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State/Territory Name: Wyoming

State Plan Amendments (SPA) #: WY-20-0015

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Children and Adults Health Programs Group

May 1, 2020

Christine Bates
Kid Care CHIP Manager
Wyoming Department of Health
Division of Healthcare Financing
6101 Yellowstone Road Suite 210
Cheyenne, WY 82002

Dear Ms. Bates:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), WY-20-0015, submitted on April 28, 2020, has been approved. This SPA has an effective date of March 12, 2020.

In response to the COVID-19 public health emergency, Wyoming requested to implement the following flexibilities during a state or federally declared public health emergency or disaster:

- Conduct tribal consultation following submission of this SPA, as permitted under section 1135 of the Social Security Act;
- Waive requirements related to timely processing of applications and renewals;
- Delay processing of renewals and extend deadlines for families to respond to renewal requests;
- Delay acting on changes in circumstances affecting eligibility, other than changes related to residency, death, voluntary termination of coverage, erroneous eligibility determinations, and becoming eligible for Medicaid; and
- Waive cost-sharing specifically for any in vitro diagnostic product described in section 2103(c)(10) of the Act and any other COVID-19 testing related service regardless of setting type.

In the event of a future disaster, this SPA provides Wyoming with the authority to implement the aforementioned temporary policy adjustments by simply notifying CMS of its intent, the effective date and duration of the provision, and a list of applicable Governor or federally-declared disaster or emergency areas. While the state must provide notice to CMS, this option provides an administratively streamlined pathway for the state to effectively respond to an evolving disaster event.

Your title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Jordan's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
E-mail: Joyce.Jordan@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Acting Director, Division of State Coverage Programs at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/signed Amy Lutzky/

Amy Lutzky
Acting Deputy Director

cc: Courtney Miller, Director, Medicaid and CHIP Operations Group
Jackie Glaze, Deputy Director, Medicaid and CHIP Operations Group

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

Preamble

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

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

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available; we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

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

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

State/Territory: Wyoming
(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))

Teri Green, State Medicaid Director
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: Coleen Collins	Position/Title: Eligibility Services Administrator
Name: Christine Bates	Position/Title: Kid Care CHIP Manager
Name:	Position/Title:

*Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Effective Date: October 2, 2017

Approval Date: March 12, 2020

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children’s Health Insurance Program (CHIP). In February 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
 - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
 - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
 - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
 - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
 - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
 - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
 - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a

complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a “clean” copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children’s Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state’s program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children’s Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of

any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, 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. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an

expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services

Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children’s Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Overview

The State of Wyoming will implement a State Children’s Health Insurance Program (SCHIP) based on Title XXI of the Social Security Act.

Kid Care CHIP is not an entitlement program. The legislature will appropriate funds for Kid Care CHIP each biennium. Enrollment will be based on funding. Enrollment will be monitored on a monthly basis and if based on the monitoring, it is determined that funds will not be available to continue the program, enrollment will be suspended via an approved enrollment freeze until adequate funding is available.

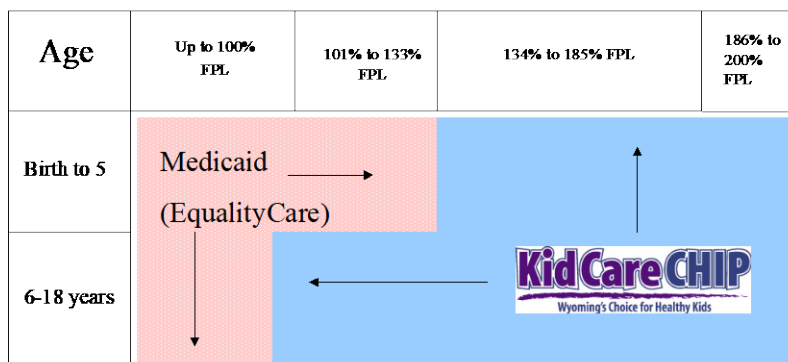
This is amendment six and replaces any previous amendments.

The existing Department of Health infrastructure will be used to support this program whenever possible.

Wyoming assures that it will conduct Kid Care CHIP in compliance with all applicable civil rights requirements.

Children up to age 19 in families up to 200% of the federal poverty level (FPL), who are uninsured and are not eligible for Medicaid will be eligible for Kid Care CHIP. The following chart displays the current age and income requirements in relation to the federal poverty level (FPL) for Medicaid and Kid Care CHIP.

State Children’s Health Insurance Program Eligibility



Effective Date: Oct

Approval Date: March 12, 2020

The Children's Health Insurance Program within the Office of Health Care Financing of the Wyoming Department of Health (WDH), will administer Kid Care CHIP.

The proposed effective date for the expansion of Kid Care CHIP is October 1, 2009.

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. A combination of both of the above. (Section 2101(a)(2))

1.1-DS The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2. Check to 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))
Wyoming assures that any expenditure for Kid Care CHIP will not be claimed prior to receiving Legislative authority to operate the plan or plan amendment as approved by CMS.

1.3. Check to 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. (42 CFR 457.130)

Wyoming assures that it complies with all applicable civil rights requirements.

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

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

Original State Plan:

Effective Date: 4/1/99

Implementation Date: 12/1/99

Amendment #1:

Effective Date: June 13, 2001

Implementation Date: Not implemented

Amendment #2:

Effective Date: July 1, 2002

Implementation Date: July 1, 2002

Amendment #3:

Effective Date: July 1, 2003

Implementation Date: July 1, 2003

Amendment #4:

Effective Date: July 1, 2005

Implementation Date: July 1, 2005

Amendment #5:

Effective Date: July 1, 2007

Implementation Date: July 1, 2007

Amendment #6:

Effective Date: October 1, 2009

Implantation Date: October 1, 2009

Amendment #7:

Mental Health Parity, Medically Necessary Orthodontia & Medically Necessary & Dental Services

Effective Date: July 1, 2010

Implementation Date: July 1, 2010

Prospective Payment System to FQHC's and RHC's

Effective date: October 1, 2009

Implementation date: September 1, 2010

SPA #WY-18-0013

Purpose of SPA: Demonstrate compliance with the Mental Health Parity and Addiction Equity Act of 2008.

Effective date: October 2, 2017

Implementation date: October 2, 2017

SPA #WY-20-0015

Purpose of SPA: To implement provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and working in State or Federally declared natural or public health emergency disaster area. In the event of a natural disaster or public health emergency, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements; the effective and duration date of such adjustments, and the applicable State declared disaster areas.

Proposed effective date: March 12, 2020

Proposed implementation date: March 1, 2020

1.4- TC

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

~~Tribal notice was sent via email on June 28, 2018.~~

To address the COVID-19 public health emergency, the State seeks a waiver under section 1135 of the Act to modify the tribal consultation process by conducting consultation after submission of the SPA.

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))

Health Insurance

- Of the 132,363 children under age 19 in the state, it is estimated that 12,629 are uninsured, based on updated 2007 U.S. Census Data and GAO estimates of the uninsured. Approximately 7,015 are children in families at or below 200% of the federal poverty level (FPL). The percentage of uninsured children increases as family income decreases.
- Uninsured children, eligible for Kid Care CHIP, are targeted for enrollment through the state's marketing and outreach efforts, coordination with other public and private programs, and through partnerships created across the state with other agencies, organizations and non-profits.
- The number of children eligible for Kid Care CHIP was determined using population and uninsured data adjusted to capture income and age eligible children.

Race and Ethnicity Statewide

Wyoming is a homogenous state, with 88 percent of people classifying themselves as "White." Data from the Census Bureau's March 2007 and 2008 CPS in the table below illustrates race and ethnicity in Wyoming.

2007 Wyoming Race and Ethnicity Profile

Race/Ethnicity	Number	Percent
Total Population	561,239	100.0
White	491,880	88%
Black	6,410	1.1%
American Indian, Eskimo, or Aleut	12,899	2%
Asian or Pacific Islander	3,795	6%
Other	7,846	1.4%
Hispanic Origin (of any race)	38,409	7%

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):

Wyoming utilizes a variety of approaches to identify and enroll children who may be eligible to participate in EqualityCare (Medicaid) or Kid Care CHIP or to obtain public health services.

Wyoming coordinates its outreach efforts with the USDA school lunch program and staffs the Kid Care CHIP hotline for calls from interested parents. Kid Care CHIP staff is knowledgeable about requirements and services available through public health programs including Medicaid. The staff responds to inquiries from the public and coordinates with public schools, school nurses, school administrators, principals, department of education and others.

