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

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

State/Territory: Tennessee
(Name of State/Territory)

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

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

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

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

Name: Richard Chapman	Position/Title: Director Division of Insurance Administration
Name: Andrea Willis, MD, MPH, FAAP	Position/Title: Director, CoverKids
Name: Tony Mathews	Position/Title: Chief Financial Officer Division of Insurance Administration

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))**

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: June 9, 2006
Implementation date: January 1, 2007

State Plan Amendment #3 (Dental and Vision Services)
Effective date: October 1, 2007
Implementation date: January 1, 2008

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))**

There are currently about 1.5 million children under age 19 residing in Tennessee. Approximately 56 percent of these children are covered through employer-sponsored insurance (ESI), 5 percent have individual coverage, 27 percent have Medicaid, 2 percent have other public coverage (such as CHAMPUS or Medicare), and 11 percent or just over 157,000 children are uninsured. As in most other states, ESI has slowly eroded over the last few years. Between 2000 and 2004 the number of children with ESI declined by more than 18,500 or 1.1 percentage point. Over the same period, the number of uninsured children grew by almost 45,000. Approximately 81,500 of these uninsured children are under 100 percent of the FPL and, therefore, are potentially Medicaid-eligible. Therefore, it is estimated that the target population for the CoverKids program is about 75,000 children whose family income is too high to qualify for TennCare.
(Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the March 2004 and 2005 Current Population Survey (CPS): Annual Social and Economic Supplements)

Over 80 percent of the population in Tennessee is white and 16.5 percent is African American. Hispanics comprise only about 2.2 percent of the population but this number is expected to double by 2010. Asians account for about 1.3 percent of the population. Geographically, about two-thirds of the African American population resides in Shelby (50 percent) and Davidson (16 percent) counties and Hispanics are primarily concentrated in 8 counties in the central part of the state. Only 4.8 percent of the population speaks a language other than English at home. No information is currently available regarding the uninsured population by age, race, ethnicity or geographic location from a Tennessee-specific survey. (Source: Tennessee Department of Health, "Populations of Color in Tennessee: Health Status Report," August 2006)

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):

Tennessee's only public child health insurance program is TennCare which is administered by the Bureau of TennCare and covers Medicaid eligible children, as well as children eligible under Medicaid section 1115 demonstration authority. Eligibility levels for children in TennCare Medicaid are: infants to 185 percent of the FPL, ages 1 through 5 to 133 percent of the FPL, and ages 6 through 18 to 100 percent of the FPL. There are currently over 596,000 children enrolled in TennCare Medicaid. TennCare Standard, as described later in more detail, covers the demonstration population and is closed to new enrollment. Current enrollment in TennCare Standard is about 29,400 children.

Tennessee has moved aggressively to identify and enroll uninsured children who are eligible to participate in TennCare. For the first year of the TennCare program (1994), enrollment was open to individuals in an Uninsured eligibility category, which included children and adults at any income level who did not have access to health insurance through an employer. There also was an Uninsurable category, which was open to children and adults at any income level who had been turned down for health insurance due to a medical condition. There was massive publicity about the new program. The State retained a marketing firm to assist in the preparation of videos, television and radio spots and other materials to encourage people to enroll. A large TennCare Information Line was established to help people with questions and local health departments conducted major enrollment efforts in their communities. Providers such as community hospitals also worked to assist people enrolling in TennCare.

The success of these efforts is shown by the fact that the Uninsured category had to be closed at the end of December 1994 because the State was nearing its cap on the number of people who could be enrolled in TennCare. (The Uninsured category remained open to two distinct groups: people losing Medicaid eligibility and people losing access to COBRA coverage. Individuals in both groups had to lack access to health insurance through an employer or family member, and they had to apply within specified timeframes after losing coverage.) Although the Uninsured category was closed, enrollment of Medicaid eligibles and Uninsurables continued without interruption.

On April 1, 1997, the TennCare Uninsured category was re-opened for children under age 18 who lacked access to health insurance through an employer or family member. Local health departments were key players in conducting outreach for the program. Health Department staff distributed flyers, posters, signs and report card inserts to WIC and Head Start programs, Offices of the Department of Human Services, Legal Aid Offices, churches, schools, day care and family resource centers, after-school programs, health fairs, hospital emergency rooms, children's museums, county hospital carnivals, the circus, fast

food/grocery/variety stores used by low-income families, child advocacy groups, minority health coalitions, physicians offices, factories, companies not offering health coverage, and bank drive-in windows. Contests were held among clerks at local health departments to see who could enroll the most children. Presentations were made at universities and neighborhood associations, and print and broadcast media were used as well. Local health department personnel personally contacted families who had applied for coverage for uninsured children after the Uninsured category was closed in December 1994 and told them about this new opportunity to enroll their children.

In January 1998, the Uninsured category was expanded to include children under age 19 without access to health insurance. In addition, an open enrollment period was held for children under age 19 whose families had access to health insurance. Uninsured children with access to health insurance could enroll in TennCare only if their family incomes did not exceed 200 percent of the federal poverty level (FPL).

In September 1999, Tennessee received approval from CMS for a title XXI plan to provide expanded Medicaid eligibility to children born before October 1, 1983 who are under age 19 with family income at or below 100 percent of the Federal Poverty Level (FPL) and who could not have enrolled in TennCare prior to April 1, 1997 because enrollment was closed to them. The effective date for the plan was October 1, 1997. The outreach efforts described earlier included this target group. The title XXI plan provided coverage to children until October 1, 2002 when the (federally-mandated) phase-in to regular Medicaid for all children under age 19 with family income to 100 percent of the FPL was completed.

In July 2002, TennCare was revamped with the intention of dividing it into three programs: one for Medicaid eligibles (TennCare Medicaid), one for demonstration eligibles (TennCare Standard), and one for low-income persons who need help purchasing available insurance (TennCare Assist: this program has not been implemented). While enrollment continued uninterrupted in TennCare Medicaid, both the Uninsured and Uninsurable eligibility categories in TennCare Standard were closed to new enrollment except for certain "grandfathered" and "rollover" groups. The grandfathered group includes: 1) children under 200 percent FPL who lack access to insurance *and* were enrolled as of June 30, 2002; 2) children who are uninsurable ("medically eligible") at any income level *and* were enrolled as of June 30, 2002; and 3) children under 200 percent FPL with access to insurance who were enrolled in the Uninsured category as of December 31, 2001. Children must be continuously eligible to be in the grandfathered group. The rollover group includes children under age 19 enrolled in TennCare Medicaid who are losing Medicaid coverage *and* are either: 1) a child who lacks access to insurance and has family income below 200 percent of the FPL, or 2) a child who is uninsurable ("medically eligible") at any income level. The medically eligible category replaces the Uninsurable eligibility category and is determined through a medical underwriting process.

In June 2006, Governor Phil Bredesen signed legislation creating a multifaceted program called Cover Tennessee that is designed to provide health insurance to many of the State's uninsured residents. Cover Tennessee includes a program that offers basic health insurance for the working poor, a high risk pool for those with pre-existing medical conditions, and Cover Kids – a Title XXI program for children. Cover Kids will be administered by the Division of Insurance Administration within the Department of Finance and Administration. It is a separate child health program that will cover children to 250 percent of the FPL. In addition, families above 250 percent of the FPL will be able to purchase coverage for their children in CoverKids for the full premium cost. Tennessee is not requesting Federal matching payments for the portion of the program which covers families with income above 250 percent of the FPL.

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:

There are no health insurance programs that involve a public-private partnership in the State of Tennessee.

2.3 Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

The CoverKids program has been working with TennCare to assure coordination of coverage. The 95 county-level Department of Human Services offices that determine eligibility for TennCare will play a role in outreach to the target population, as many children who are not eligible for TennCare may be eligible for CoverKids. Local offices will send application information of children denied TennCare Medicaid and TennCare Standard eligibility to the CoverKids TPA and will also be provided with CoverKids outreach materials to be made available to families. Children who are eligible for TennCare Medicaid and TennCare Standard are not eligible for CoverKids. Eligibility systems for CoverKids are being developed to screen for potential Medicaid eligibility and a process has been established to transfer applications between the two programs. (See Section 4 for further information.)

