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

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

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

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like benefits definitions, maintenance of effort provisions, 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.

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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 State Child Health Insurance Plan (Section 2103); OR

1.1.2 Providing expanded benefits under the States 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 HCFA. (42 CFR 457.40(d))

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

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

Effective date: _____

Implementation date: _____

Enrollment Cap effective December 15, 2001.

No eligibility restrictions are in place.

Benefit changes were effective January 1, 2002.

Premium implementation was effective February 1, 2002.

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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 section 2110(c)(2)). 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))
- 2.2 Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))
- 2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):
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- 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:
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- 2.3 Describe the procedures the state uses to accomplish coordination of the state title XXI program(s) with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))
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(42CFR 457.80(c)(2)) (Now in 4.4.3)

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

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

- 3.1 Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4) (42CFR 457.490(a))

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3.2 Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4) (42CFR 457.490(b))

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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 states 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 457.320(a))

4.1.1 Geographic area served by the Plan: _____

4.1.2 Age: _____

4.1.3 Income:

Change the word "recertification" to "renewal".

~~10. The first \$1,620 of earned income a child earns in a year will be excluded from household income if the child meets the following criteria:~~

- ~~a) the child is a student who is regularly attending school, which includes secondary school, post-secondary school, vocational and trade schools;~~
- ~~b) the child is under age 19; and~~
- ~~c) the child is not the head of the household.~~

~~The child must be attending school at the time of application for CHIP, or be expected to return to school during the certification period to receive this exclusion. The \$1,620 exclusion applies to income expected to be earned during the 12 month certification period for CHIP eligibility.~~

10. The income of a child, earned or unearned, who is under the age of 19 is not counted when determining CHIP eligibility, unless the child is the head of household.

Budgeting:

~~Farm and self-employment income is determined by using the individuals recent tax return forms. The annual income is divided by 12 to determine the monthly income for the upcoming certification period. If prior tax returns are not available, the department shall request income and expense information from the most recent period of time for which an individual has records.~~

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~~Expenses will be deducted from gross income to determine the countable income of the individual. For self-employment and farm income, the Department will deduct the same expenses from gross income which the Internal Revenue Service allows as deductions.~~

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): _____
- 4.1.5 Residency (so long as residency requirement is not based on length of time in state): _____
- 4.1.6 Disability Status (so long as any standard relating to disability status does not restrict eligibility): _____
- 4.1.7 Access to or coverage under other health coverage:
~~If a child has health insurance coverage, the child is not eligible for CHIP enrollment. This includes coverage under a group health plan or other health insurance coverage as defined by HIPAA.~~

~~If a child has not enrolled but has access to coverage under a parent's or legal guardian's employer-sponsored plan, the child is not eligible for CHIP enrollment. If the child has access to coverage, except that the child must wait for an open enrollment period, the child may enroll in CHIP until the next open enrollment period begins. If the child is not enrolled during the next available open enrollment period, the child will be ineligible for CHIP enrollment for three months after the end of the open enrollment period.~~

~~If a child, parent or legal guardian, voluntarily terminates health insurance coverage for the child, the child is not eligible for CHIP~~

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~~enrollment for three months after the date such coverage was terminated.~~

~~If an absent parent is court-ordered to provide health insurance for a child and has access to an employer's health insurance plan, the child is not eligible for CHIP enrollment.~~

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, through 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.

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

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 has reasonable access to a health insurance plan, the child is not eligible for CHIP enrollment.

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4.1.8 Duration of eligibility _____

Change the word "recertification" to "renewal".

4.1.9 Other standards (identify and describe):

Household Composition:

- ~~a. A child who meets CHIP age requirement,~~
- ~~b. Siblings, half siblings, adopted siblings, and step siblings of the child who meets CHIP age requirement if such individuals also meet CHIP age requirement,~~
- ~~c. Parents of any child who is included in the household size,~~
- ~~d. Children of any child who is included in the household.~~

- 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.
- g. The father of any unborn child who is not married to the pregnant woman and has acknowledged paternity.

~~4. If an individual is caring for a child of his or her former spouse, in the case where a divorce has been finalized, the household may include that child in the household if the child resides in the home and meets CHIP age requirement.~~

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.