These approaches are described in the following paragraphs:

- ✓ EqualityCare (Medicaid), which is administered by the Wyoming Department of Health, provides health coverage to children from birth through age five up to 133 percent of the federal poverty level (FPL) and children age six through 18 up to 100 percent of the FPL. Children are also eligible for EqualityCare benefits if they are eligible for developmental disability waiver program services or are receiving Supplement Security Income (SSI) payments. Infants born to Medicaid enrolled women remain eligible for EqualityCare for 12 months.
- ✓ Kid Care CHIP, is also administered by the Wyoming Department of Health, provides health coverage to children age 6 through 18 from 101% to 200% FPL and children birth through age 18 from 134% to 200% FPL.

✓ Wyoming takes the following steps to enroll children in EqualityCare and Kid Care CHIP:

1. The Wyoming Department of Health has an interagency agreement with the Department of Family Services (DFS) to determine eligibility for EqualityCare and the Department of Health, Children's Insurance Section will determine eligibility for Kid Care CHIP. The interagency agreement with DFS will allow for the coordination of eligibility between the Department of Health and the Department of Family Services.
2. Posters, brochures, applications and a 1-800 number provide EqualityCare and Kid Care CHIP information to potentially eligible families at numerous locations across the state including public health nursing offices, provider offices, Indian Health Services, local government offices, schools, insurance offices and WIC offices.
3. A State funded program which provides medical care for foster children in DFS custody is administered by the Office of Medicaid and provides the same level of medical benefits to low income foster children and children in subsidized adoptions who are not eligible for EqualityCare or Kid Care CHIP.
4. Public Health Nursing (PHN) - Thirty-one offices statewide provide direct health services such as immunizations. PHN offices work closely with the Health Department and with DFS to assure appropriate referrals are made to Kid Care CHIP. Some PHNs determine presumptive eligibility for the Medicaid pregnant woman program. Funding comes from a combination of state, county, and/or federal funds.
5. Women, Infants and Children's (WIC) offices statewide provide referral to Kid Care CHIP and/or EqualityCare for clients who are income eligible. WIC coordinates with EqualityCare by referring clients to Medicaid if appropriate. WIC is funded by the Department of Agriculture.
6. Maternal and Child Health (MCH) offers several programs which lead to referral to Kid Care CHIP. These programs include:
 - a. Best Beginnings - A coordinator in each county assists pregnant women to get care and services necessary to help assure a healthy pregnancy.
 - b. Home Visiting for Pregnant and Parenting Families - A program designed to help young, first-time mothers during pregnancy and child rearing.

Funding comes from a combination of private, state, county, and/or federal funds. Referrals are made to Medicaid if a financial need for medical care is identified.

7. Children's Special Health (CSH) - This program provides care coordination and case management for low income children under age 19 up to 200% of the FPL and high-risk mothers who have special health care needs who are not eligible for EqualityCare or other

health care insurance. Kid Care CHIP works closely with CSH and refers applications that indicate a child has a special healthcare need on a daily basis. The CSH application includes an income determination to screen for Kid Care CHIP eligibility. Program activities are funded with state and federal funds.

8. Federally Qualified Health Centers - Wyoming has 6 federally qualified health centers. These facilities have the resources necessary to determine presumptive eligibility for pregnant women and to make referrals to other programs. These clinics provide health care services and are funded with state and federal funds.
9. Indian Health Services (IHS) Clinic - Wyoming has two IHS clinics on the Wind River Indian Reservation. The clinic provides comprehensive ambulatory medical care and preventative services at the Fort Washakie and Arapahoe clinics.
10. Migrant Health Services - There are two migrant health programs in Wyoming covering six counties which provide limited service in a clinic setting and provide vouchers for participants to obtain services from private medical providers. These programs are funded by federal funds.
11. Part C of the Individuals with Disabilities Education Act - The program provides statewide early intervention services to meet the needs of Wyoming's infants and toddlers with diagnosed disabilities or with developmental delays which warrant concern for future development. Children deemed eligible for Part C Services in Wyoming who appear to be EqualityCare eligible are referred to a DFS field office for Medicaid determination.

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:

- 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 state's goal is to provide all targeted low-income children with an accessible and comprehensive system of care that secures a medical home for children. This coordination is directed to ensuring that Kid Care CHIP will not supplant or replace existing programs. Rather, the goal of coordination will be close cooperation between these programs to enhance the health care resources available to low-income children.

The Wyoming Department of Health, the single state agency which administers EqualityCare, also administers Kid Care CHIP. This administrative structure has helped to coordinate both Medicaid and CHIP for facilitating enrollment in the respective programs.

Kid Care CHIP coordinates with the state Maternal and Child Health program to ensure that children with needs beyond what Kid Care CHIP cover are referred to the Children with Special Health Care Needs (CSH) program. Because the CSH program provides limited diagnosis specific benefits, children who apply for CSH will be screened for eligibility for Equality Care (Medicaid) or Kid Care CHIP and referred appropriately.

Collaborative efforts are in place between the CSH program and EqualityCare to provide case management for children who are dually eligible for both programs. The Medicaid fiscal agent also processes claims for the CSH program.

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 Department of Health, Children’s Health Insurance Program Office has primary responsibility for the operation of Kid Care CHIP. Wyoming has very little to no managed care in the state. Because of this Wyoming will rely primarily on one insurance plan for coverage under Kid Care CHIP.

An RFP is issued to private health insurance carriers every two to three years. Carriers are asked to propose plans that provide the **required** basic level of benefits that was set by Wyoming state statute and the Health Benefits Committee. A contract is awarded to one insurance company that in its proposal best addresses: price, level of benefits, provider network, outreach efforts, cost sharing, marketing, member rights, access to care, grievance procedures and continuation of a private pay basis if the family ceases to be eligible for CHIP.

Financing for Kid Care CHIP will be through Federal CHIP allotments matched by State General Funds.

Kid Care CHIP will follow the process described in the State Health Official letter (Page 3 – Supplemental Payments to FQHC and RHC managed Care Subcontractors) to pay the supplemental payments to these organizations. Kid Care CHIP will be implementing an APM as part of this PPS requirement utilizing the Medicaid PPS rates that are already established in the state.

The supplemental payment amount will be calculated as follows:

- Our Contractor will pay their regular negotiated rate for each claim (so if they normally pay \$85 for an office visit then they will pay \$85). The Health plan will reimburse less than the APM and the supplement will pay up to PPS.

- Then, each quarter, the contractor will run a report for Kid Care CHIP that shows every claim for each FQHC and RHC in the state and what they paid.
- Kid Care CHIP will then take the Medicaid PPS rate that is already established and compare that to the rate that contractor paid.
- Kid Care CHIP will then calculate what is owed based on the difference between what is paid by the contractor and what the PPS rate is. (If the contractor paid \$85 to an FQHC and the PPS rate is \$210.00, then Kid Care CHIP will pay \$125.55 difference)
- Kid Care CHIP will then pay the FQHC or RHC a lump sum payment every four months to make up this difference of all claims paid by the contractor in the last quarter.

The FQHC's and RHC's have been sent information and agreements to sign. They are due back by August 16, 2010. We have been in contact with them and have not heard of any disagreements to date.

State funding will come from State General Funds. The General Funds appropriated for the PPS payment system are funds that are specifically allocated to the Department of Health, Kid Care CHIP program.

Kid Care CHIP will be implementing this process with payments effective in September 2010. This change is being made as the system to make the payments will not be ready on July 1, 2010 as originally expected.

- 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))

Administrative mechanisms that will be used to ensure appropriate medically necessary approved care are as follows:

- The contractor is required to have at least the "floor level" of benefits that have been developed for Kid Care CHIP in order to be considered an acceptable plan.
- Educational activities will be conducted to make certain that insured individuals and health care providers are knowledgeable about the extent of coverage.
- The insurer will be required to have adequate staff and procedures in place to ensure that services provided to those eligible are medically necessary and appropriate.
- The plan offered complies with requirements of Wyoming Insurance Law and the insurer is licensed by the Wyoming Department of Insurance.
- The Department of Health approves the complaint and grievance process for addressing eligibles

complaints and appeals. Those eligible receive a copy of the complaint and grievance process upon eligibility and at least annually thereafter.

- Quarterly reports are provided by the insurer on all grievances and complaints handled.

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

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

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

Transmittal Number	SPA Group	PDF#	Description	Superseded Plan Section(s)
WY-13-0011 Approval date: 05/09/14 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Incorporate within a separate subsection under section 4.3
WY-13-0008 Approval Date: 07/22/14 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
WY-13-0012 Approval Date: 04/01/14 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1

WY-13-0009 Approval Date: 04/08/14 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
WY-13-0010 Approval Date: 07-10-14 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS 18 CS19 CS20 CS27	Non-Financial Eligibility – Residency Non-Financial Eligibility – Citizenship Non-Financial Eligibility – Social Security Number Non-Financial Eligibility – Substitution of Coverage Non-Financial Eligibility – Continuous Eligibility	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1-LR; 4.1.1-LR Supersedes the current section 4.1.9.1 Supersedes the current section 4.4.4 Supersedes the current section 4.1.8

- 4.1.1 Geographic area served by the Plan: State Wide
- 4.1.2. Age: Available to children from age 6 through age 18 (from 134% to 200% FPL) and children age birth through age 18 (from 101% to 200%). Coverage for children who are eighteen years of age will continue until the child turns 19.
- 4.1.3. Income: Available to children at or below 200 percent of the federal poverty level who are not eligible for Medicaid. See Attachment A for eligibility definitions.
- 4.1.4. Resources (including any standards relating to spend downs and disposition of resources): There will be no resource test.
- 4.1.5. Residency (so long as residency requirement is not based on length of

time in state) : U.S. Citizenship and Wyoming residency is required. A child is considered a resident if they are living in the state voluntarily with the intention of establishing a permanent residence. Wyoming follows Federal guidelines in determining whether a child is a U.S. citizen or Qualified Alien who is eligible for Kid Care CHIP.