CoverKids will also build on many of the previous efforts to reach eligible children. Through outreach, CoverKids will collaborate and coordinate appropriate communications and resources with ongoing programs and efforts such as local health departments, WIC, Maternal and Child Health Block Grant, Head Start, and children's hospitals. CoverKids will also engage the efforts of private sector partners for no cost or low cost avenues for publicizing the program in local communities statewide. These efforts include working with providers across the state to outreach to their patients who need the program and to solicit their input on effective operation of the program. (See Section 5 for a more complete description of outreach efforts.)

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

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

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

The State of Tennessee will provide health insurance benefits through a health plan managed by the Division of Insurance Administration. The Division will contract with a commercially licensed insurance plan to provide health benefit coverage to CoverKids enrollees on a statewide basis. The health plan will receive a monthly premium payment from the state for each enrollee and will assume full risk. Each enrollee will be provided with a list of participating providers in their area and will receive all services from providers within the network, with exceptions permitted if the network lacks a particular specialist. The health plan selected for CoverKids will be a separately contracted, commercial network. Providers within the CoverKids network do not necessarily have to be TennCare providers.

The responsibilities of the selected health plan will include, but are not limited to:

1. Providing insurance coverage;
2. Processing and distribution of benefit payments to providers;
3. Establishing a network of physicians, pharmacies, and other providers capable of meeting the demands of the CoverKids Program, including Centers of Excellence (Centers of Excellence are locations, usually children's hospitals, where highly specialized procedures are performed.), and operate a credentialing process;
4. Maintaining an effective utilization/medical management program and incorporate an internal quality assurance program;
5. Furnishing coverage information and ID cards;
6. Responding to inquiries from plan members and providers;
7. Claims certification, investigation, adjudication, and internal appeals process;
8. Maintaining and updating enrollment data;
9. Production of management information that captures claim and utilization experience and trends;
10. Assisting with fraud detection through periodic audits;
11. Meeting specific performance guidelines and guarantees;
12. Encouraging the use of a medical home for each enrollee;
13. Appropriate and accurate fee administration;

14. Strict financial accounting and reconciliation;
15. Production of claims, contract, and other legal forms as required;
16. Establishment and maintenance of appropriate banking arrangements;
17. Continuous and accurate electronic transmission of all data;
18. Other special services as may be requested from time to time.

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))**

The same utilization controls used in the State Employees Health Plan will also be used in the Title XXI program. Selection of a health plan for the CoverKids program will be based on evidence of the plan's provider credentialing policies, provider accessibility, cost-effectiveness, and efficiency. Before being approved for participation in CoverKids, the selected health plan will be required to develop and have in place utilization review policies and procedures to ensure that children use only health care that is appropriate and medically necessary. Utilization management guidelines may include guidelines on prior authorizations, use of drug formularies, and the vendor's medical necessity definition. The health plan may not deny coverage due to the existence of a pre-existing medical condition. The health plan will be required to regularly report key contract indicators to the Division on a quarterly and annual basis.

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

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

4.1 The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1 ☒ Geographic area served by the Plan: Tennessee's Title XXI plan is available statewide.

4.1.2 ☒ Age: CoverKids: Children under 19 years of age.
CoverKids Healthy Babies Program: Unborn children from conception through birth.

4.1.3. ☒ Income:
1. For the unborn from conception: from 0 percent to 250 percent of the FPL and not eligible for Medicaid;
2. For the child from birth to the child's first birthday: above 185 percent to 250 percent of the FPL;
3. For the child from age 1 to the child's 6th birthday: above 133 percent to 250 percent of the FPL; and
4. For the child from age 6 to the child's 19th birthday: above 100 percent to 250 percent of the FPL.

CoverKids' nominal income eligibility level will be 200 percent of the FPL, although the State will disregard income amounts above 200 percent FPL up to 250 percent FPL. Thus our effective income eligibility level will be 250 percent of the FPL.

4.1.4 ☐ Resources (including any standards relating to spend downs and disposition of resources): None

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state): Must reside in the State of Tennessee.

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): None

4.1.7 ☒ Access to or coverage under other health coverage:

Comprehensive employer-based coverage or other creditable health insurance will preclude enrollment in CoverKids. CoverKids enrollment will also be precluded if the applicant was covered by creditable employer-based or individual health insurance within three months of application for CoverKids. However, if the applicant was terminated from employer-based health insurance within three months of making the CoverKids application for reasons such as layoff, business closing, or similar circumstance that resulted in the involuntary loss of previous insurance, then CoverKids enrollment will not be precluded.

CoverKids enrollment will also be precluded if the applicant has access to coverage under a state employee health benefit plan.

4.1.8 ☒ Duration of eligibility:

With approval of the CoverKids application, the child will be eligible for twelve months. CoverKids eligibility may end prior to twelve months of coverage if the child is found ineligible at random review or at audit, turns age 19, or moves from the State. Because of the desire to simplify the application process as much as possible, upfront verification has been minimized but reasonable audit to detect errors or fraud is planned. There will be a sample of applications audited with application information fully verified. Families will be notified of the audit by letter as they would be requested to provide documentation to verify information given. If an audit shows that a child or children in the family were not, in fact, eligible for CoverKids, the TPA will contact the family to give them the opportunity to provide information establishing eligibility within 10 days. Families who do not provide information that establishes eligibility will be notified by letter of termination of eligibility, subject to the appeal rights described in section 12 of the State plan. Timeframes for disenrollment will be consistent with timeframes for disenrollment at redetermination, i.e., the last day of the month in which a final determination of ineligibility is made.

At the end of the twelve-month eligibility period, the family will be requested to confirm the eligibility information currently on file with CoverKids. The family completes the form and then signs and returns the form. Following return of the renewal form, eligibility will be reviewed, and if eligibility continues, the family will be sent a new enrollment card for another twelve-month period. They will also be sent information advising that if the family income is now lower, the application will be referred for Medicaid determination. Children whose applications have been sent to TennCare may remain in CoverKids for up to 60 days after the end of the 12-month CoverKids eligibility period if necessary while DHS reviews the TennCare application**.**

4.1.9 ☒ Other standards (identify and describe):

Applicants are required to provide a social security number (SSN) or they must have applied for an SSN. Non-applicant family members are not required to provide an SSN.

The CoverKids Healthy Babies program is available to unborn children (from conception through birth) of pregnant women (of any age) with incomes at or below 250% FPL who are not otherwise eligible for TennCare. This program provides maternity benefits and pregnancy-related services consistent with those available under the CoverKids program. The following eligibility standards will apply:

- The pregnant woman is not Medicaid eligible. A pregnant woman

applying for CoverKids will be screened first for eligibility in TennCare. If she is not TennCare eligible, a CoverKids eligibility determination will be performed for the unborn child.

- The unborn child or children are counted as if born and living with the mother in determining family group size.
- The unborn child may not have creditable health insurance coverage, i.e., the mother is either uninsured or her coverage does not include prenatal care; and she has not voluntarily dropped comprehensive private health insurance coverage during the last 3 calendar months prior to application processing.

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

4.2.1 ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2 ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3 ☒ These standards do not deny eligibility based on a child having a pre- existing medical condition.

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

Start Up: The CoverKids eligibility and enrollment third party administrator (TPA) will develop an application form that is short, easy to understand and easy to complete; and will develop the necessary approval/denial eligibility letters. The TPA will be responsible for the mailing of applications/letters/etc., telephone access (e.g., a 1-800 number), maintenance of forms, and maintenance of data systems. The TPA will make applications available at local sites (e.g., schools, health departments) and will mail applications to families when requested. Applicants may submit paper applications by mail. Online applications are also expected to be available by mid-2007. Initially, there will be a downloadable application but not an interactive web application as that will have to be developed. The downloadable application will require a signature and be mailed to the TPA.