4.2 The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1 These standards do not discriminate on the basis of diagnosis.

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- 4.2.2 Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
 - 4.2.3 These standards do not deny eligibility based on a child having a pre-existing medical condition.
- 4.3 Describe the methods of establishing eligibility and continuing enrollment.
(Section 2102)(b)(2)) (42CFR 457.350)

Enrollment Procedures:

Change the word "recertification" to "renewal".

~~To apply for CHIP benefits, individuals may file an application in person, over the telephone, or through the mail. A combined, newly named form will be used to apply for both Medicaid and CHIP. Applications will be accepted at any Department of Health, Bureau of Eligibility Services local office, outreach location, or telephone unit. Applicants may also apply for CHIP through the mail. The date of the application shall be the day the signed applications form is received. When applying over the telephone, the application date will be the date of the telephone contact.~~

To apply for CHIP benefits, individuals may file an application through the postal mail, or online at a central location, if available. Applicants may apply with a CHIP application, a Medicaid application or a DWS form 61A. The date of the application shall be the day the signed application form is postmarked or received online. When an emergency of 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. To receive the coverage, the applicant must inform the eligibility staff that medical services were received during those four days and request the coverage.

The effective date of CHIP enrollment is the date a completed and signed application is received.

~~Re-certification/Termination of Coverage:~~

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Eligibility Renewal/Termination of Coverage:

~~The department will complete a re-certification of CHIP eligibility in the twelfth month following the month of application. Recertification forms will be mailed to the recipient in the 11th month of the certification period. The recipient must complete the recertification forms and return them to the Bureau of Eligibility Services worker by the first working day of the recertification month. If the child continues to be eligible, coverage will continue for an additional 12 months.~~

~~If the recipient returns the recertification forms and/or required verifications after the end of the recertification month, the department will treat it as a new application for CHIP benefits. Coverage for continued benefits will begin on the date the recertification form and/or verifications are received by the department, if the child continues to be eligible.~~

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 or access to coverage under a group health plan or other health insurance coverage **except as provided in Section 4.1.7**
- f) the child has entered a public institution or an institute for mental disease.

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

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the number it enrolls according to the funds available for the program.

The enrollment cap is 24,000. Open enrollment periods will be held throughout the year in order to enroll a sufficient number of children so the average number of enrollees during the year is 24,000. 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.

4.4 Describe the procedures that assure:

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

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

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 457.350(e))

4.4.4 That 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))

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

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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 The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

(Now in 2.3) **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 under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90(a) and (b))

(Now in 2.3)

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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 states 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))

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)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.**

6.1.3 Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [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 457.250)

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- 6.1.4.1 Coverage the same as Medicaid State plan
- 6.1.4.2 Comprehensive coverage under a Medicaid Section 1115 demonstration project
- 6.1.4.3 Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.4 Coverage under a group health plan that is equal to or exceeds benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)
- 6.1.4.5 Other (Describe)

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

6.2.1 Inpatient services (Section 2110(a)(1))
Level of coverage

For enrollees at 100% through 150% federal poverty level:

~~No co-payment or co-insurance due for inpatient and outpatient hospital services.~~
\$5.00 co-payment for inpatient hospital services.

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

~~Inpatient and outpatient hospital services require co-insurance of 10% of the allowed amount. The allowed amount is the billed charge less 25%.~~
Inpatient hospital services require co-insurance of 10% of the allowed amount.

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

Level of coverage

For enrollees at 100% through 150% of the federal poverty level:

~~\$5 co-payment for each emergency room visit for emergent reasons.~~

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\$5.00 co-payment due for outpatient hospital services and emergency room visits.

\$10 co-payment for each emergency room visit for non-emergent reasons.

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

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

~~\$30.00 co-pay for each emergency room visit.~~

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

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

Level of coverage

For enrollees at 100% through 150% of the federal poverty level:

~~\$5.00 co-payment per medical visit.~~

**\$5.00 co-payment per medical visit, including hospital inpatient and outpatient
physician visits.**

For enrollees at 151% through 200% federal poverty level:

~~\$10.00 co-payment per medical visit.~~

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

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

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 test; 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.