- 4.1.6. ☒ Disability Status (so long as any standard relating to disability status does not restrict eligibility): No child will be denied eligibility based on disability status. If the child receives SSI, the child will be denied coverage based on their eligibility for Medicaid, not for reasons of disability status.
- 4.1.7. ☒ Access to or coverage under other health coverage: A child will be found ineligible when: 1) the child is eligible for Medicaid; 2) the child is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; 3) the parent has voluntarily dropped coverage under another health insurance plan within one month of application. 4). The child is eligible to receive health insurance benefits under Wyoming's state employee benefit plan.
- 4.1.8. ☒ Duration of eligibility: A child will be eligible for 12 months. The eligibility is a continuous period of time from the effective date unless the child moves out-of-state, becomes Medicaid eligible, fails quality control or enters a public institution. Coverage for children who are eighteen years of age will continue until the child's 19th birthday. The family will be asked to report changes in residency. At the end of the 12 month period, eligibility will be redetermined.
- Failing Quality Control means the State randomly selects 20% of the approved applications and renewals for a quality control check; where the family is obligated to provide proof of income. If a family fails to return this information, the enrolled child(ren) is taken off of Kid Care CHIP for non-compliance. This family is welcome to re-apply, but will need to provide proof of income before eligibility is determined. If a family returns the requested information and the income puts the child within Medicaid income guidelines, the child is taken off Kid Care CHIP and the application and proof of income is forwarded to the Department of Family Services (who determine eligibility for Medicaid). If a family returns the requested information and the actual income exceeds Kid Care CHIP income guidelines, the child is removed from Kid Care CHIP at the end of the month for being over income.
- 4.1.9. ☒ Other standards (identify and describe): A child who is a resident of an

institution for mental disease or a public institution will not be eligible at application or redetermination for Kid Care CHIP.

Wyoming's healthcare coverage application requires a social security number for children as part of the screen and enroll process even though Kid Care CHIP does not require them. Wyoming automatically screens for Medicaid eligibility first which requires the social security number and then for SCHIP eligibility.

- 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)

Application

The state uses a combined Medicaid and CHIP application. Information requested on the combined application includes: income, health insurance status, and current address, U.S. Citizenship, Race (optional) and Primary Language spoken (optional). Applications are available at the Kid Care CHIP office, Kid Care CHIP website, provider offices, schools, Head Start facilities and private entities such as insurance agents, Department of Family Services, local government office and FQHC, RHC, IHS, PHN offices. Applications are accepted by mail or via our online application.

Applications can be mailed to Kid Care CHIP directly from families or other agencies or organizations assisting the families in their application process. Families will also be able to submit an application via our online application.

The application contains a statement advising the family that the application will be sent to their county DFS office if the child(ren) appear to be EqualityCare eligible. An application will be deemed to be complete when all of the questions have been answered, when it has been signed, date stamped and when proof of citizenship is attached.

Eligibility Determination

Eligibility for Kid Care CHIP is determined by the Department of Health. All applications are screened for EqualityCare (Medicaid) eligibility first and then for Kid Care CHIP eligibility. If the application appears eligible for EqualityCare (Medicaid), the application is forwarded to a county DFS office via fax or mail. Eligibility for Kid Care CHIP is determined within 45 days of the receipt of the application. All applications received on or before the 25th of each month that are made eligible for Kid Care CHIP begin

eligibility on the first day of the following month. If an application is received after the 25th of the month, eligibility will begin the month thereafter. (For example: If an eligible application is received on January 10th, the child's benefits would begin on February 1st. If the application is received on January 27th, the child's benefits would begin on March 1st.) The Department provides the insurance company with a list of all newly eligible children no later than the last working day of the month. The insurance company has 10 days from the date of receipt to send the eligible child's family an enrollment packet that includes an identification card, list of providers, benefit book, contact/grievance/complaint numbers, information on cost sharing, etc.

Kid Care CHIP staff date stamp the application when it comes in to track the time in which it takes to make the eligibility determination as well as for the Department of Family Services so that they are aware as to when the application was originally received. It takes one or two days for the postal service to deliver the application to the respective county office or one day via fax.

If the application is sent to the county DFS office, Kid Care CHIP sends a letter to the family advising them that the child or children appear to be eligible for EqualityCare and that their application has been forwarded to their county DFS office for eligibility determination. The letter includes a phone number to their county office in case the family has questions.

If the DFS office finds the child(ren) ineligible for Medicaid, the county office advises Kid Care CHIP of the denial and the children will possibly be made eligible for CHIP. All enrollments are subject to funding and eligibility requirements.

Continuous Eligibility

A child determined eligible for Kid Care CHIP is eligible for a continuous 12 month period, unless they reach their nineteenth birthday within the 12 month period, they move out of state, fail Quality Control, become eligible for SSI, Pregnant Woman's program, foster care, request their policy be closed or they enter a public institution.

Once eligibility is determined, changes in a family's composition or income will not affect a child's eligibility during the 12 months continuous period

Notification

A confirmation of eligibility for Kid Care CHIP is mailed to the family by the Department of Health. The family also receives an enrollment packet from the insurance company that includes an identification card, welcome letter, provider list, information on the benefits covered and not covered, information on co-payments, information on tracking of cost sharing, contact information and grievance procedures. If a family is ineligible for Kid Care CHIP the Department also sends out a letter advising the family why they are ineligible and provides information on other resources available.

Annual Notices

Children participating in Kid Care CHIP must reapply for the program every 12 months. A notice is mailed to the family both at 60 days prior to the end of the eligibility period and 30 days prior to the end of the eligibility period informing them when their CHIP eligibility period will end and providing

instructions for reapplying. The notice will also be emailed to families at the same time period for those that provide their email address to Kid Care CHIP. The family must complete the renewal form that is mailed/emailed to them which will include name, address, income, insurance status, family composition and signature and return it to the Department of Health. Families may return their form via mail, fax, email, through the online application system or they may call the Kid Care CHIP office and speak to an Eligibility staff member to have their eligibility renewed. If Kid Care CHIP Eligibility staff has not received the families' renewal form/information by the 20th of the month, Kid Care CHIP Eligibility staff will begin contacting families by phone to attempt to assist them in the renewal process. If the renewal form is not returned by the 25th of the month, coverage will terminate. The Department will send an additional notice to the family ten days prior to their policy closing to advise that coverage will terminate and to advise that they may still re-apply for coverage.

Training & Support for Department of Health and DFS field offices

Because the Department of Health will be determining eligibility for Kid Care CHIP and DFS determines eligibility for Medicaid (EqualityCare), there continues to be ongoing training and coordination that takes place to ensure that children are moved between programs smoothly. Kid Care CHIP participates in quarterly supervisor trainings with DFS field offices, annual benefit specialists meetings and travels to local offices to train one on one with staff members. Kid Care CHIP also sends each employee at DFS a quarterly newsletter that provides up to date information on Kid Care CHIP.

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.

Kid Care CHIP is not an entitlement program. The legislature will appropriate funds for Kid Care CHIP each biennium. The Department of Health assures that any waiting list, enrollment cap or closed enrollment period for Kid Care CHIP will be implemented in accordance with 42 CFR 457.65(d). If the state determines that due to an increase in costs that an enrollment freeze must be implemented, an amendment will be submitted in order to implement the freeze.

The Kid Care CHIP program will notify CMS via a state plan amendment prior to implementing an Enrollment Freeze for the program. The program will also have published a public notice prior to the effective date of the freeze as well as notifying existing families and all organizations that are in contact with potential Kid Care CHIP enrollees – including the Department of Family Services, Public Health, WIC, etc.

Kid Care CHIP will continue to accept applications and screen for Medicaid, however all applications that would be eligible for Kid Care CHIP will be denied and the family will be notified that there is an enrollment freeze in place. If it looks as if a family is eligible for Medicaid that application will be forwarded to the Department of Family Services.