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Eligibility Determination and Enrollment Process: The TPA will receive completed applications at a central location and will follow-up with families by phone or mail to obtain any missing information or documentation. When all necessary information has been received, the TPA will determine eligibility for CoverKids based on criteria established by the state and mail notices of approvals/disapprovals. The TPA will also notify the health insurer of new CoverKids enrollees and the insurer will then issue member enrollment cards. Eligibility for CoverKids will begin on the first day of the month following completion of the eligibility determination. For applications processed within five

work days of the beginning of the next month, coverage will begin the first day of the following month.

Presumptive Eligibility: CoverKids will permit qualified entities to conduct presumptive eligibility (PE) determinations for pregnant women and newborns from birth through 3 months of age. Qualified entities may include hospitals, physician groups or similar entities that provide health care services to CoverKids enrollees. Entities that choose to determine presumptive eligibility will be provided with application forms and instructions on how to assist families in completing the forms and will have the following responsibilities:

- Receive completed applications and any required verifications.
- Determine initial eligibility based on information presented within two days of receipt of the completed application.
- Follow-up on incomplete applications by telephone or mail.
- Forward completed applications within two days to the CoverKids TPA for final determination of CoverKids eligibility.

CoverKids will provide CoverKids providers who volunteer to be qualified entities, with applications and training to perform presumptive eligibility to assure that these entities understand their responsibilities and are capable of conducting accurate presumptive eligibility determinations.

A pregnant woman may only be presumptively eligible if she has no comprehensive health insurance coverage and has not had group or individual coverage within the last 3 calendar months (exceptions permitted). If the qualified entity determines that the family income of the pregnant woman or newborn falls within the CoverKids eligibility range, the signed application is submitted to the CoverKids TPA and presumptive eligibility is established. Presumptive eligibility begins on the date on which a qualified entity determinines that a pregnant woman or newborn child is presumptively eligible and lasts until the TPA makes an eligibility determination. If any additional information necessary to make the eligibility determination is not submitted within 60 days of the start date, the application will be deactivated and presumptive eligibility will end. A pregnant woman or newborn may receive only one period of presumptive eligibility in an 18 month period.

Presumptive eligibility will also be provided for children transitioning from TennCare. This will allow children whose TennCare coverage is ending to have immediate coverage under CoverKids when TennCare coverage ends as long as all PE requirements are met. This type of presumptive eligibility will be performed by the CoverKids TPA. DHS will forward to the TPA a list of children who will lose TennCare coverage, including the date that coverage will end. The TPA will work with the family to obtain a signed CoverKids application. The period of presumptive eligibility will begin the day following the date that TennCare coverage ends, and end when the TPA makes a final determination of CoverKids eligibility or, if a completed application is not submitted, the last day of

the month following the month in which the PE determination was made.

Renewal: Following approval of the CoverKids application, the child will be eligible for twelve months of continuous coverage regardless of changes in income. CoverKids eligibility may end prior to twelve months of coverage if the child is found ineligible at audit, turns age 19, or moves from the State. At the end of the twelve-month eligibility period, the family will be requested to update the eligibility information currently on file with CoverKids. Redetermination notices will be sent out 45 to 50 days prior to the end of the 12-month continuous eligibility period for CoverKids. This time period has been established so that there is sufficient time to identify children who are potentially eligible for TennCare and move them seamlessly to TennCare when eligible. The family will be asked to complete, sign and return the renewal form. Following return of the renewal form, eligibility will be reviewed and the family will be notified of the outcome. If the family income is now lower, they will also be sent information advising that the child appears to be Medicaid eligible and the TPA will assist the family in completing a Medicaid application. When a child is disenrolled from CoverKids, the vendor will also provide the family with a certificate of creditable coverage.

Eligibility Criteria: In order to be eligible for CoverKids, a child must meet the following criteria.

- The child must be a resident of Tennessee, a documented alien, or the family has come to Tennessee with the intent to stay or work in Tennessee. Some legal immigrants are not eligible for the first five years of residency. Excepted groups include refugees and children of veterans. Alien status can be verified by the I-551 or I-94. CoverKids will notify the enrollment vendor of the appropriate methods for verifying alien status.
- The child must reside in a family with a countable income of less than or equal to 250 percent of poverty. No asset test is used. Income will be self-declared. The TPA or the state will periodically audit a sample of enrollees for verification.
- The child must be between the ages of 0 and 19 (a child who turns age 19 is no longer eligible for CoverKids after the month he turns 19).
- Emancipated minors are considered as a family in their own right.
- The child must currently have no comprehensive, creditable health insurance coverage and have had no comprehensive, creditable employer-based or individual health insurance coverage for the past three months. (Specialty insurance coverage such as dental only coverage is not considered a comprehensive insurance.)

Excluded Children: The following individuals are not eligible for CoverKids.

- Children who appear to be eligible for Medicaid (even if not enrolled in Medicaid). This includes:
    - Children who are eligible for TennCare Medicaid at the following levels: Infants to 185 percent of the FPL; ages 1 through 5 to 133

percent of the FPL; ages 6 through 18 to 100 percent of the FPL.
    - Children who are eligible for the grandfathered or rollover groups in TennCare Standard.
- Children who are involuntarily admitted to a non-medical public institution (A public institution means a government-operated facility that does not provide medical care, e.g., jail or prison).
- Children who are admitted to an institution for the mentally disabled (e.g., IMD).
- Children who are members of a family that is eligible for health coverage under a state health benefits plan on the basis of a family member's employment by a public agency in Tennessee.
- Children who have had comprehensive employer-based or individual insurance in the past three months, including Medicare, with exceptions allowed for non-voluntary loss of insurance.
- Children who are covered under a group health plan or other creditable health insurance coverage.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**
☒ Check here if this section does not apply to your state.

4.4 Describe the procedures that assure that

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

The State of Tennessee will assure through enrollment screening processes that applications of children who appear eligible for Medicaid are referred for a determination of Medicaid eligibility. The CoverKids eligibility system is being designed to be consistent with Medicaid eligibility rules in order to assure that the screening process identifies children who are potentially Medicaid eligible. For example, the family group composition used for determining CoverKids eligibility will be the same as that for Medicaid and income deductions will be consistent with those used by Medicaid. Additionally, the TPA eligibility staff will query the Medicaid eligibility system to ensure applicants are not currently enrolled in any Medicaid program. These screening processes will be used both at initial eligibility determination and at redetermination.

The CoverKids application will ask families about current health insurance coverage, as well as coverage within the past 3 months. The application also asks applicants whether the child or pregnant woman has access to State of

Tennessee administered insurance as a result of a family member's employment with a state or local government agency. This information is self-declared; however, the TPA eligibility staff may contact the family when information is not provided or clarification is needed. Using the responses to the application questions, TPA eligibility staff will deny coverage to children or pregnant women who: are currently insured, voluntarily dropped private health insurance coverage during the last 3 calendar months prior to application processing, and are eligible for a state-administered health benefits plan for state or local government employees. If necessary, TPA staff may contact the State Division of Insurance Administration for clarification of eligibility for a state health benefits plan. In addition, the Division of Insurance Administration is exploring the possibility of doing tape matches with one or more insurers in the State to verify that children are not covered by private health insurance.

The State will perform periodic random reviews and post-eligibility audits of the applications to assure compliance with CoverKids eligibility and enrollment policies. These reviews will include examination of applications and any additional information or documentation to assure that: a proper determination of eligibility was made, all the required information is obtained, the system contains needed edits, and referrals to Medicaid are made when indicated. The reviews will also audit applications for a sample of children to verify that the information provided by self-declaration during the application process is accurate. Families will be notified of the audit by letter and asked to provide documentation to verify information given. If an audit shows that a child or children in the family were not, in fact, eligible for CoverKids, the TPA will contact the family to give them the opportunity to provide information establishing eligibility within 10 days. Families who do not provide information that establishes eligibility will be notified by letter of termination eligibility, subject to the appeal rights described in section 12 of the State plan. Timeframes for disenrollment will be consistent with timeframes for disenrollment at redetermination, i.e., the last day of the month in which a final determination of ineligibility is made.

