the services.

A consequence for an enrollee or applicant who does not pay a premium is the possibility of closure on their CHIP policy. Enrollees will be given reasonable notice of and an opportunity to pay past due premiums.

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

- X 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))**
- X 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))**
- X In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the Childs cost-sharing category as appropriate. **(42CFR 457.570(b))**

- X The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

The state assures that the above disenrollment protections are being applied. If the client chooses to appeal their disenrollment, the Medicaid fair hearing applies.

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. X No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**
- 8.8.2. X 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. X 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. X 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. X 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. X 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)**

The state assures that is has made the above findings with the respect to the payment aspects of out plan.

**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))

Strategic Objective 1.0

Reduce the percentage of Utah children, from birth to 19 years of age, who are uninsured.

Strategic Objective 2.0

Improve access to health care services for Utah children enrolled in Utah CHIP.

Strategic Objective 3.0

Ensure that children enrolled in Utah CHIP receive timely and comprehensive preventive health care services.

Strategic Objective 4.0

Ensure that CHIP-enrolled children receive high quality health care services.

Strategic Objective 5.0

Improve health status among children enrolled in Utah CHIP.

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

Performance Measures for Strategic Objective 1.0

- 1.1 By June 30, 1999, at least 10,000 previously uninsured low-income eligible children will be enrolled in the Utah CHIP.
- 1.2 By June 30, 2000, the percentage of Medicaid-eligible Utah children younger than 19 years of age who are enrolled in Medicaid will be increased from 80 percent to 90 percent.

- 1.3 By June 30, 1999, the percentage of Utah children from birth to 19 years of age without health insurance will be decreased from 8.5 percent to 6 percent.
- 1.4 By December 31, 1998, a coordinated statewide outreach program for the identification and enrollment of CHIP-eligible children into the Utah CHIP will be established.
- 1.5 By December 31, 1998, a mechanism will be established to measure any change in rates of individuals purchasing or employers offering private insurance ("crowd-out") that may be due to implementation of the Utah CHIP.

Performance Measures for Strategic Objective 2.0

- 2.1 By June 30, 1999, at least 90 percent of children enrolled in Utah CHIP will have an identified usual source of care.
- 2.2 By June 30, 2000, there will be a decrease in the proportion of CHIP enrolled children who were unable to obtain needed medical care during the preceding year.
- 2.3 By June 30, 2000, at least 50 percent of five-year old CHIP-enrolled children will have received dental services prior to kindergarten entry.

Performance Measures for Strategic Objective 3.0

- 3.1 By June 30, 2000, at least 50 percent of children who turned 15 months old during the preceding year and were continuously enrolled in Utah CHIP from 31 days of age, will have received at least four well-child visits with a primary care provider during their first 15 months of life.
- 3.2 By June 30, 2000, at least 60 percent of three, four, five, or six year old children who were continuously enrolled in Utah CHIP during the preceding year, will have received one or more well-care visits with a primary health care provider during the preceding year.
- 3.3 By June 30, 2000, at least 85 percent of two-year old children enrolled in Utah CHIP will have received all age-appropriate immunizations (using HEDIS measure definition).
- 3.4 By June 30, 2000, at least 90 percent of 13-year old children enrolled in Utah will have received a second dose of MMR (using

HEDIS measure definition).

- 3.5 By June 30, 2000, at least 50 percent of CHIP-enrolled children eight years of age will have received protective sealants on at least one occlusal surface of a permanent molar.

Performance Measures for Strategic Objective 4.0

- 4.1 By June 30, 2000, the annual readmission rate for asthma hospitalizations among CHIP-enrolled children will have decreased, compared to the rate during the preceding year.
- 4.2 By June 30, 1999, a set of quality of care indicators will be selected and methods established for ongoing data collection and monitoring of these indicators.
- 4.3 By June 30, 2000, at least 90 percent of CHIP enrollees surveyed will report overall satisfaction with their health care.

Performance Measures for Strategic Objective 5.0

- 5.1 By June 30, 2000, no more than 20 percent of Utah CHIP-enrolled children ages six through eight years old will have untreated dental caries.
- 5.2 By June 30, 1999, a method will be established and a survey instrument developed and/or adapted for use in assessing overall health status among the Utah CHIP enrollees, over time and as compared to other groups of children.
- 5.3 By June 30, 1999, a set of child health status indicators will be selected and methods established for ongoing data collection and monitoring of these indicators. During the selection of health status indicators, careful consideration will be given to the particular health problems and areas of concern that significantly impact selected subgroups such as American Indians and other ethnic minorities, and children with special health care needs.