Under the freeze, all Kid Care CHIP eligible children would be denied coverage and the family would be notified that there is an enrollment cap in place. After the enrollment cap is lifted, the State would also send notices to individuals denied coverage in the last 60 days to inform them that the enrollment cap is no longer in place. All applications would be screened on a first come first serve basis.

At the State's discretion, requirements related to timely processing of applications may be temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area.

At the State's discretion, requirements related to timely processing of renewals may be temporarily waived for CHIP clients who reside and/or work in a State or Federally declared disaster area.

At the State's discretion, the State may temporarily delay acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by a State or Federally declared disaster such that processing the change in a timely manner is not feasible. The state will continue to act on changes in circumstance related to residency, death, voluntary termination of coverage, erroneous eligibility determinations, and becoming eligible for Medicaid.

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 access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))

The healthcare coverage application asks if a child applying for Kid Care CHIP has been covered by health insurance within the last month. If the child has been covered and it was not cancelled due to an allowable reason, or a child has access to the state employees insurance because of a family member's employment with a public agency (even if the family declines to accept coverage) per 42 CFR 457.310 (c)(1) then the child will be denied coverage. The insurer contracting with Kid Care CHIP is required to notify Kid Care CHIP if they have reason to believe an enrollee has other coverage.

Kid Care CHIP exchanges information with other agencies about the availability of insurance coverage for children applying for or determined eligible for Kid Care CHIP. We work with other programs in the Department of Health (Office of Medicaid, Children's Special Health and Dental Health) as well as Blue Cross Blue Shield.

- 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))

The State of Wyoming is committed to enrolling uninsured children in a health insurance program appropriate to their age and family income level.

Kid Care CHIP will screen for Medicaid eligibility. If, upon initial screening, it is found that the application is eligible for Medicaid, the application is forwarded to the county DFS office to process. If the child is ineligible for Medicaid, the application is screened for Kid Care CHIP.

At renewal, if a child is determined to qualify for Medicaid then the Kid Care CHIP programs forwards the renewal form to DFS to process for Medicaid eligibility.

- 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(e)(2)) (42CFR 431.636(b)(4))

If a child or children are ineligible for Medicaid, the county DFS office notifies Kid Care CHIP by mail or email about the decision and forwards a copy of the application via fax or mail to Kid Care CHIP. The county DFS office advises the family that they are ineligible for Medicaid, but that Kid Care CHIP coverage may be available.

- 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.

The Kid Care CHIP application asks whether the applicant has lost health insurance coverage during the month prior to applying for Kid Care CHIP. A child will be ineligible for Kid Care CHIP if the applicant has voluntarily terminated their group health plan/employer-sponsored or individual coverage within the month prior to the application date for coverage.

If a parent who is providing the primary insurance is fired, laid off, can no longer work because of a disability, has passed away or has a lapse in insurance coverage because he/she obtains new employment, the child may be eligible for Kid Care CHIP.

Wyoming monitors for crowd-out. The Department of Health can verify the information provided on the application regarding the availability of creditable coverage with the families' employers as well as with Blue Cross Blue Shield. If the results of monitoring indicate crowd-out is occurring, the state will develop and implement additional strategies to prevent crowd-out from occurring.

- 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. N/A
- 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. N/A

- 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))

Kid Care CHIP works directly with the tribes, the Tribal Health Services and the Indian Health Service to inform Native Americans in Wyoming about Kid Care CHIP as well as with other organizations located on the reservation. The insurer will be required by contract to offer a provider contract to Indian Health Service providers who meet certification requirements.

If a Native American child is found to be eligible for Kid Care CHIP there will be no cost sharing for the family. The family will be required to provide proof of tribal membership so that the cost sharing exemption can be processed. The identification card that the child receives from the insurer will indicate that no co-payment is required when the child receives services. The insurance card will not identify the child as a Native American.

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)

Outreach and Marketing Campaign

Kid Care CHIP uses an outreach and marketing campaign developed by the Kid Care CHIP program to inform families of children likely to be eligible for Kid Care CHIP or other public or private health coverage programs of the availability of these programs and to assist them in enrolling their children. The insurance company that is contracted with Kid Care CHIP will conduct direct marketing efforts, which further outreach activities. The Insurance Company will not be allowed to do any “cold calling”, however but will be allowed to market Kid Care CHIP along with their other products, but

will not be able to specifically target low income families. The insurance company will be required to have all marketing materials approved by the State prior to release.

The Kid Care CHIP program works closely with its community and state wide partners across the state. These partners are a result of work of the previous Covering Kids Coalition and the continuous work of the Kid Care CHIP outreach unit. Our partners include representatives from child advocacy organizations, education organizations, health care provider associations, the insurance industry, and other public and private providers who are concerned with children's health including:

- American Academy of Pediatrics
- AARP
- Albany County Well Aware Committee
- American Red Cross
- Best Beginnings
- Board of Nursing
- BOCES
- Boys and Girls Club
- Boys and Girls Club of the Northern Arapahoe Tribe
- Wyoming Business Council
- Caring Program of Wyoming
- Cheyenne Children's Clinic
- Child Development Services of Wyoming
- Children's Nutrition Services
- Community and Family Health Division Programs -Adolescent Services, Children's Special Health, Dental Health Services, Help Me Grow-Safe Kids Campaign, Immunization Program, Maternal and Child Health Programs, Public Health Nursing, WIC
- Fremont County Health Planning Coalition
- Governor's Early Childhood Development Council
- Governor's Planning Council on Developmental Disabilities
- Indian Health Services
- Laramie County Community Partnership
- March of Dimes
- National Association of Social Workers (NASW)
- Natrona County Health Care Advisory Council
- Prevent Child Abuse Wyoming
- Protection & Advocacy
- The ARC (Association of Retarded Citizens) of Wyoming
- Uinta County Planned Approach to Community Health (PATCH)
- UPLIFT
- WAMHSAC
- Washakie County Community Health Planning Board
- Wyoming Association of Elementary School Principals
- Wyoming Association of Secondary School Principals

- Wyoming Association of Municipalities
- Wyoming Chapter, American Academy of Pediatrics
- Wyoming Children’s Action Alliance
- Wyoming Church Coalition
- Wyoming Coalition of Healthy Mothers/Healthy Babies
- Wyoming Dental Association
- Wyoming Department of Education
- Wyoming Department of Family Services
- Wyoming Department of Health
- Wyoming Head Start Association
- Wyoming Head Start State Collaboration
- Wyoming Health Resources Network
- Wyoming Hospital Association
- Wyoming Insurance Commissioner’s Office
- Wyoming League of Women Voters
- Wyoming Medical Society
- Wyoming Motel & Restaurant Association
- Wyoming Nurses Association
- Wyoming Optometric Association
- Wyoming Parent Information Center
- Wyoming Parent-Teacher Association
- Wyoming Pharmacists Association
- Wyoming Press Association
- Wyoming Primary Care Association
- Wyoming Reproductive Health Council
- Wyoming Section American College Obstetricians and Gynecologists
- Wyoming Youth Services Association

Marketing Methods:

Direct appeals are made using press releases, public service announcements, print media, radio and television, and printed materials. Kid Care CHIP specific materials will be developed and will continue to be evaluated and adjusted as needed.

Collaboration:

The Kid Care CHIP Program provides education to local agencies and organizations and providers by developing materials about Kid Care CHIP, speaking at training sessions, and/or meetings, and by submitting information to professional newsletters and bulletins. Kid Care CHIP will collaborate with the Department of Education on the free and reduced school lunch program, school administrators, principals, secretaries and school nurses to conduct back to school enrollment drives.

Kid Care CHIP works closely with Native American leaders to develop specific outreach activities that are acceptable to the tribes. Kid Care CHIP works with the Migrant Health programs to develop specific outreach activities for migrant workers statewide.

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, identifies the plan and attaches 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. Wyoming is requesting Secretary Approved coverage for Kid Care CHIP. Based on SCHIP Statute, Secretary approved coverage is “coverage that provides appropriate coverage for the population of targeted low-income children covered under the program.”

Wyoming is bound by State statute to provide the services listed in the Categories of Basic

Services listed in Section 2103 (c) (1) of Title XXI. Wyoming's benefits do not meet those of a Benchmark, so a comparison to a benchmark is not possible. These benefits are based on the basic services listed in Section 2103 (c) (1) of Title XXI and Wyoming State Statute.

- 6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage
- 6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)
- 6.1.4.7. Other (Describe)

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

The services covered for Kid Care CHIP have been recommended by the Health Care Benefits Committee appointed by the Governor that was formed due to State Statute requirements. These benefits are based on the basic services listed in Section 2103 (c) (1) of Title XXI and Wyoming State Statute.

The Lifetime maximum benefit coverage per insured person is \$1 million.