In addition, part of the quality assurance methodology will be planned reports on the following:

- lists of CoverKids enrollees by county (this will be compared to the Medicaid population to assure the enrollee is not receiving both Medicaid and CoverKids services)
- number of applications received
- number of denials of applications with the reasons for denial
- number of pregnant women and newborns who were determined to be CoverKids eligible, using presumptive eligibility, who were subsequently determined not eligible by the TPA
- number of disenrollments with the reasons for disenrollment
- number of hearings requested and their disposition
- number of annual redeterminations
- enrollee survey results

Application reviews will include assurance that any required verifications have been used, time frames have been met, and appropriate referrals have been made.

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))**

When a child appears to be eligible for either TennCare Medicaid or TennCare Standard as determined by the CoverKids TPA, the TPA will notify the family, provide the family with a TennCare application, and offer assistance in completing the application. The TPA (or the family at their option) will send the completed TennCare application to the appropriate Department of Human Services (DHS) office for a determination of TennCare eligibility. The child will not be enrolled in the CoverKids program and the application will be suspended pending a determination by DHS. If DHS ultimately determines the child to be ineligible for TennCare, they will notify the CoverKids TPA and CoverKids eligibility will be automatic based on the TPA's updating of the original application with information provided by TennCare. The TPA will have look-up access to the DHS eligibility and enrollment system to assure that applicants are not already covered by TennCare Medicaid or TennCare Standard.

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))**

When a child is determined ineligible for TennCare Medicaid or TennCare Standard and potentially eligible for CoverKids, DHS will forward the TennCare application to the CoverKids TPA. The TPA staff will enter relevant information from DHS into their system and award coverage beginning on the first day of the month following receipt of the application from TennCare. For applications processed within five work days of the beginning of the next month, coverage will begin the first day of the following month.

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

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

4.4.4.2 ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

The CoverKids application form will request information regarding other insurance coverage for each child. The TPA will not enroll any child that has creditable employer-based group health coverage or any child whose family has dropped coverage in the previous three months, unless due to reasons such as layoff, business closing, or similar circumstance that resulted in the involuntary loss of previous insurance. The fact that employer-based group health coverage was dropped will be documented and there is a 3-month waiting period to apply for CoverKids if the child's family has dropped employer-based group health coverage unless the exception criteria are met.

The State will monitor substitution through information that is gathered during the application process and through surveys of families. The TPA will collect information about whether children have had coverage in the past three months and the reason for dropping that coverage as part of the application process. This data will be utilized to analyze the extent of substitution. In addition, the evaluation contractor will conduct surveys of families with children enrolled in CoverKids. Those surveys will include information on past coverage and the reasons that the child lost that coverage. The evaluation contractor will analyze that data and that analysis will be included in the annual reports to CMS. If substitution levels are found to be unacceptable, the State will consider increasing the waiting period or instituting other actions to reduce the occurrence of crowd out.

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))**

The State of Tennessee assures the provision of child health assistance to targeted low-income children in the State who are American Indians and Alaska Natives (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)). Enrollees identified as being an American Indian and Alaska Natives will not be charged copayments. The State of Tennessee does not have

any recognized tribes; however, the CoverKids program is coordinating with the Director of Indian Affairs in the state to ensure Native American families are aware of the opportunity to enroll their children in CoverKids. The Director of Indian Affairs has been informed about CoverKids and the cost sharing exemptions for Native American children so that he may tell families with whom he has contact about the program. He will also be provided with outreach materials to share with those families. In addition, CoverKids is pursuing with him contacts for federally recognized tribes located in neighboring states so that we can determine how best to reach their members who reside in Tennessee.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

The State's marketing and outreach efforts will be comprised of two components: (1) coordinated marketing outreach in conjunction with other Cover Tennessee initiatives through use of demographically targeted media campaigns and existing information dissemination channels and (2) outreach through partner programs, agencies, and organizations that have contact with families likely to have children eligible for CoverKids.

1) Coordinated Marketing Outreach

As part of a comprehensive approach to marketing and outreach, a statewide media campaign will be conducted. This will happen both in conjunction with other Cover Tennessee initiatives, and in a specific media campaign for CoverKids. Paid media outlets including television, radio, print, internet and outdoor advertising will be evaluated to determine the best mix of media to effectively reach the target audience. The design of the campaign will be demographically targeted to maximize the return for advertising dollars by matching the timing and placement of advertisements to the habits of the target populations. We anticipate production of television and radio spots, as well as outdoor advertising to be run statewide. In addition, collateral pieces such as brochures, posters and other materials that will serve as tools for CoverKids outreach will be developed for widespread dissemination. These materials will be used by communities to reach the target audience. The available information will include an application form for return mailing. All materials will direct readers to a toll free number for further information or questions. In addition, the state will do a kick-off, press event in one or more media markets. The Division of Insurance Administration also will maintain a website with current information regarding the CoverKids program for access by the general public.

2) Outreach through Partner Programs, Agencies, and Organizations

CoverKids will work with a number of partners including schools and day care centers, other government programs, community service organizations, health care providers, professional associations, businesses, and faith-based organizations to publicize the program and encourage enrollment.

Schools: Schools and day care programs will be an important avenue for outreach to families. A contact person at each public school will be responsible

for distributing brochures and applications to students. School nurses, Head Start programs, day care providers, private schools and home school organizations will also be provided with information about CoverKids to give to students and families.

Other Government Programs: State and local agencies will also distribute CoverKids brochures and applications. The Department of Human Services (which is responsible for TennCare eligibility, Child Care, Child Support, disability determination, TANF, Food Stamp, Home Energy Assistance, and Vocational Rehabilitation) has a central office in Nashville and offices in all 95 counties in the state. The Tennessee Health Department also has local offices in each county. Tennessee Early Intervention Services within the Department of Education (which serves children with special needs from birth through age 3) has service coordinators throughout the state. Each of these programs will be provided with information and application materials for the CoverKids program. Unemployment and Department of Motor Vehicles offices, WIC programs, public housing, homeless shelters, community centers, employment and training centers, recreation centers, and libraries are other locations for distribution of brochures and other information. CoverKids will also coordinate closely with TennCare to assure applicants to either program are referred to the appropriate program in a timely, efficient manner. (See section 4.4 for a complete description.) The CoverKids program will also work with the Tennessee Office of Minority Health and multicultural service agencies in local communities to reach diverse ethnic groups.

Providers: CoverKids will work with providers such as hospitals, community health centers, clinics, and physician groups to publicize CoverKids with brochures, newsletter articles, and education sessions. Major hospital systems and hospitals in Tennessee include Baptist Memorial, Methodist Healthcare, Mountain States Health Alliance, Wellmont Health Systems, West Tennessee Healthcare System, University of Tennessee Medical Center, St. Jude Children's Research Hospital, and Metro Nashville General Hospital. CoverKids will work with these and other Tennessee hospitals, clinics, and physician groups (especially pediatricians) to outreach to families.

Community Organizations and Businesses: CoverKids will be contacting community service, civic, and professional organizations to establish partnerships. These organizations include YMCAs, Chambers of Commerce, Kiwanis and Rotary clubs, and Junior Leagues. Businesses such as department and grocery stores, pharmacies, fast food chains, and insurance agents will also be asked to help distribute information through activities such as displaying posters and placing the CoverKids logo and toll-free phone number on bags, fast food tray liners, etc. Local faith-based organizations (e.g., synagogues, churches, mosques, temples) will also be involved in outreach.

To date, CoverKids has received a remarkable groundswell of support from

community and provider organizations interested in assisting with outreach and enrollment. At this point, CoverKids plans to make an array of tools available for groups interested in doing outreach and enrollment and to encourage programs with an affiliation to the state to utilize these tools. As necessary, the state at a later date may decide to offer a more extensive grant or incentive program to encourage enrollment assistance from community organizations.