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

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

Level of coverage

For enrollees at 100% through 150% of the federal poverty level:

\$2.00 co-pay for generics and brand name drugs on the approved list.

~~\$2 co-pay for brand name drugs not on approved list.~~

\$5.00 co-payment for generics and brand name drugs not on the approved list.

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

~~\$4 co-pay for generics and brand name drugs on the approved list.~~

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

~~50% co-insurance for brand name drugs not on approved list.~~

50% co-insurance for generics and brand name drugs not on the approved list.

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

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

Level of coverage Laboratory

For enrollees at 100% through 150% of the federal poverty level:

~~No co-payment or co-insurance is required for laboratory services.~~

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

\$3.00 co-payment for laboratory services over \$50.00

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

~~No co-pay or co-insurance for laboratory services under \$50~~

\$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 at 100% through 150% of federal poverty level:

~~No co-payment or co-insurance is required for x-ray services.~~

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\$2.00 co-payment for x-ray services under \$100.00
\$5.00 co-payment for x-ray services over \$100.00

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

~~No co-pay or co-insurance for X-Ray services under \$100~~

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

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

6.2.9 Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

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

For enrollees at 100% through 150% if federal poverty level:

~~No co-insurance.~~

\$5.00 co-payment for each visit, 30 days per plan year, per child limit.

For enrollees at 151% through 200% of 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.

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

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

For enrollees at 100% through 150% of federal poverty level.

\$5.00 co-payment per office visit.

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

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Co-insurance, 50% of allowed amount.

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

Level of Coverage.

For enrollees at 100% through 150% of federal poverty level:

No co-insurance

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

Co-insurance, 20% of allowed amount.

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

Level of Coverage

For enrollees at 100% through 150% of federal poverty level

No co-insurance.

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

Co-insurance, 20% of allowed amount

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

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.

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

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

6.2.17 Dental services (Section 2110(a)(17))

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

~~00110-00130, 00274, 00120 (cleaning), 01201 & 01203 (fluoride),~~

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~~01351 (sealants), 01510–01550, and 02110–02161 (fillings).~~

0120-limit two exams every 12 months, 0140 (exams); 0220, 0230, 0270, 0272, 0274 (x-rays); 1110, 1120 (cleanings); 7110, 7120, 7110-D, 7120-D (extractions); 3220, 3230, 3240 (pulpotomy); 9110 (palliative/emergency).

Level of coverage

For enrollees at 100% through 150% federal poverty level:

~~No co-insurance~~

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

\$3.00 co-payment for emergency services including extractions and pulpotomies.

For enrollees at 151% through 200% federal poverty level:

~~100% coverage for cleaning, oral exam and fluoride. 20% co-insurance for dental fillings.~~

Plan pays 100% for cleanings, exams, and x-rays. 20% co-payment for emergency services including extractions and pulpotomies.

- 6.2.18 Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
See 6.2.10
- 6.2.19 Outpatient substance abuse treatment services (Section 2110(a)(19))
See 6.2.10
- 6.2.20 Case management services (Section 2110(a)(20))
- 6.2.21 Care coordination services (Section 2110(a)(21))
- 6.2.22 Physical therapy, occupational therapy, **chiropractic service** and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

Level of coverage

~~No co-insurance or co-payments.~~

For enrollees at 100% through 150% of the federal poverty level

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\$5.00 co-payment per visit.

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

\$15.00 co-payment per visit.

- 6.2.23 Hospice care (Section 2110(a)(23))
- 6.2.24 Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

Vision Care

Levels of Coverage

~~100% up to \$30 for 1 exam every 24 months for eye refraction's, examinations.~~

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

Hearing Services

~~Levels of Service~~

Levels of Coverage

~~100% up to \$30 for 1 examination every 24 months.~~

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

- 6.2.25 Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26 Medical transportation (Section 2110(a)(26))
Ambulance (air and ground) service for medical emergencies only.
- 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))

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6.3 **Waivers - 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 waiver. To be approved, the state must address the following: (Section 2105(c)(2) and (3))

6.3.1 **Cost Effective Alternatives.** 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)):

6.3.1.1 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))

6.3.1.2 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; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.3.1.3 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(d)(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))

6.3.2 **Purchase of Family Coverage.** Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family

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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)