The cost-sharing amounts for participants is discussed in Section 8.2.4

6.2.1. Inpatient services (Section 2110(a)(1))

Semi private room; intensive and coronary care units; general nursing; drugs; oxygen; blood transfusions; laboratory; imaging services; physical, speech, occupational, heat and inhalation therapy; operating, recovery, birthing, and delivery rooms; routine and intensive care for newborns and other medically necessary benefits and prescribed supplies for treatment of injury or illness are covered.

Coverage of postpartum care for at least forty-eight hours for vaginal delivery and ninety-six hours for caesarean section is guaranteed. Any decision to shorten the length of inpatient stay to less than these stated amounts shall be made by the attending provider and the mother.

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

All benefits described in the inpatient hospital section which are provided on an outpatient basis in a hospital (including but not limited to observation beds and partial hospitalization benefits) or ambulatory surgical center; chemotherapy; emergency room benefits for surgery, injury or medical emergency; and other services for diagnostic or outpatient treatment of a medical condition, injury or illness are covered.

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

Office, clinic, home, outpatient surgery center and hospital treatment for a medical condition, injury or illness by a physician, mid-level practitioner or other covered provider are covered.

Well child, well baby and immunization services are recommended by the American Academy of Pediatrics are covered.

Routine physicals for sports, employment or as required by a government authority are covered.

Anesthesia services rendered by a physician-anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist are covered provided that surgical and/or hospital services are also covered.

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

Covered as described in inpatient and outpatient hospital and physician benefit descriptions. In addition professional services rendered by a physician, surgeon or doctor of dental surgery for treatment of a fractured jaw or other injury to sound natural teeth and gums are covered.

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

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

Coverage includes prescribed by a practitioner acting within the scope of his practice. Chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines, prenatal vitamins, and drugs needed after an organ or tissue transplant are covered.

The contractor may use a Medicaid formulary if it chooses to employ a formulary.

Prescribed diabetic supplies including insulin, test tape, syringes, needles and lancets are covered as a prescription drug.

Food supplements and vitamins are not covered with the exception of prenatal vitamins and medical foods for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exists. The need for a

prescription to obtain a food supplement or vitamin shall not affect the application of this provision.

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

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

Coverage includes imaging and laboratory services for diagnostic or therapeutic purposes due to accident, illness or medical condition that are not described elsewhere in this section. X-ray, radium or radioactive isotope therapy is covered.

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

Prenatal care is covered as described for other medical conditions in this section. Pre-pregnancy family planning services and prescribed supplies are covered including birth control contraceptives.

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))

Mental Health or substance abuse disorders will be covered. Mental Health or substance abuse benefits will be provided in parity with medical/surgical benefits to the extent provided in the following categories: inpatient, outpatient, in-network, out of network, emergency and prescription drugs.

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))

Mental Health or substance abuse disorders will be covered. Mental Health or substance abuse benefits will be provided in parity with medical/surgical benefits to the extent provided in the following categories: inpatient, outpatient, in-network, out of network, emergency and prescription drugs.

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)) Coverage will be provided for medically necessary medical supplies and equipment. Hearing Aides will not be covered.

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

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

- 6.2.15. Nursing care services (See instructions) (Section 2110(a) (15))
- 6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. Dental services (Section 2110(a)(17))
 Kid Care CHIP will provide a State Defined Dental Benefit Package. This package will include requirements from section 2103(c)(5) of CHIPRA, including “coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.”
 Benefits include:
 Exams, cleanings, bitewing x-rays, fluoride treatments, sealants, full mouth x-rays, space maintainers, fillings, simple extractions, gold or porcelain crowns for teenagers with adult or permanent dentition, full mouth debridement for teenagers with permanent dentition, partials for teenagers with permanent dentition and missing anterior teeth, sedation for younger children and emergency treatment for the relief of pain, medically necessary dental services and medically necessary orthodontics. Annual maximum is \$1,000 per benefit year. Preventive and diagnostic services (Exams, cleanings, fluoride, space maintainers, sealants and x-rays) are subject only to frequency limitations and are not included in the child’s yearly benefit maximum. The \$1,000 is not a hard cap and medically necessary dental services will be covered above the \$1,000 annual maximum with pre-authorization.
- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a) (18))
 Mental Health or substance abuse disorders will be covered. Mental Health or substance abuse benefits will be provided in parity with medical/surgical benefits to the extent provided in the following categories: inpatient, outpatient, in-network, out of network, emergency and prescription drugs.
- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19)
 Mental Health or substance abuse disorders will be covered. Mental Health or substance abuse benefits will be provided in parity with medical/surgical benefits to the extent provided in the following categories: inpatient, outpatient, in-network, out of network, emergency and prescription drugs.
- 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))
Covered up to \$750 per year. Spinal Manipulation is covered up to \$250 per year.

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)) Rehabilitation covered up to \$25,000 lifetime if completed in a home, school or other setting if recognized by State law and prescribed or furnished by a physician or other licensed or registered practitioner.

Comprehensive Outpatient Rehabilitation Facility (CORF) - In a home, school or other setting if recognized by State law and prescribed or furnished by a physician or other licensed or registered practitioner.

Well Baby and Well Child visits will be covered up to the recommendations of the AAP & Immunizations will be covered up to the recommendation of the ACIP.

Vision Services: Services for the medical treatment of diseases or injury to the eye by a licensed physician or optometrist working within the scope of his/her license are covered. One exam every 12 months, one pair of lenses every 12 months (except in the case of a change in prescription) and one set of frames every 12 months. Frames are limited to \$100 per frame. (If the cost of the frame is more than \$100 families will be responsible for any additional cost). Contacts lenses are covered up to \$100 per year – if the cost of the contacts is more than \$100 families will be responsible for any additional cost. Children may only have glasses OR contacts. The program will not pay for both.

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

6.2.26. Medical transportation (Section 2110(a)(26)) Ground and Air ambulance is covered in the event of an emergency

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))
Air and Ground ambulance will be covered in the event of an emergency

KID CARE CHIP EXCLUSIONS

In addition to any exclusions noted in the individual coverage descriptions, the following services need not be considered covered benefits under the contract.

However, the contractor may at its option, offer coverage of one or more of the following benefits so long as the optional coverage does not increase the premium specified in the contract.

- Experimental services or services generally regarded by the medical profession as unacceptable treatment.
- Custodial Care.
- Personal comfort/hygiene/convenience items, which are not primarily medical in nature.
- Organ and tissue transplants
- TMJ treatment
- Whirlpools
- Treatment for Obesity
- Acupuncture
- Biofeedback
- Chiropractic services
- Cosmetic surgery
- Private duty nursing
- Treatment for which other coverage such as worker's compensation is responsible.
- Routine foot care
- Orthodontia
- Medical Transportation
- For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of any form, or charges for medical information
- For inpatient admissions which are primarily for diagnostic studies or primarily for physical therapy
- For custodial care, domiciliary care or rest cures or treatment in a facility, or part of a facility, that is mainly a place for: (a) rest; (b) convalescence or (c) custodial care
- For screening examinations, except as provided for wellness benefits under this program
- For radial keratotomy, myopic keratomileusis, and any surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error
- For therapeutic or elective termination of pregnancy prior to full term
- For complications or side effects arising from services, procedures, or treatments excluded by this policy
- For private duty nursing
- Hearing Aides

The following services shall not be considered covered benefits under the contract. The contractor is prohibited from offering any of the following benefits:

- In vitro fertilization, gamete or zygote intra fallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery, fertility enhancing treatment beyond diagnosis.
- Benefits for a child incarcerated in a criminal justice institution. The child is excluded from coverage only if he/she meets the definition of an inmate of a public institution as defined at 42 CFR 435.1009
- For services provided out of state. A referral from a Wyoming provider is not required to obtain out of state benefits. The insurance company may authorize a family to obtain coverage out of state if the closest provider is out of state.
- Any treatment that is not medically necessary.
- Any treatment that is not medically necessary.

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS’s contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If “Other” is selected, please provide a description of that standard.

International Classification of Disease (ICD) ICD-10-CM

Diagnostic and Statistical Manual of Mental Disorders (DSM)

State guidelines (Describe:)

Other (Describe: _____)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

Yes

No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer “yes.”

Yes

No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state’s provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

All children covered under the State child health plan.

A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3-MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

The final regulations specify that requirements for FRs and treatment limitations apply by benefit classification. Kid Care CHIP benefits were classified and mapped into four categories, as directed by the CMS Parity Toolkit. The following definitions were used to determine benefit classifications:

Inpatient: Treatment as a registered bed patient in a hospital or facility other provider and for whom a room and board charge is made.

Outpatient: All covered services or supplies not included in inpatient, emergency care, or prescription drug categories.

Prescription Drugs: Medications that have been approved or regulated by the Food and Drug Administration that can, under federal and state law, be dispensed only pursuant to a Prescription Drug order from a licensed, certified, or otherwise legally authorized prescriber.

Emergency Care: All covered emergency services or items (including medications) provided in an emergency department (ED) or emergency room (ER) setting in an OP hospital setting.