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

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

6.1 The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1 ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1 ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2 ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3 ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2 ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)**

Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3 ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4 ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1 ☐ Coverage the same as Medicaid State plan

6.1.4.2 ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3 ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4 ☒ Coverage that includes benchmark coverage plus

additional coverage

Benefits under the CoverKids program will be the same as the benefits for the HMO option of the State Employee Health Plan; however, the annual number of visits for outpatient mental health/substance abuse and PT/OT/SP has been increased from 45 to 52. Beginning in January 2008, the benefit package will also include dental and vision services. Attachment A is the summary of benefits for CoverKids. Attachment B is the benefit summary for the State Employee Health Plan.

6.1.4.5 ☐ Coverage that is the same as defined by "existing comprehensive state-based coverage"
6.1.4.6 ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit-by-benefit comparison (Please provide a sample of how the comparison will be done)
6.1.4.7 ☐ Other (Describe)

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

6.2.1 ☒ Inpatient services **(Section 2110(a)(1))**
6.2.2 ☒ Outpatient services **(Section 2110(a)(2))**
6.2.3 ☒ Physician services **(Section 2110(a)(3))**
6.2.4 ☒ Surgical services **(Section 2110(a)(4))**
6.2.5 ☒ Clinic services (including health center services) and other ambulatory health care services **(Section 2110(a)(5))**
6.2.6 ☒ Prescription drugs **(Section 2110(a)(6))**
6.2.7 ☐ Over-the-counter medications **(Section 2110(a)(7))**
6.2.8 ☒ Laboratory and radiological services **(Section 2110(a)(8))**
6.2.9 ☒ Prenatal care and 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))**

Limited to 30 days per year

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)**

Limited to 52 sessions mental health and substance abuse

combined.

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

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

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

Home Health Services with prior approval

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))**

Dental Benefits will include preventive, diagnostic, and basic restorative services as follows:

- Diagnostic services
  - 2 oral examinations per year
- Preventive
  - Fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a year up to age 14
  - Dental sealants for permanent molars
  - 2 cleanings per year
- Emergency Services
  - 2 visits during office hours per year
  - 2 visits after office hours per year
- Restorative services
  - Stainless steel crowns
  - Routine fillings (silver or tooth colored)
- Simple extractions
- Radiographs
  - Bitewing x-rays once per year
  - Full mouth x-rays once every three years
- Therapeutic pulpotomy

The maximum annual benefit shall not exceed $600 per child per year.

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

Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay.

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

Limited to 52 sessions mental health and substance abuse combined.

6.2.20 ☒ Case management services **(Section 2110(a)(20))**
6.2.21 ☒ Care coordination services **(Section 2110(a)(21))**
6.2.22 ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

Limited to 52 visits per year per condition.

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 which includes the following:

- Annual vision exam (including refractive exam and glaucoma testing)
- Prescription eyeglass lenses including bifocal or trifocal, fitting and dispensing fee (once every 12 months - $ 85 maximum)
- Eyeglass frames (including routine replacement once every 24 months - $100 maximum).
- Prescription contact lenses in lieu of eyeglasses (once every 12 months - $150 maximum)

Approved optical services, supplies, and solutions must be obtained from licensed or certified ophthalmologists, optometrists, or optical dispensing laboratories participating with CoverKids. Prior approval is required for any other services or visual aids deemed to be necessary by recommendation of the provider.

6.2.25 ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**
6.2.26 ☒ Medical transportation **(Section 2110(a)(26))**

Ambulance Service – Air and Ground: When medically necessary.

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))**

In addition to the services indicated above, the CoverKids benefit

package will also include:

- Emergency Care
- Chiropractic Care: Maintenance visits not covered when no additional progress is apparent or expected to occur.
- Routine Health Assessments and Immunizations in accordance with AAP and ACIP recommendations.
- Mothers of unborn children eligible under the CoverKids Healthy Babies program will receive maternity services consistent with those available under the CoverKids program.
- Mothers of unborn children eligible under the CoverKids HealthyTNBabies program will receive dental benefits consistent with those available under the CoverKids program for the duration of their maternity coverage.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1 ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2 ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)**

6.4.1 ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1 Coverage provided to targeted low-income children

through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2 The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above. **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3 The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2 ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1 Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (**Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2 The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3 The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.**

7.1 Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

CoverKids will use the expertise of an independent evaluation contractor in the assessment of the CoverKids program. Quality and appropriateness of care will be assessed through the use of enrollee surveys, review of claims data, and medical record review. Both process and outcome measures will be considered when assessing the quality and appropriateness of care. Among the items to be used in tracking are claims data indicators such as whether children have a usual source of care, whether children are receiving the recommended well-child exams and are appropriately immunized; whether non-trauma based emergency room use is going down, how referrals are being made, whether specialty care and related services are being received, and patterns of prescription drug use. CoverKids plans to monitor consumer and provider satisfaction through surveys and informal communications with families, advocacy groups, and providers. In addition to these monitoring strategies, the State assures access to care through monitoring of the geographic distribution of providers.

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

The State ensures quality through contracted performance measures.

7.1.3 ☒ Information strategies

The contracted insurer will be required to provide key health indicators information.

7.1.4 ☒ Quality improvement strategies

The contracted insurer will be required to maintain an effective quality improvement program.

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

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

CoverKids member handbooks will explain the importance of, and recommended timing for well-child care visits and immunizations. Access is monitored through a number of methods including periodic review of the number and types of providers by county, review of claims data, review of enrollee survey data, feedback from families via telephone, e-mail, and postal service mail, and feedback from providers.

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))**

The health plan is required to maintain an adequate provider network that includes emergency room services. In addition, PCPs who participate in the health plan are required to have identified after hour patient access to address medical questions and concerns. Access to emergency services will be monitored through periodic review of the number and types of providers by county, review of claims data, review of enrollee survey data, feedback from families and feedback from providers.

The geographic access standard for children's primary care practitioners (pediatricians, general medicine and family practice physicians), at a minimum, will be 2 physicians within 20 miles. The standard for acute care hospitals will be at least 1 facility within 30 miles. The standard for pediatric specialists is 5 physicians within 100 miles. The standard for specialists assures that enrollees will, at a minimum, have access to a children's hospital where they may access specialty care.

One aspect of the initial measure of network adequacy in the procurement of a plan administrator and network is the distribution and absence of plan participants. The state will employ a proxy, the distribution of children in households with incomes below the federal poverty level, in executing the geoaccess analysis.

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))**

The health plan is required to maintain an adequate provider network including

specialists. Access to specialty services will be monitored through periodic review of the number and types of providers by county, review of claims data, review of enrollee survey data, feedback from families and feedback from providers. In the rare instance that the provider network is not adequate to meet a member's needs, the member will be referred out-of- network to obtain medically necessary services.

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))**

The health plan will be required to have policies in place to assure that prior authorizations of health services are completed within 14 days.

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

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

8.1 Is cost sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1 ☒ YES
8.1.2 ☐ NO**, skip to question 8.8.**

8.2 Describe the amount of cost sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1 Premiums: None
8.2.2 Deductibles: None
8.2.3 Coinsurance or copayments:

Children will be subject to copayments for most services provided under the plan; however, no copayments will be charged for well-child visits, immunizations, or lab and x-ray services. There is also no copayment for ambulance services when deemed medically necessary by the health plan. For children in families with income at or below 150 percent of the FPL, co-payments will not exceed $5.00, except the copayment for non-emergency use of the emergency room will be $10. Copayments for children in families with income above 150 percent of the FPL will vary by service. Attachment A details the copayments for each income group.

8.2.4 Other: None

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))**

Families of applicants and enrollees, providers, and the public will be informed of the cost-sharing requirements (including the cumulative maximum) in the CoverKids application and enrollment materials. Copayments are listed in the benefits booklet. Outreach workers and administrative staff who answer phone inquiries are trained to discuss with families the co-payments required and the annual out-of-pocket limit. The CoverKids eligibility and enrollment TPA will notify families of the dollar amount of their out-of-pocket limit based on 5% of their annual income in the same letter that notifies the family of enrollment into

the health plan. The TPA will also notify the health plan of the limit on out-of-pocket spending for enrollees. The health plan will electronically accumulate the money spent for cost sharing for eligible children in a family and notify the family via a letter when the dollar amount is met. The health plan's electronic claims system will annotate the child's file to notify providers that no further cost sharing is required.