- 6.3.2.1 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))
- 6.3.2.2 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))

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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-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495)
-

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1 Quality standards
- 7.1.2 Performance measurement
- 7.1.3 Information strategies
- 7.1.4 Quality improvement strategies

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

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

7.2.2 Emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

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

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

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

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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 and any sliding scale based on income:
(Section 2103(e)(1)(A)) (42CFR 457.505(a))

8.2.1 Premiums: _____

~~There will be no premiums required for participation in CHIP.~~

No premium will be collected for CHIP enrollees at or below 100% of the federal poverty level. Enrollees from 101% through 150% of the federal poverty level will be charged a monthly premium of \$5.00 per child with a family maximum which will not exceed the amounts permitted under 42 CFR 447.52. Enrollees from 151% through 200% of the federal poverty level will be charged a monthly premium of \$10.00 per child.

Effective July 1, 2002:No premium will be collected for CHIP enrollees at or below 100% of the federal poverty level, 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: _____

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 at 100% through 150% of the federal poverty level.

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

~~\$5 co-payment for each emergency room visit for emergent reasons.~~

\$5.00 co-payment for inpatient, outpatient, and emergency department visit.

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\$10 .00 co-payment for each emergency room visit for non-emergent reasons.

Outpatient Office Visits:

\$5.00 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:

\$2 co-pay for generics and brand name drugs on the approved list.

~~\$2 co-pay for brand name drugs not on the approved list.~~

\$5.00 co-payment for generics and brand name drugs not on the approved list.

Laboratory:

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

\$3.00 co-payment for laboratory services over \$50.

X-ray:

\$2.00 co-payment for x-ray services under \$100.

\$5.00 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, and x-rays.

\$3.00 co-payment for emergency services including extractions and pulpotomies.

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Mental Health Services, In-Patient Care:

\$5.00 co-payment for each visit
30 days per plan year, per child limit

Mental Health Services, Out-Patient Care:

\$5.00 co-payment for each visit
30 visits per child, per plan year limit

Out-of Pocket Maximum:

~~\$500 per family per year~~

The out of pocket expense is 5% of a family's annual gross income. The state database will track the out of pocket expense.

Co-Insurance and Co-Payment requirements for CHIP clients/enrollees at 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%.

~~\$30 co-payment for each emergency department visit.~~

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

Outpatient Office Visits:

Inpatient/Outpatient office visits:

~~\$10 co-payment per visit. This includes physician, physician-related, physical therapy, speech therapy, chiropractic, and podiatry 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:

~~\$4 co-pay for generics and brand name drugs on an approved list.~~

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

~~50% co-insurance for brand name drugs not on an approved list.~~
50% co-insurance for prescriptions not on the approved list.

Laboratory and X-Ray Services:

~~No co-payment or co-insurance for laboratory services under \$50~~
\$5.00 co-payment for laboratory services under \$50.00

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

~~No co-payment or co-insurance for x-ray services under \$100~~
\$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 to one exam every 12 months.**

Hearing Screening Services:

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

Durable Medical Equipment and Supplies:

Co-insurance, 20% of allowed amount.

Dental Services:

~~100% coverage for cleaning, oral exam and fluoride. 20% co-insurance for dental fillings.~~
Plan pays 100% for cleanings, exams, and x-rays.
20% co-insurance for emergency services including extractions and pulpotomies.

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.**

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Mental Health Services Out-Patient

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

Out-of-Pocket Maximum

~~\$800 per family per year.~~

The out of pocket expense is 5% of a family's annual gross income. The state database will track the out of pocket expense.

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

No co-payments or premiums are charged for the CHIP Native American policy.

8.2.4 Other: _____

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

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

8.4.1 Cost sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2 No cost sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 No additional cost sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515)

8.4.4 No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

Moved to 8.8.2

8.5 Describe how the state will ensure that the annual aggregate cost-sharing for a family

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does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State: (Section 2103(e)(3)(B)) (42CFR 457.560(b))

The HMO's report the out of pocket cost each member incurs to the State. This information is then entered into the state database and is tracked. Once the family reaches the 5 percent, a notification is mailed. Once this has occurred, the HMO will no longer apply any cost sharing to the enrollee for the remaining of the policy year.