- 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))**

In order to assess performance under Utah CHIP and progress made toward achievement of stated performance goals, a number of indicators and/or performance measures have been identified. Selected performance measures include all HEDIS 3.0 measures relevant to children and adolescents, as well as several additional performance measures independent of HEDIS. Collection of data relative to Utah CHIP performance measures is a collaborative effort among various divisions, bureaus, and programs within the Utah Department of Health (UDOH). Whenever possible, data collection and analysis is utilized and/or built upon existing databases and data collection systems. For, example, the Office of Health Data Analysis, in collaboration with Utah Medicaid and participating HMOs, has already established a data collection and analysis system for verified HEDIS 3.0 measures for Medicaid and commercial HMOs. Since it is from this same pool of HMOs that CHIP services are contracted with in the urban areas of the state, it is possible to build upon the existing data collection system for HEDIS.

A requirement for collection of HEDIS measures is written into all HMO/MCO contracts (see below) for CHIP provision of services along the Wasatch Front, that is, the urban areas of the State. "Audited Health Plan Employer Data and Information Set (HEDIS) performance measures will cover services rendered during each calendar year and will be reported as set forth in State rule by the Office of Health Data Analysis or HEDIS measures will be calculated based on submitted encounter data by the DEPARTMENT. For example, calendar year 1999 HEDIS measures will be reported in 2000."

The Office of Public Health Data within the Utah Department of Health currently conducts a Health Status Survey of a representative sample of Utah families. This survey includes questions about insurance coverage, usual source of care, and how many times during the previous year a family had difficulty in obtaining needed medical services for a child.

During the first year of CHIP implementation, a thorough review of existing child health status survey instruments that are available for use will be conducted by professional and technical staff from within the Division of Community and Family Health Services, the Office of Health Data Analysis, and the Office of Public Health Data within UDOH. The purpose of this review will be to identify and/or adapt an appropriate tool to use in obtaining a standardized measure of health status in children, which can then be applied to CHIP-enrolled children at various intervals, and to other child population groups for comparison, such as commercial and HMO Medicaid child enrollees.

The review and subsequent development or adaptation of any health status indicators and surveys for use in CHIP will be done in consultation with representatives of the American Indian population of Utah. Recommendations will also be solicited from representatives of other populations. This will help to ensure that selected indicators and survey instruments will adequately apply to the special groups of Utah children.

The Consumer Assessment of Health Plans Survey (CAHPS) is currently being used as a customer satisfaction tool for Medicaid and commercial HMOs in Utah. The CAHPS survey will be also used as a satisfaction survey for CHIP-enrolled families. The Office of Health Data Analysis will provide oversight for the administration and data analysis of this survey.

See below for the selected performance measures that will be used to track progress and measure the impact of the Utah CHIP. The measures are numbered according to the specific performance goal to which they apply. (Please note that although Utah CHIP will be collecting all HEDIS 3.0 measures relevant to children and adolescents, the only HEDIS 3.0 measures listed below are those pertaining to identify Utah CHIP Performance Goals. For a complete listing of HEDIS 3.0 measures that the Utah CHIP will be using, see Section 7. of this Plan.)

Measures Pertaining to Utah CHIP Performance Goals

Measure	Rough Definition of Measure
CHIP enrollment of previously uninsured, low-income children. (Performance Goal 1.1)	Number of previously uninsured, low-income, non-Medicaid eligible children enrolled in CHIP during Year 1.
Percentage of Medicaid-eligible children enrolled in Medicaid. (Performance Goal 1.2)	Proportion of Medicaid-eligible Utah children younger than 19 years of age who are enrolled in Medicaid.
Percentage of Utah children without health insurance. (Performance Goal 1.3)	Proportion of Utah children younger than 19 years of age without health insurance.
CHIP outreach program.	State -wide coordinated CHIP outreach program in

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(Performance Goal 1.4)	place.
Percentage of CHIP enrollees and selected subgroups of CHIP enrollees with a usual source of care. (Performance Goal 2.1)	Proportion of CHIP-enrolled children whose care-takers report their child having a usual source of Care. Same as above, but for selected subgroups, including ethnic minorities, American Indians, and children with special health care needs.
Unmet needs among CHIP enrollees and selected subgroups of CHIP enrollees. (Performance Goal 2.3)	Proportion of CHIP-enrolled children whose care-takers report being unable to obtain some needed medical service for their child during the preceding year. Same as above, but for selected subgroups, including ethnic minorities, American Indians, and children with special health care needs.
Children's access to dental services. (Performance Goal 2.5)	Percentage of five-year old CHIP-enrolled children who have received dental services prior to kindergarten entry.
Well-child visits in the first 15 months of life. (Performance Goal 3.1)	Percentage of CHIP-enrolled children who turned 15 months old during the reporting year, who were continuously enrolled from 31 days of age, and who received at least 4 well child visits with a primary care provider during their first 15 months of life (derived from HEDIS definition).