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

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

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

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

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

Very few families are likely to exceed the 5 percent limit on out-of-pocket expenses because of the CoverKids copayment structure. For example, a single parent with one child (two person family) at 101 percent of the FPL ($13,332 annually) would have an annual out-of-pocket maximum of $667. This family could have a total of 134 doctor visits and prescriptions before reaching the limit on out-of-pocket expenses. A child in family of two at 151 percent of FPL ($19,932 annually) could have 66 physician office visits before reaching the out-of-pocket maximum of $996.

Families will be informed in all literature and outreach workers will be trained to educate families about the limit on out-of-pocket expenses. Upon enrollment in CoverKids, families will receive notification of the dollar amount of their out-of-pocket limit based on 5% of their annual income. The 5 percent annual cost sharing limit will be calculated by the CoverKids eligibility and enrollment TPA at the time of eligibility determination. The TPA's accuracy in calculating the limit will be monitored by the State as a part of the audits it will conduct to verify the accuracy of the TPA's eligibility determinations. The TPA will also notify the health plan of the limit to the amount of copayments. The health plan will electronically accumulate the money spent on cost sharing for eligible child(ren) in a family and notify the family via a letter when the dollar amount is met. The health plan's electronic claims system will annotate the child's file to notify providers that no further cost sharing is required. In case of error caused by filing

delays, families may request a manual review of their receipts and families will be reimbursed should computer notification fail to work. The health plan will be asked to submit reports to the State identifying families who have met their annual out-of-pocket limit**.**

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)**

The brochure explaining application and enrollment procedures will state that there is no cost sharing for American Indian/Alaska native children. If the family indicates on the application form that a child is American Indian or Alaskan Native, but does not provide tribal membership documents, a letter will be sent by the TPA requesting this information when the child is determined otherwise eligible. Upon receipt of proof of federally recognized tribe status, the TPA will notify the health plan to flag the child's electronic account to notify providers that copayments are not required. The health plan will be responsible to reimburse the family for any co-payments that may have been made prior to notification of exempt status.

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))**

A family that does not pay a required copayment remains enrolled in the program. An individual provider may at his or her discretion refuse service for non-payment of a copayment. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay copayments.

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

The CoverKids Program does not disenroll anyone under the current system for non-payment of copayments. If the State makes changes in the program that would permit disenrollment we would make sure that:

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

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

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

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

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

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

8.8.2 ☒ No cost sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3 ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4 ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5 ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6 ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1 Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

Strategic Objective 1: Increase health insurance coverage for Tennessee's targeted low-income children and other low-income children through the CoverKids program.

Strategic Objective 2: Administer an effective outreach/marketing campaign designed to reach targeted low-income children and other low-income children.

Strategic Objective 3: Increase access to health care services for targeted low-income children as a result of enrollment in CoverKids.

Strategic Objective 4: Improve health outcomes through appropriate utilization of health care resources for targeted low-income children through CoverKids.

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

Strategic Objective 1: Increase health insurance coverage for Tennessee's targeted low-income children and other low-income children through the CoverKids program.

Performance Goals:

1A. Enroll 25 percent of uninsured, non-Medicaid eligible children with family income below 250 percent of the FPL in the first full year of operation.
Measure: Percentage of eligible children enrolled.

1B Decrease the number of low-income (≤ 250 % FPL) children who are uninsured by 1% each year.
Measure: Percentage of uninsured low-income children based on CPS three-year average.

Strategic Objective 2: Administer an effective outreach/marketing campaign designed to reach targeted low-income children and other low-income children.

Performance Goals:

2A Outreach/marketing will have a visible campaign to repeatedly inform and educate families.
Measure: Percent of eligible children enrolled by outreach strategy.

2B Outreach/marketing will target ethnic and rural populations identified as historically underserved.
Measure: Number of persons contacted by media and events for ethnic and rural populations.

Strategic Objective 3: Increase access to health care services for targeted low-income children as a result of enrollment in CoverKids.

Performance Goals:

3A Increase the percentage of children with a regular source of care.
Measures: 1) Percent of enrollees whose families report a usual source of care after enrollment in CoverKids as compared to before enrollment.
2) Percent of enrollees ages 2 – 11 who had at least one visit with a primary care physician (PCP).

3B Decrease the percentage of children who use the emergency room.
Measure: Percent of enrollees whose families report that their children have used a hospital emergency room since enrollment in CoverKids as compared to before enrollment.

Strategic Objective 4: Improve health outcomes through appropriate utilization of health care resources for targeted low-income children through CoverKids.

Performance Goals:

4A Increase preventative care for children.
Measures: 1) Well-child visits in the first 15 months of life.
2) Well-child visits in the 3rd, 4th, 5th, and 6th years of life.
3) Number of well-child visits and immunizations compared to national benchmarks.

4B Increase appropriate care for children with asthma and children with diabetes.
Measures: 1) Percent of enrollees ages 5 – 17 with persistent asthma who were prescribed appropriate medications for long-term control of asthma.

2) Number of primary care visits for children with asthma.
3) Emergency room visits for children with asthma.
4) Hospitalizations for children with asthma.
5) Number of HbA1c tests for diabetics.
6) Number of primary care visits for children with diabetes.
7) Emergency room visits for children with diabetes.
8) Hospitalizations for children with diabetes.

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))**

The strategic objectives and accompanying performance goals have been initiated based on the desire of Tennessee to plan, implement and administer a successful SCHIP program. In order to be successful in the early years of the program specific attention has been focused on program outreach, enrollment, access and health care outcomes. The CoverKids program will contract with an independent evaluator to assist with evaluation of the performance goals and strategic objectives. The evaluator's responsibilities will include establishing baseline levels and collecting and analyzing data for each goal. In order to effectuate the evaluation of the performance goals, data from the following sources will be utilized:

- Information on outreach strategies from the program outreach/marketing vendor.
- Application and enrollment data from the program enrollment vendor.
- Data on the provider population from the program insurance vendor.
- Claims and encounter data from the program insurance vendor and the state's decision support system (claims data warehouse).
- Consumer surveys focusing on overall program satisfaction and utilization.

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.

CoverKids plans to use a modified HEDIS measurement set, at a minimum, to evaluate the four core performance measures suggested by CMS including:

- Immunizations
- Well child care
- Appropriate medications for treatment of asthma, and
- PCP visits.

CoverKids will work with its evaluation contractor to determine additional HEDIS-like or other appropriate measures for evaluation of the program.

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.

Asthma and diabetes.

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

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

CoverKids will comply with the annual assessment by submitting a report, utilizing the Framework for Annual Evaluation developed by the National Academy for State Health Policy in conjunction with state SCHIP staff and CMS on an annual basis. This report will be completed by CoverKids staff with the assistance of our independent evaluator. The evaluator will be responsible for evaluating the CoverKids strategic objectives and goals described in sections 9.1 and 9.2 and will provide data and analysis for the preparation of annual reports. The annual report will be submitted to the Secretary by January 1 following the end of the federal fiscal year.