6.2.3.1.1 MHPAEA The State assures that:

- The State has classified all benefits covered under the State plan into one of the four classifications.
- The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

- Yes
- No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

- The sub-classifications are only used to distinguish office visits from

other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to “classification(s)” includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

Aggregate lifetime dollar limit is applied

Aggregate annual dollar limit is applied

No dollar limit is applied

Guidance: A monetary coverage limit that applies to all CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes,

please specify what type of limits apply.

Yes (Type(s) of limit:

No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on any mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on any mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

Less than 1/3

At least 1/3 and less than 2/3

At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar

limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

- The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

- The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance

use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

Yes (Specify: _____)

No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar

amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state’s methodology and results as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to “substantially all” (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The “predominant level” of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the

predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

Yes

No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

State

Managed Care entities

Both

Other

Guidance: If other is selected, please specify the entity.

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

- State
- Managed Care entities
- Both
- Other

Guidance: If other is selected, please specify the entity.

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

- 6.3.1. The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b) (1) (B) (ii)); **OR**
- 6.3.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*

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

- 6.4.1. **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):
 - 6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))
 - 6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise

be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

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

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

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

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

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

Section 7. Quality and Appropriateness of Care

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

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

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

7.1.1. Quality standards

- 7.1.2. ☒ Performance measurement
- 7.1.3. ☒ Information strategies
- 7.1.4. ☒ Quality improvement strategies

7.1.2 Performance measurements :

Information on immunization and well-child visits for Kid Care CHIP will be obtained from the insurance company that is contracted by the Department of Health to provide services for Kid Care CHIP participants. The information is provided to the Department in the form of quarterly reports. Pharmacy, dental and vision utilization as well as large claims data are also be provided by the insurance company.

7.1.3 Information Strategy

Immunization schedules, well-baby and well-child schedules are distributed by the Kid Care CHIP and through providers to participants of Kid Care CHIP.

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))

Kid Care CHIP works closely with the insurance company to ensure that all children have access to wellness and immunization benefits.

Well child, immunization and claim reports are requested from the Insurance company to determine rates in visits as well as close monitoring of provider networks.

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))

To assure that Kid Care CHIP participants have adequate access to covered services – including emergency services--the Department will review (on an annual basis) the provider networks to determine that there are still a sufficient number of providers in each county.

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 Insurance Company that contracts with Kid Care CHIP is required to have an adequate number of specialists enrolled in their provider networks as well as out-of –

network providers. Children may also be eligible for the Children with Special Health program.

The insurer is required to have a system that ensures prompt referrals for medically necessary care including specialty, secondary and tertiary.

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))

Decisions related to prior authorization of health services will be completed in accordance with State law and the medical needs of the patient, within 14 days after the receipt of a request for services.

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))

There are three levels of cost sharing: Plan A for enrollees up to 100% of the federal poverty level and Native American Children: Plan B for enrollees 101% through 150% of the federal poverty level; and Plan C for enrollees 151% through 200% of the federal poverty level.

- 8.2.1. Premiums: No premiums will be charged to families.
8.2.2. Deductibles: No deductibles will be charged to families
Coinsurance or copayments:

Plan A:
No Co-payment for Services

Plan B:

	Benefits	Co-payments
Total Family Out of Pocket Maximum per Benefit Year		5% of the family's gross yearly income**
Medical and Vision Out of pocket maximum per benefit year		\$200 per child
	Office Visits (including mental health)	\$5
	Well Child Exams	No co-payment required
	Immunizations	No co-payment required
	Lab and X-ray	No co-payment required
	Outpatient Hospital	\$5
	Inpatient Hospital	\$30
	Emergency Room	\$5
Pharmacy out of pocket maximum per benefit year		\$100 per child
	Generic prescriptions	\$3
	Brand name prescriptions	\$5
Dental out of pocket maximum per benefit year		\$15 per child \$15 per child - orthodontics
	Preventive and Diagnostic Services (exams, cleanings, fluoride, sealants)	No co-payment required
	Basic and major Services (fillings, extractions, etc)	\$5 per visit
	Medically Necessary Orthodontics	\$5 per visit

** Kid Care CHIP will send families an approval letter telling them the out of pocket maximum amount for their family.

Plan C:

	Benefits	Co-payments
Total Family Out of Pocket Maximum per Benefit Year		5% of the family's gross yearly income**
Medical and Vision Out of pocket maximum per year		\$300 per child
	Office visits (including mental health)	\$10 per child
	Well Child Exams	No Co-payment Required
	Immunizations	No Co-payment Required
	Lab and X-ray	No Co-payment Required

	Outpatient Hospital	\$10
	Inpatient Hospital	\$50
	Emergency Room	\$25
Pharmacy out of pocket maximum per benefit year		\$200 per child
	Generic prescriptions	\$5
	Brand Name prescriptions	\$10
Dental out of pocket maximum per benefit year		\$75 per child \$75 per child - orthodontics
	Preventive and Diagnostic Services (exams, cleanings, fluoride, sealants)	No co-payment required
	Basic and Major Services (fillings, extractions, etc)	\$25 per visit
	Medically Necessary Orthodontics	\$25 per visit

Kid Care CHIP mailed cost sharing updates to families on April 30, 2010 that outlined upcoming changes to the program. This document was also provided to provider offices and any other organization partnering with Kid Care CHIP to conduct outreach and enrollment activities. Revisions to our benefit books from both Blue Cross Blue Shield and Delta Dental of Wyoming were also mailed to families in June 2010. These revisions outline the upcoming changes to the benefits and cost sharing in Kid Care CHIP.

~~At the State's discretion, co-payments may be temporarily waived for CHIP clients who reside and/or work in a State of Federally declared disaster area. During the COVID-19 public health emergency, cost sharing shall be waived for any in vitro diagnostic product described in section 2103(c)(10) of the Social Security Act and any other COVID-19 testing-related services regardless of setting type.~~

8.2.4. Other:

- There will be no co-payments on well child/well baby, immunizations, preventive dental or vision.
- No co-payments will be charged to American Indians and Alaska Natives
- Co-payments will be tracked by the families through the shoe box method. Families will be advised by Kid Care CHIP of what their 5% out of pocket maximum is at approval and renewal and will be required to submit receipts when they feel that they have met the families annual out of pocket maximum. When the total co-payment has been reached, the Kid Care CHIP program will notify the insurance company and the company will include on any future EOB's that the family has met their yearly obligation. The family can take this EOB to any

provider to show that they are no longer required to pay a co-payment for the year.

- Families will pay three different maximums per child per year based on the income provided at the time of application. The insurance contractor will still track these co-payments and let families know on their EOB's when they have met each of the maximums (medical, prescriptions drugs, dental). No family will pay more than their required child maximum since it will be tracked. If families exceed the 5% out of pocket maximum, they will be reimbursed by the insurance contractor. The insurance contractor will continue to track the individual child's cost sharing maximum requirements (ex: \$200 medical, \$100 pharmacy, \$15 dental) and report to the family via their Explanation of Benefits (EOB's). The EOB's will advise the families where they are at in regard to each child's maximum and tell them when they no longer have to pay co-payments.
- Kid Care CHIP will provide each family with a form that they can fill in to track their cost sharing. Families will also be advised by the insurance contractor of where they are at with their per child maximums via their EOB's. Families will also have the ability to contact Kid Care CHIP via phone and/or email with any questions.
- If the family is charged more than their 5% out of pocket maximum, the family will be reimbursed by the insurance company.
- The family will be notified through enrollment materials of the above process. Any existing families will be advised through individual letters to the families, through the Kid Care CHIP family newsletter and by the insurance company.

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

The public will be made aware of this cost sharing through brochures, applications and through contact with Kid Care CHIP. The handbook given to families by the insurance company once they are made eligible for the program will include information on the cost sharing. It will also be included in the insurance company's contracts with providers.

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

Kid Care CHIP will produce a public schedule that will be provided to all enrollees, applicants, participating providers and the public of all cost sharing charges, and groups subject to the cost sharing charges. There are no consequences for not paying the cost sharing requirements. Kid Care CHIP will advise the public of the above by public notices in papers, meetings open to the public, information listed in

applications, brochures, benefit guides, through the Kid Care CHIP website, provider and recipient bulletins and through the Kid Care CHIP hotline.

- 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))

8.4.1- MHPAEA There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

Yes (Specify: Wyoming CHIP applies a co-payment to all services, both medical/surgical and MH/SUD, as outlined in Section 8.)

No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in

Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state’s methodology and results of the parity analysis as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds (“substantially all”) of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all

medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

- 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))

At application and renewal, families will be sent an approval notice telling them what their 5% out of pocket maximum amount is. Families are required to keep track of their out of pocket expenses and to notify the Kid Care CHIP office when they have met their out of pocket maximum. Information packets sent to new Kid Care CHIP enrollees by the insurance company will include a brochure explaining the process and a form for them to use to document their out of pocket expenses.