Childhood immunization status (Performance Goal 3.3)	Percentage of CHIP-enrolled children who turned age two years during the reporting year, who were continuously enrolled in CHIP for one year immediately preceding their 2nd birthday, and who received all age-appropriate immunizations by their 2nd birthday (HEDIS definition).
Adolescent immunization status (Performance Goal 3.4)	Percentage of CHIP-enrolled children who turned age 13 years during the reporting year, who were continuously enrolled in CHIP for one year immediately preceding their 13th birthday, and who received a second dose of MMR by age 13 years (HEDIS definition).
Dental sealants. (Performance Goal 3.5)	Proportion of CHIP-enrolled children eight years of age who have received protective sealants on at least one occlusal surface of a permanent molar.
Rate of hospital readmissions for asthma among CHIP-enrolled children. (Performance Goal 4.1)	Rate of repeat asthma-related hospitalizations of CHIP-enrolled children.

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Satisfaction with care. (Performance Goal 4.3)	Percentage of CHIP-enrolled survey respondents reporting overall satisfaction with their health care, as measured by a standardized client satisfaction survey (e.g., CAHPS).
Dental caries among 6, 7, and 8-year-old CHIP-enrolled children. (Performance Goal 5.1)	Percentage of CHIP-enrolled 6 through 8 year-old children with untreated dental caries in primary or permanent teeth.

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:
- 9.3.8. Performance measures for special targeted populations.

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

The state hereby assures that 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.

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

The state hereby assures that it will comply with the annual assessment and evaluation required under Sections 10.1. and 10.2.

Evaluation of Utah CHIP will be conducted through a collaborative effort involving CHIP administrative staff, the liaison for Indian health, the Office of Health Data Analysis, the Office of Public Health Data, and the Division of Community and Family Health Services within UDOH. In addition, child health experts and other representatives from the provider and consumer communities (e.g., physicians, mid-level providers, ethnic minority representatives, tribal health board representatives, parents, advocates) will be invited to participate in planning and implementing various evaluation activities.

One way in which the impact of CHIP will be assessed is through monitoring changes over time in the number of uninsured, low-income Utah children. Utah has conducted a health status survey, which includes measurement of health insurance coverage. A baseline estimate of uninsured low-income Utah children has been calculated by applying the results of the 1996 Utah Health Status Survey to the 1998 Utah population estimate prepared by the Governor's Office of Planning and Budget. For future estimates of the number of uninsured children subsequent to CHIP implementation, a similar approach will be employed. This survey (and/or set of survey questions) measures not only insurance coverage, but also whether a child has a usual health care provider, and if the family has had difficulty in obtaining needed health care services for the child within the past year. The survey also provides an indicator of a child's overall health status.

Program effectiveness will be evaluated on at least two levels. First,

Utah CHIP will be measured against achievement of stated performance goals as defined in Section 9.3 of this Plan. In addition, a systematic assessment will be conducted of the impact of program policies, service quality, and cost on health outcomes of CHIP population. During the first year of Utah CHIP implementation, a comprehensive plan for evaluating program effectiveness will be developed, to include effectiveness-evaluation questions, and a description of methods and data needed to conduct this component of evaluation. Also during the first year of program implementation, baseline data will be gathered which will be important in assessing the relationship between the economic and health outcome aspects of the program in the second year.

Overall program evaluation will be comprised of several components, including but not limited to:

- 1) the collection of data related to designated performance measures and comparisons of these data prior to CHIP implementation and at least annually thereafter;
- 2) monitoring of progress made toward achievement of performance goals, including those goals which are primarily process-oriented (e.g., establishment of a coordinated statewide outreach program; selection and/or development of an appropriate child health status survey; selection of a set of quality of care and health status indicators); and
- 3) the comparison of selected quality of care and health status indicators among CHIP enrollees to other child population groups such as HMO and commercial child enrollees.

As previously mentioned within this section and within Section 7 (Quality and Appropriateness of Care), HEDIS 3.0 measures relevant to children and adolescents is collected by Utah CHIP. Several performance goals for the Utah CHIP are developed around HEDIS measures related to quality of care, such as well-child visits and immunizations. In addition to those HEDIS measures related to quality, involved UDOH staff and consultants have developed a set of quality of care and child health status indicators.

Satisfaction with the experience of care, also a HEDIS quality indicator, will be measured by the Office of Health Data Analysis, through utilization of the Consumer Assessment of Health Plans Survey (CAHPS)—referenced earlier in this Section, and in Section 7.

Data required for the tracking of the Utah CHIP performance related to various performance measures will be derived from several sources, some of which are already developed, and others that are yet to be developed. Data sources will include the following: CHIP eligibility file; hospital inpatient discharge records; child health status survey; health plan/HEDIS measures; CAHPS; review of paid dental claims; special oral health screenings on CHIP enrollees; and health plan descriptive information. The UDOH health information infrastructure was expanded to accommodate CHIP information and evaluation needs.