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

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

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

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

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

Division of Insurance Administration and CoverKids program representatives have held a number of meetings during the summer of 2006 to inform the public and provider groups about plans for CoverKids and obtain input on program design. The meetings took place in various locations throughout the state to facilitate participation of a wide range of groups, including four children's hospitals and representatives from a number of advocacy groups. The following meetings have been held:

- Vanderbilt Children's Hospital - CEO, administrators, and hospitalists - 7/20
- Nashville area community pediatric providers - 7/20
- T.C. Thompson Children's Hospital (Chattanooga) - CEO, administrators, and hospitalists - 7/25
- Chattanooga area community pediatric providers - 7/25
- East Tennessee Children's Hospital (Knoxville) - CEO, administrators, and hospitalists - 7/26
- Knoxville area community pediatric providers - 7/26
- LeBonheur Children's Hospital (Memphis) - CEO, administrators, and hospitalists - 7/28
- Memphis area community pediatric providers - 7/28
- Governor's Office of Children's Care Coordination Steering Committee (advocacy groups) - 8/5

- TN Commission on Children and Youth - convening of children's advocacy groups - 8/25

The state anticipates that many of these groups will be instrumental in the implementation of CoverKids both through outreach efforts and as providers of service. In addition, CoverKids is establishing an advisory group composed of provider and advocacy group representatives to provide ongoing feedback on the implementation of the program. We anticipate that this group will meet twice per year and meetings will be open to the general 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))**

There are no recognized Indian Tribes within the State of Tennessee; however, CoverKids is coordinating with the Tennessee Director of Indian Affairs to assure that Native American families residing within the state are informed of the CoverKids program and aware that there is no cost sharing for eligible Native American/Alaska Native children. (See also section 8.6.)

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).

Eligibility, benefits and cost sharing were discussed during the public meetings described above and public input was considered in the design of this plan. Brochures and informational materials developed for the program will include descriptions of eligibility, benefits and cost sharing.

9.10 Provide a 1-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;
- Assumptions on which the budget is based, including cost per child and expected enrollment; and
- Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

See next page for budget information.

Tennessee's SCHIP (CoverKids) Budget Plan FFY '08 (10/1/07 – 9/30/08)

	CoverKids	TennCare	Total
	Federal Fiscal Year Costs	**Federal Fiscal Year Costs**	**Federal Fiscal Year Costs**
Enhanced FMAP rate	**74.56%**	**74.56%**	
Benefit Costs			
Insurance payments	83,085,581		83,085,581
Managed care		46,656,570	46,656,570
per member/per month rate @ # of eligibles			
Fee for Service			
per member/per month rate @ # of eligibles			
Total Benefit Costs	**83,085,581**	**46,656,570**	**129,742,151**
(Offsetting beneficiary cost sharing payments)		(2,332,829)	(2,332,829)
Net Benefit Costs	**83,085,581**	44,323,741	127,409,322
Administration Costs			
Personnel	257,500	0	257,500
General administration	66,950	0	66,950
Contractors/Brokers (e.g., enrollment contractors)	4,401,000	0	4,401,000
Claims Processing	0	4,136,832	4,136,832
Outreach/marketing costs	515,000	0	515,000
Other	0	0	0
Total Administration Costs	5,240,450	4,136,832	9,377,282
10% Administrative Cost Ceiling (net benefit costs ÷ 9)	9,231,731	4,924,860	14,156,591
Federal Share (multiplied by enh-FMAP rate)	65,855,889	36,132,203	101,988,092
State Share	22,470,142	12,328,370	34,798,512
TOTAL COSTS OF APPROVED SCHIP PLAN	88,326,031	48,460,573	136,786,604

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

* FFY '08 Enrollment = 30,700

Base Plan	77,207,895
Vision	1,324,426
Dental	4,553,260

Funding for the state match is appropriated from the State's general fund.

Section 10. Annual Reports and Evaluations (Section 2108)

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

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

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

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

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

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

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

11.2 The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))**

The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

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

Section 12. Applicant and enrollee protections (Sections 2101(a))

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

Eligibility and Enrollment Matters

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

Upon denial of eligibility (including suspension or termination of enrollment), a parent will be notified by mail of the reason for the denial and the process to notify CoverKids if the parent believes the denial is in error. Parents may also request a review for situations in which eligibility determination have not been made in a timely manner. Parents will first be directed to call the eligibility and enrollment TPA's toll-free number and report additional information or clarify information on the applicant's account. The TPA will document the call and any additional information/clarification provided. The family may also file a request for review in writing. The information or clarification will be input into the TPA eligibility system and a review of eligibility will be initiated. TPA eligibility staff may request senior management input into this decision. If the information provided does not result in the child being eligible, the parent will be notified of the reason the denial was upheld. If the parent disagrees with the denial, the notification letter will inform the parent that they may submit a formal request in writing to the Division of Insurance Administration, to be reviewed by the state-level CoverKids Eligibility Appeals Committee.

The member will have 30 days from the issuance of the letter to submit a request for a formal appeal. Receipts of requests for review will be acknowledged in writing within 10 days, including notification that that member will receive a decision within one calendar month. The Eligibility Appeals Committee is the impartial entity that reviews eligibility and enrollment matters and is composed of five Division of Insurance Administration staff. The Committee will meet weekly to review requests for reconsiderations of denials. (This schedule may be altered depending on the volume of requests for review.) If the Committee disagrees with the decision of the TPA, the child will be enrolled in CoverKids. If the Committee agrees with the decision to deny eligibility, a letter will be sent to the parent detailing the reason for denial. The decision of the Eligibility Appeals Committee will be the final recourse available to the member. If at any level of dispute, the appropriate party determines the child is eligible for enrollment in CoverKids, the enrollment will become effective retroactive to the first day of the month following the initial eligibility determination.

Reviews of general eligibility and enrollment matters will be completed within a 90-day timeframe. Expedited reviews will be completed within 10 days from the

initial receipt of the request for review. The appropriate notices will be issued within those timeframes. Notices for denials, suspension, or termination of enrollment, or failure to make a timely eligibility determination will include information on the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited timeframes for review, the manner in which review can be requested and the circumstances under which enrollment may continue pending review.

The State assures that in the review process, enrollees have the opportunity to fully participate in the review process (including representing themselves or have representatives of their choosing in the review process) and review information relevant to the review of the decision in a timely manner; decisions are made in writing; impartial reviews are conducted in a reasonable amount of time and consideration is given for the need for expedited review when there is an immediate need for health services. Enrollees will remain enrolled pending completion of the review in the case of suspension or termination of enrollment.

Health Services Matters

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

For health services matters, CoverKids will use a process that includes both internal review by the insurer and external review by the State Division of Insurance Administration. The State's contract with the insurer will require the insurer to have grievance/complaint procedures for denials, delays, reductions, suspensions, or terminations in providing or paying for health services and for failure to approve, furnish or provide payment in a timely manner. These procedures must include participation by a pediatrician in the review, must be followed prior to appealing to the state, and must be completed within 30 days. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional perceives the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning.

After the insurer's internal review is completed, the parent of an enrollee who disagrees with the decision may request further review by submitting a letter or form to the State Division of Insurance Administration. The Appeals Coordinator within the Division will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator may also request review by the by state's independent medical consultant. Reviews generally are completed within 16 days and the member will be notified

in writing of the decision. It is anticipated that most appeals will be resolved either through the insurer's internal process or at this level.

If the appeal is not resolved, the request will be scheduled for impartial review by the CoverKids Review Committee. The Committee will meet once per month to consider any appeals and will be composed of five members, including Division of Insurance Administration staff and at least one licensed medical professional, selected by the Commissioner or his designee. The parent will be given the opportunity to review the file, provide supplemental information and appear in person. The parent will receive written notification of the final decision, normally within one week from the date of the Committee meeting. The decision of the CoverKids Review Committee is the final recourse available to the member.

Internal and external reviews will be completed within 90 days. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours) for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional perceives the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning. All required notices, including the final notice of the results from the CoverKids Review Committee, will be issued within the specified timeframes (90-days or 72 hours, as applicable). Notices for denials, delays, reductions, suspensions, or terminations in providing or paying for health services and for failures to approve, furnish or provide payment in a timely manner will include information on the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited timeframes for review, the manner in which review can be requested and the circumstances under which enrollment may continue pending review.

The State assures that in the review process, enrollees have the opportunity to fully participate in the review process (including representing themselves or have representatives of their choosing in the review process) and review information relevant to the review of the decision in a timely manner; decisions are made in writing; impartial reviews are conducted in a reasonable amount of time and consideration is given for the need for expedited review when there is an immediate need for health services.

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.