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

Once the maximum out of pocket is met, the insurance company blocks the cost

sharing for the rest of the plan year so the client is not billed any additional co-payments. Any copayments paid in excess of the 5% maximum will be refunded.

- 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 contract with the insurance company requires that Native American and Alaska Native children do not have a co-payment for services. The identification cards will also indicate that there is no co-payment required.

- 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))

Families will not be disenrolled for not paying cost sharing.

~~At the State's discretion, co-payments may be waived for clients living and/or working in the Governor or FEMA declared disaster areas at the time of a disaster event. During the COVID-19 public health emergency, cost sharing shall be waived for any in vitro diagnostic product described in section 2103(c)(10) of the Social Security Act and any other COVID-19 testing-related services regardless of setting type.~~

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

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

Families will not be disenrolled for nonpayment of cost sharing charges

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))

Families will not be disenrolled for nonpayment of cost sharing charges

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))

Families will not be disenrolled for nonpayment of cost sharing charges

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

A fair hearing will be granted to any Kid Care CHIP eligible child or guardian when an adverse action resulted in their disenrollment. Eligibles will not be disenrolled for non-payment of cost sharing charges.

- 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 Objectives listed in following table.
- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))
Performance Goals listed in following table.
- 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))

Performance measures are listed in the following table. The table provides a clear picture of the strategic objectives, performance goals, and performance measures and the data elements proposed to measure them. The strategic objectives may have more than one goal. Each goal has a performance measure and a corresponding set of

measurable data elements which are depicted horizontally. As a first step in assessing progress in meeting the strategic objectives, evaluators will establish a baseline, or standard point of comparison, for each measure. In most cases, the baseline will be a snapshot of the performance measure at a point in time prior to implementation of the Kid Care CHIP. In areas where data is difficult to obtain, such as the number of uninsured children or health outcome indicators, all efforts will be used to gather and report as accurate information as possible.

Kid Care CHIP Strategic Objectives, Performance Goals and Measures, and Data Elements

Strategic Objective	Performance Goals	Performance Measures/Data Elements
1. Provide an application and enrollment process that is easy for targeted low-income families to understand and use.	a) Increase the reapplication rate among SCHIP eligibles.	a) Track number of renewals sent out in the year and the number returned.
2. Decrease the number of children in Wyoming who are uninsured.	a) Decrease the proportion of uninsured children either at or below 200% FPL by 10% each year.	a) Utilize data from the Census Bureau
3. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low income children.	a) Ensure transfer of children from CHIP to Medicaid and vice versa is seamless. b). Evaluate the transfer process of cases to Medicaid and the Children’s Special Health Program each month.	a) Conduct a quality control review. b). Conduct Quality Assurance on approximately 20% of all applications leaving the program each month to ensure the timely transfer of applications and 100% screenings
4. Ensure that children enrolled in Kid Care CHIP receive timely and comprehensive preventive health care services. Increase the percentage of low-income children with a regular source of care.	a). Encourage use of a Primary Care Provider through Health Plan policies and education.	a). Percent of enrolled children who seek care from their selected primary care provider.

<p>5. Ensure that there are a sufficient number of network providers in each county for Kid Care CHIP participants.</p>	<p>a). 60% of counties will have a sufficient network of providers so that participants in Kid Care CHIP will have adequate access to covered services.</p> <p>b). 60% of counties will have a sufficient network of dental providers so that participants in Kid Care CHIP will have adequate access to covered services.</p>	<p>a & b). A review of the networks in each county will be completed annually by the Department & Insurance Company.</p>
<p>6. Decrease unnecessary use of emergency departments for non-emergency services</p>	<p>Reduce the number of emergency department visits for non-emergency services</p>	<p>Rate of non-emergency ER visits per year for the population enrolled.</p>
<p>7. Ensure use of primary care providers through health plan policies and education</p>	<p>At least 60% of children are utilizing a primary care provider</p>	<p>Review data on number of children that have utilized a primary care provider.</p>
<p>8. Increase the number of children receiving well child visits.</p>	<p>a). At least 50 percent of children who turned 15 months old during the preceding year and were continuously enrolled in Kid Care CHIP from 31 days of age, will have received at least four well-child visits with a primary care provider during their first 15 months of life.</p> <p>b). At least 50 percent of three, four, five, or six year old children who were continuously enrolled in Kid Care CHIP during the preceding year, will have received one or more well-care visits with a primary health care provider during the preceding year</p>	<p>a). Reports will be ran by the insurance carrier and compared to data from previous years.</p>

<p>9. Increase the number of children utilizing dental benefits</p>	<p>At least 50 percent of five and six -year old children enrolled in Kid Care CHIP will have received dental services prior to kindergarten entry</p> <p>At least 50 percent of Kid Care CHIP enrolled children seven to ten years will have received protective sealants on at least one occlusal surface of a permanent molar</p>	<p>Reports will be ran by the insurance carrier and compared to data from previous years.</p>
<p>10. Implement a state-wide outreach and public awareness campaign regarding the importance of preventive and primary care and the availability of health care benefits through Kid Care CHIP.</p>	<p>a) Create Kid Care CHIP information materials targeted to potential eligibles, health care providers, and other professionals that have contact with families with children.</p>	<p>b) Documentation of development and distribution of materials.</p>

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 (Equality Care)
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. Immunizations
 - 9.3.7.2. Well child care
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care

- 9.3.7.5. Mental health
- 9.3.7.6. Dental care
- 9.3.7.7. Other, please list:
- 9.3.8. Performance measures for special targeted populations.

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

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

The State assures it will comply with the annual assessment and evaluation required under Sections 10.1 and 10.2. The Children's Health Insurance Program Office will be responsible for the annual assessment and report on the program progress and activities.

The number of uninsured children referred to in the demographic information provided in Section 2 of the document will be used as a baseline for evaluating progress toward decreasing the number of children without health insurance. Effectiveness will be measured by using the performance measures and data elements identified in the table in Section 9.

The state will require the insurance company to provide monthly reports of expenditures so that trends and changes in types of services can be monitored. Quarterly monitoring efforts will focus on identifying trends and changes in the State that may impact the operation of Kid Care CHIP.

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))

The design and ongoing performance of Kid Care CHIP continues to be a collaborative process. The program has been designed by a broad-based coalition which includes the public, the legislature, child advocates, medical providers, insurance companies and agents, professional associations, and government agencies. Public comment was solicited and received on the program in numerous forums including legislative testimony and through the news media.

- 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))

As indicated in section 4.4.5 Kid Care CHIP works directly with the tribes, the Tribal Health Services and the Indian Health Service to inform Native Americans in Wyoming about Kid Care CHIP. The representatives of the tribes and organizations in the state have been in all state-wide partnerships and individual relationships have been made, which assures their input in the design of an effective outreach and marketing campaign for Kid Care CHIP that will be acceptable to the tribes.

Kid Care CHIP presented upcoming changes to Indian Health Services, Wind River Health Systems and other organizations on the reservation in May 2010.

Kid Care CHIP attempted to present to the Joint Tribal Councils, twice (once in May and once in June) but due to Tribal Council cancellations & recent flooding we were unable to present to them in person. We have contacted their offices but have not received any comments back from the Tribal Council on the documents we provided to them.

The meeting with Wind River Health Systems was attended by Indian Health Services, Tribal Council Members, Wind River Health Systems, Public Health, School officials, WIC and Head Start officials.

- 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).

Public Notice for all cost sharing changes to Kid Care CHIP will be made according to State law. The public notice for the public meeting and rules will be published in Wyoming newspapers and the public meeting will be held

within no less than thirty days prior to implementation. The published notice will advise of the changes being made to Kid Care CHIP cost sharing. As an additional step, the Department of Health will also address the cost sharing in the public notice for the administrative rule for Kid Care CHIP that will be issued prior to July 2010.

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

- Planned use of funds, including --
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

SCHIP Budget Plan Template	Wyoming
	Federal Fiscal Year 2011 Costs
Enhanced FMAP rate	65.00%
Benefit Costs	
Insurance payments	
Managed care	
per member/per month rate @ # of eligibles	\$223.50 @ 5505
FQHC & RHC Managed Care PPS payments	\$150,000
Med. Necessary Ortho @# of <u>estimated</u> eligibles	\$168,750
Fee for Service	
Total Benefit Costs	\$14,764,410
	\$150,000
	\$168,750
(Offsetting beneficiary cost sharing payments)	\$0
Net Benefit Costs***	\$15,083,160
Administration Costs	
Personnel	\$526,532

General administration	\$ 72,669
Contractors/Brokers (e.g., enrollment contractors)	\$96,000
Claims Processing	Included in Premiums
Outreach/marketing costs	\$34,000
Other (Indirect/Rent)	\$132,818
Total Administration Costs	\$862,019
10% Administrative Cost Ceiling	\$1,508,316
Federal Share (multiplied by enh-FMAP rate)	\$10,364,366
State Share	\$ 5,580,813
TOTAL PROGRAM COSTS	\$15,945,179

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

Funding:

State funding will come from one source: State General Funds.