The UDOH is integrating and standardizing major health data systems throughout the Department, and CHIP information initiatives are consistent with these activities. The Office of Health Data Analysis and the Office of Public Health Data works with the Utah CHIP staff, CHIP advisory committee(s), and the Division of Community and Family Health Services, to design a health information reporting system (including data collection, data management, and analytic support) that is consistent with public health data integration policies and structured to support the program and policy information needs.

The state will monitor in the annual distributions of health insurance among children by family income, age, geographical areas, ethnicity, and health status, to identify changes and trends in the state. Potential changes can be traced by the major data sources outlined above.

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

The state hereby assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit.

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

The state hereby assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

- 9.8. The state assures, to the extent they apply, that the following provisions**

of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

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

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

The Utah Health Policy Commission (HPC) was given the responsibility by the Governor to recommend options available to Utah for implementing CHIP and developing the required state plan. The HPC is comprised of 6 legislators, 6 members from the business and academic community, with the Governor serving as chair.

All HPC meetings are open to the public and are advertised through the following means:

1. a state-wide mailing to over 250 individuals and health care organizations;
2. an information hotline that includes details of all HPC meetings, and;
3. a fax to all parties that expressed an interest in CHIP's development.

The Health Policy Commission discussed CHIP during the following meeting dates: September 8, 1997, September 22, 1997, October 6, 1997, November 3, 1997, November 17, 1997, December 1, 1997, December 19, 1997, and January 12, 1998. During almost every meeting, the HPC received public input.

In addition to these meetings, the HPC held statewide public hearings on a variety of issues, including CHIP. The basic elements of Utah's CHIP plan were presented to the public during these meetings. The public was encouraged to ask questions and give comments. The public hearings were held from October 28, 1997 through November 20, 1997 in locations

including: Salt Lake City, Price, Monticello, Farmington, Richfield, St. George, Provo, Logan, Ogden, and Vernal.

In an effort to solicit even more input from the public, the HPC advertised and held another public hearing on December 9, 1997, in Salt Lake City specifically devoted to a dialogue regarding CHIP. The benefit design and eligibility criteria were the most often discussed topics by the public in attendance during these 3-plus hours of discussion.

In October of 1997, the HPC established a Benefit Design Work Group to recommend to the HPC the benefits and benefit levels that should be included in the CHIP benefit plan. This group has met eight times, to date. The group was comprised of a professor of economics, the executive director of the state's health plan, a representative of Utah Children (a children's advocate group), a pediatrician, an actuary, a general consumer, the insurance commissioner for the state, the medical director of the North Western Shoshone Indian tribe, the deputy director of the Health Department (also a pediatrician), and the executive director of the Utah Community Health Centers. These meetings were again open to the public. They were also included on the information hotline and interested parties were sent a fax of the details of upcoming meetings, with a summary of past meetings. In addition to regular scheduled meetings, this group met several times with advocacy groups having specific interests in mental health, dental, and vision benefits.

Presentations of the CHIP plan were given to, and input was sought from several community groups including the Utah Coalition for People with Disabilities, Utah Issues (a low-income advocacy group), Utah Children, Kids Coalition, Utah Women's Legislative Council, Utah Health Insurance Association, Primary Children's Hospital, Utah Association of Local Health Officers, and the Jordan District Head Start Program.

The legislation authoring the Utah CHIP requires the creation of the Utah Children's Health Insurance Program Advisory Council (CHIPAC). The CHIPAC will advise the Health Department, who will administer the program, on benefit design, eligibility criteria, outreach, evaluation, and special strategies for under-served populations. A member from the general public is guaranteed a seat on this eight-to-eleven member board. This council ensures an ongoing dialogue between CHIP administrators and the public.

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))

The CHIP Advisory Council meet's quarterly to discuss and implement procedures for CHIP enrollees. The committee composition includes a representative from the American Indian Population.

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

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

Planned use of funds, including --

- Projected amount to be spent on health services;
- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.

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

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

The state hereby assures that it will assess the progress made in reducing the number of uncovered low-income children and report it to the Secretary by January 1.

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

The state hereby assures that it will comply with future reporting requirements as they are developed.

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.

The state hereby 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 X 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. X 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. X 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
 - 11.2.2. X Section 1124 (relating to disclosure of ownership and related information)
 - 11.2.3. X Section 1126 (relating to disclosure of information about certain convicted individuals)
 - 11.2.4. X Section 1128A (relating to civil monetary penalties)
 - 11.2.5. X Section 1128B (relating to criminal penalties for certain additional charges)
 - 11.2.6. X 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.

The Medicaid fair hearing process is used as the state's review process for eligibility and enrollment matters.

Health Services Matters

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

The state of Utah uses the Medicaid Fair Hearing Process for health services matters. The state hereby assures that it is in compliance with 42CFR 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.