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

-
- 8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570)

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

State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

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

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

- 8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1 No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))

8.8.2 No cost sharing (including premiums, deductibles, copays, coinsurance

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- and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3 No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4 Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.310)
- 8.8.5 No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105(c)(7)(B)) (42CFR 457.475)
- 8.8.6 No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105(c)(7)(A)) (42CFR 457.475)
- 8.9 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)
- 8.9.1 The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**
- 8.9.2 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 6.3.2 of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe:
-

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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))

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

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 states performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A), (B)) (42CFR 457.710(d))

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

- 9.3.1 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

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- 9.3.7.7 Other, please list: _____
- 9.3.8 Performance measures for special targeted populations.
- 9.4 The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)
- 9.5 The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the states plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)
- _____
- 9.6 The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)
- 9.7 The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))
- 9.8 The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)
- 9.8.1 Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2 Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3 Section 1903(w) (relating to limitations on provider donations and taxes)
- Moved to 11.2.1 Moved to 11.2.2 Moved to 11.2.3 Moved to 11.2.4* 9.8.4
Section 1132 (relating to periods within which claims must be filed)
- 9.9 Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))
- _____

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9.9.1 Describe the process used by the state to ensure interaction with Federally recognized Tribes on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))

9.9.2 For an amendment that eliminates or restricts eligibility or benefits, please describe how and when prior public notice was provided as required in 457.65(b) through (d).

Notification of the enrollment cap was provided through the media on December 14, 2001. A fact sheet was provided to interested reporters during the governor's press conference. Enrollee letters describing all plan changes was mailed on December 24, 2001. Public Notice was provided on December 31, 2001 in two newspapers of general circulation in the legal section.

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.

The source of non-Federal plan expenditures is the tobacco settlement funds.

Section 10. Annual Reports and Evaluations (Section 2108)

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

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

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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 states Medicaid plan, and continue to Section 12.

- 11.1 The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))
- 11.2 The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) *The items below were moved from section 9.8 (Previously items 9.8.6 - 9.8.9)*
- 11.2.1 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
 - 11.2.2 Section 1124 (relating to disclosure of ownership and related information) 11.2.3 Section 1126 (relating to disclosure of information about certain convicted individuals)
 - 11.2.4 Section 1128A (relating to civil monetary penalties)
 - 11.2.5 Section 1128B (relating to criminal penalties for certain additional charges)
 - 11.2.6 Section 1128E (relating to the National health care fraud and abuse data collection program)

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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 states Medicaid plan.

- 12.1 Please describe how participating providers comply with state-specific grievance and appeal requirements currently in effect for health insurance issuers (as defined in section 2791(b) of the Public Health Service Act) in the state.
-
- 12.2 In absence of state-specific requirements governing grievance and appeals, describe the procedures the state will use to assure that applicants and enrollees have an opportunity for review of **eligibility or enrollment matters** as described in 42 CFR 457.1130(a). Please describe the states procedures which assure the following: (42CFR 457.1140(a)-(c))
- 12.2.1 Review by an impartial person
 - 12.2.2 Decisions are timely (including the need for an expedited review when there is an immediate need for health services).
 - 12.2.3 Review decisions are written
- 12.3 In absence of state-specific requirements governing grievance and appeals, describe the procedures the state will use to assure that applicants and enrollees have an opportunity for review of **health service matters** as described in 42 CFR 457.1130(b). Please describe the states procedures which assure the following: (42CFR 457.1140(a)-(c))
- 12.3.1 Review by an impartial person
 - 12.3.2 Decisions are timely (including external reviews, will be completed within 90 calendar days of the date an enrollee requests the review).
 - 12.3.2.1 An expedited review when there is an immediate need for health services (including an external review, as described in 42 CFR 457.1160, within 72 hours if operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. If the enrollee has access to internal and external review, then each level of review may take no more than 72 hours).
 - 12.3.3 Review decisions are written

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- 12.4 State assures that the review procedures provide for the following: (42CFR 457.1140(d))
- Opportunity for applicants and enrollees to represent themselves or be represented
 - Right to review files relevant to decision
 - Right to fully participate in the review process whether the review is conducted in person or in writing
 - Right to review prior to termination of enrollment.