*****Net Benefit Costs are based on enrollment by month multiplied by the premium of \$223.50.**

Below please find estimated enrollment for Kid Care CHIP by month * does not include FQHC/RHC PPS or Medically Necessary Orthodontia (10/10 – 8/11)

Month	Enrollment Number	Total Premium	Federal	State
10/10	5450	\$1,218,075	\$791,749	\$426,326.25
11/10	5460	\$1,220,310	\$793,202	\$427,108.50
12/10	5470	\$1,222,545	\$794,654	\$427,890.75
1/11	5480	\$1,224,780	\$796,107	\$428,673.00
2/11	5490	\$1,227,015	\$797,560	\$429,455.25
3/11	5500	\$1,229,250	\$799,013	\$430,537.50
4/11	5510	\$1,231,485	\$800,465	\$431,019.75
5/11	5520	\$1,233,720	\$801,918	\$431,802.00
6/11	5530	\$1,235,955	\$803,371	\$432,584.25
7/11	5540	\$1,238,190	\$804,824	\$433,366.50
8/11	5550	\$1,242,660	\$807,729	\$434,931.00
Total		\$14,764,410		

PPS for FQHC's and RHC's: In the first two quarters of FFY 2010, the difference between the payments made by Blue Cross Blue Shield and Delta Dental of Wyoming and the PPS rates established by Wyoming Medicaid equaled approximately \$75,000. Since this is the data we have to date we are utilizing this to make our estimates for the next year. \$75,000 x 2 = \$150,000 for one year. \$150,000 x 2 = \$300,000 for two years.

Medically Necessary Orthodontia: \$3,750 maximum per child x 45 children (estimated) = \$168,750

Personnel

Kid Care CHIP will have seven positions dedicated to administering the program.

Supportive Services

General operations costs include equipment, travel, office supplies, and postage, printing, and telephone toll charges.

Case Services

Estimated monthly premium is \$223.50 based on the programs most recent RFP that was issued in 2010.

Contractual Services

The services listed below will be contracted services:

- Consultant services to conduct research and assist in the design and implementation of the eligibility system for Kid Care CHIP.
- Legal fees for the development of administrative rules

Sources of Non-Federal Share of Expenditures

In addition to federal funds, Kid Care State general fund appropriations will be used. Enrollment projections are based on current estimates of funds which will be appropriated for Kid Care CHIP. If enrollment expectations exceed those projected for funding, new enrollment may be suspended.

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.

Kid Care CHIP uses the same review process for eligibility and enrollment matters that Wyoming Medicaid does. Kid Care CHIP will inform applicants in writing of their rights and responsibilities and how and when fair hearings may be requested. Upon request a fair hearing shall be granted if the applicant is denied eligibility, if the Kid Care CHIP has failed to make a timely determination of eligibility or if there has been a termination of enrollment.

The Department of Health will conduct the review process for eligibility and enrollment matters in accordance with the Kid Care CHIP/Medicaid Fair Hearing policy. Families will be notified of their right to a fair hearing when they apply or are enrolled in Kid Care CHIP.

A hearing request must be submitted in writing within 90 days of the Department’s action notice. A hearing request is defined as a clear demonstration by the applicant or eligible that he or she wants to be able to present their problem or concern for review.

Hearings will be conducted by an impartial representative of the Department of Health who has not been involved in the determination that caused the hearing. This is done to assure an applicants right to due process and hearing.

A decision will be made within 90 days from the conclusion of the hearing. The decision is final unless the Department of Health or the applicant/eligible chooses to appeal the decision. It must be appealed within 15 days.

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

Kid Care CHIP will be using the statewide standard review as described in 42 CFR 457.1120(a) (2) for the review process for health service matters. The health services matters subject to review are consistent with the intent of 42 CFR 457.1130 (b).

If a family does not agree with a decision made by the insurance company providing the health services, they will be advised in their enrollee handbook to contact the Customer Service Department to ask questions, ask for a review of a decision or make verbal complaints. All inquiries will be answered within 10 days. Families will be advised that they can also file a written complaint and will be provided with an address in their enrollee handbook. All written complaints will be acknowledged within 10 days and families should receive a decision or written response within 45 days. The enrollee may then submit a complaint to the Department of Health. The enrollee handbook will also have information on how to appeal a decision.

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.

Not applicable

Attachment A

Eligibility Definition

TERM	DEFINITION
Income	Money received from any source, excluding any item specified in policy.

Earned Income	Except as specifically excluded in this section, all countable earned income of the household will be counted for determining Kid Care CHIP eligibility including, but not limited to, wages, salaries, commissions, self employment income and income paid under a contract.
Unearned Income	Except as specifically excluded in this section, all unearned income of the household will be counted for determining Kid Care CHIP eligibility including, but not limited to, public assistance payments, child support, alimony, Social Security benefits, pensions, unemployment compensation, worker's compensation and interest.
Exempt Income	<p>Money set aside or free from program policy or limits, not counted against program income limits. The following income is excluded:</p> <ul style="list-style-type: none"> X Income which is required to be excluded from income under other Federal statutes X Unearned income paid in-kind to a household member such as Payments made to a third party for food, shelter, clothing or needs X Reimbursements of Medicare premiums made by the Social Security Administration by the Division of Public Health X Educational income such as grants, scholarships, fellowships, Educational loans, and work study income provided the individual is Enrolled in an educational program X Needs-based veteran's pensions X Reimbursements for expenses incurred by the individual X Child Care assistance paid under Title XX of the Social Security Act <p>The following income will be counted as assistance unit income:</p> <ul style="list-style-type: none"> X Rental income except that the following expenses may be deducted: taxes and attorney fees needed to make the income available; upkeep and repair costs necessary to maintain the current value of the property; interest only on a loan or mortgage secured by the rental property X The value of income paid in-kind for which the individual performed a Service or which is provided as part of the individual's wages from employment
Income Standard	All countable household income must be between 101% and 200% of the federal poverty level.
Institutional Status	Residents of public institutions are not eligible. Applicants who are in an institution for mental disease are not eligible

Household Composition	<p>1. The following financially responsible individuals who reside together must be included in the household for purposes of determining the household size, whether or not they are eligible to receive benefits:</p> <ul style="list-style-type: none">✓ A child who meets Kid Care CHIP age requirements✓ Siblings, half-siblings, adopted siblings, and step-siblings of the child who meets Kid Care CHIP age requirements✓ Parents of any child who is included in the household size✓ Children of any children who are included in the household <p>2. Any individual described in the bullets above who is temporarily absent solely by reason of employment, school, training, military service or medical treatment or who will return home to live within 90 days from the date of the application is part of the household.</p> <p>3. Household members who do not qualify for Kid Care CHIP due to their alien status must be included in the household size and their income be counted.</p> <p>4. If an individual is caring for a child of his or her former spouse, in the case where a divorce has been finalized, the household may include that child if the child resides in the home and meets Kid Care CHIP requirements.</p>
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Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices

CMS Regional Offices	States		Associate Regional Administrator	Regional Office Address
Region 1- Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2- New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3- Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4- Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4 th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5- Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6- Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7- Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8- Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9- San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103
Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term ‘child health assistance’ means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
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.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
 - a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
 - b. performed under the general supervision or at the direction of a physician, or
 - c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. **IN GENERAL-** Subject to paragraph (2), the term ‘targeted low-income child’ means a child--
 - a. who has been determined eligible by the State for child health assistance under the State plan;
 - b. (i) who is a low-income child, or
(ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
 - c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. **CHILDREN EXCLUDED-** Such term does not include--
 - a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
 - b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. **SPECIAL RULE-** A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. **MEDICAID APPLICABLE INCOME LEVEL-** The term ‘Medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under Section 1902(1)(2) for the age of such child.
5. **TARGETED LOW-INCOME PREGNANT WOMAN.**—The term ‘targeted low-income

pregnant woman' means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. **CHILD-** The term 'child' means an individual under 19 years of age.
2. **CREDITABLE HEALTH COVERAGE-** The term 'creditable health coverage' has the meaning given the term 'creditable coverage' under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. **GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC-** The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. **LOW-INCOME CHILD -** The term 'low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. **POVERTY LINE DEFINED-** The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. **PREEXISTING CONDITION EXCLUSION-** The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. **STATE CHILD HEALTH PLAN; PLAN-** Unless the context otherwise requires, the terms 'State child health plan' and 'plan' mean a State child health plan approved under Section 2106.
8. **UNINSURED CHILD-** The term 'uninsured child' means a child that does not have creditable health coverage.