Attachment A: CoverKids Benefit Summary

BENEFIT	FAMILY INCOME BETWEEN 150-250% FPL	FAMILY INCOME AT OR BELOW 150% FPL
Annual Deductible	None	None
Preexisting Condition Requirement	None	None
Physician Office Visit	$15 copay PCP; $20 copay specialist	$5 copay PCP or specialist
Hospital Care	$100 per admission (waived if readmitted within 48 hours for same episode)	$5 per admission (waived if readmitted within 48 hours for same episode)
Prescription Drug Coinsurance/Copay	$5 generic; $20 preferred brand; $40 non-preferred brand	$1 generic; $3 preferred brand; $5 non-preferred brand
Maternity	$15 copay OB, first visit only; $20 copay specialist; $100 hospital admission	$5 copay OB or specialist, first visit only; $5 hospital admission
Routine Health Assessment and Immunizations – Child	No copays for services rendered under American Academy of Pediatrics guidelines	No copays for services rendered under American Academy of Pediatrics guidelines
Emergency Room	$50 copay per use (waived if admitted)	$5 copay per use in case of an emergency (waived if admitted); $10 copay per use for non-emergency
Chiropractic Care	$15 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur	$5 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur
Ambulance Service – Air & Ground	No copay 100% of reasonable charges when deemed medically necessary by claims administrator	No copay 100% of reasonable charges when deemed medically necessary by claims administrator
Lab and X-ray	No copay 100% benefit	No copay 100% benefit
Physical, Speech & Occupational Therapy	$15 copay per visit; Limited to 52 visits per year per condition	$5 copay per visit; Limited to 52 visits per year per condition
Mental Health Inpatient (preauthorization required)	$100 copay per admission; Limited to 30 days per year	$5 copay per admission; Limited to 30 days per year
Substance Abuse Inpatient (preauthorization required)	$100 copay per admission; Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay	$5 copay per admission; Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay
Mental Health/Substance Abuse Outpatient (preauthorization required)	$20 copay per session; Limited to 52 sessions mental health and substance abuse combined	$5 copay per session; Limited to 52 sessions mental health and substance abuse combined
Dental Services	No copay for routine preventive oral exam, x-rays, cleaning and fluoride application $15 copay per visit	No copay for routine preventive oral exam, x-rays, cleaning and fluoride application $5 copay per visit
Vision Care	Preventive services (annual exam and glaucoma testing) – No copay $ 15 copay - prescription lenses and frames or contact lenses	Preventive services (annual exam and glaucoma testing) – No copay $5 copay - prescription lenses and frames or contact lenses
Annual Out-of-Pocket Maximums	5% of family income	5% of family income

Attachment B: 2006 Medical Options Comparison

BENEFIT	PPO OPTION		POS OPTION		HMO OPTION
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Annual Deductible*	$300 per individual; $750 family*		None	$300 per individual; $750 family	None
Preexisting Condition Requirement	6 months if no immediately prior coverage		6 months if no immediately prior coverage		None
Physician Office Visit	90% of MAC	70% of MAC	$20 copay general***; $25 copay specialist	70% of MAC after deductible	$15 copay PCP; $20 copay specialist
Hospital Care	90% of MAC	70% of MAC	$100 per admission	$300 per admission then 70% per diem after deductible	$100 per admission
Prescription Drug Coinsurance/Copay**	$5 generic; $20 preferred brand; $40 non-preferred brand**	$5 generic; $20 preferred brand; $40 non-preferred brand + amount exceeding MAC**	$5 generic; $20 preferred brand; $40 non-preferred brand**	70% of MAC after deductible	$5 generic; $20 preferred brand; $40 non-preferred brand**
Maternity	90% of MAC	70% of MAC	$20 copay OB, first visit only; $25 copay specialist; $100 copay per hospital admission	$300 copay then 70% per diem after deductible	$15 copay OB, first visit only; $20 copay specialist; $100 hospital admission
Routine Health Assessment and Immunizations – Child	90% of MAC; Covered through age 5; Maximum of 12 visits	70% of MAC; Covered through age 5; Maximum of 12 visits	100% benefit; Covered through age 5; Maximum of 12 visits	70% of MAC after deductible; Covered through age 5; Maximum of 12 visits	$15 copay PCP; $20 copay specialist; Covered through age 17
Routine Health Assessment – Adult	not covered		100% benefit	70% of MAC after deductible	$15 copay PCP; $20 copay specialist
Emergency Care	$25 copay (waived if certain conditions are met); 90% of MAC	$25 copay (waived if certain conditions are met); 70% of MAC	$50 copay per visit (waived if certain conditions are met)	$50 copay per visit then 70% of MAC after deductible (copay waived if certain conditions are met)	$50 copay per visit (waived if certain conditions are met)
Chiropractic Care	90% of MAC; Maintenance visits not covered when no additional progress is apparent or expected to occur	70% of MAC; Maintenance visits not covered when no additional progress is apparent or expected to occur	$20 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur	70% of MAC after deductible; Maintenance visits not covered when no additional progress is apparent or expected to occur	$15 copay; Maintenance visits not covered when no additional progress is apparent or expected to occur
Ambulance Service – Air & Ground	80% of reasonable charges when deemed medically necessary by claims administrator		100% of reasonable charges when deemed medically necessary by claims administrator		100% of reasonable charges when deemed medically necessary by claims administrator
Lab and X-ray	90% of MAC	70% of MAC	100% benefit	70% of MAC after deductible	100% benefit
Physical, Speech & Occupational Therapy	90% of MAC; Some limitations may apply	70% of MAC; Some limitations may apply	$20 copay per visit; Limited to 45 visits per year per condition	70% of MAC; Limited to 45 visits per year per condition after deductible	$15 copay per visit; Limited to 45 visits per year per condition
Mental Health Inpatient* (preauthorization required)	90% of MAC; Limited to 45 days per year	70% of MAC; Limited to 45 days per year	$100 copay per admission; Limited to 30 days per year	Not covered	$100 copay per admission; Limited to 30 days per year
Substance Abuse Inpatient* (preauthorization required)	90% of MAC; Limited to two 5-day detox stays per lifetime; plus two 28-day lifetime stays	70% of MAC; Limited to two 5-day detox stays per lifetime; plus two 28-day lifetime stays	$100 copay per admission; Limited to two 5-day detox stays per lifetime; plus two 28-day lifetime stays	Not covered	$100 copay per admission; Limited to two 5-day detox stays per lifetime; plus one 28-day lifetime stay
Mental Health/Substance Abuse Outpatient* (preauthorization required)	1-15: $5 copay/session 16-45: $25 copay/session Limited to 45 sessions mental health and substance abuse combined	1-15: $40 copay/session 16-45: $100 copay/session Limited to 45 sessions mental health and substance abuse combined	$25 copay per session; Limited to 45 sessions mental health and substance abuse combined	Not covered	$20 copay per session; Limited to 45 sessions mental health and substance abuse combined
Annual Out-of-Pocket Maximums (excludes mental health/sub abuse)	$1,300 per individual; $2,600 family	$3,900 per individual; $7,800 family	None		None
Annual Pharmacy Copay Maximum	$1,350 per individual**		None		None

MAC – Maximum Allowable Charge. Use of out-of-network providers will result in increased cost to members as you will be required to pay the difference between the MAC and the amount billed by the provider.
* Separate $150 deductible for mental health/substance abuse care required under the PPO; Benefits must be preauthorized by Magellan Health Services to be reimbursable at the highest level for the PPO. If preauthorization is not obtained, benefits will be reduced for the PPO and denied for the POS and HMO.
** Does not apply to annual medical deductible or the annual medical out-of-pocket, if applicable. If cost of prescription is less than the copay, the lesser amount will apply. Extended prescriptions written for 90-102 days (as authorized by the claims administrator) available for one copay when using home delivery or certain participating retail pharmacies.
*** A PCP designation is not required for the POS. The $20 copay will apply when using any in-network pediatric, family practice, internal medicine or OB-GYN physician.