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State/Territory Name: Nebraska

State Plan Amendments (SPA) #: NE-18-0014

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Final Approved State Plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850



Children and Adults Health Programs Group

MAY 10 2018

Matthew Van Patton
Director, Division of Medicaid & Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South, 3rd Floor, PO Box 95026
Lincoln, NE 68509-5026

Dear Mr. Van Patton:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), NE-18-0014, submitted on May 8, 2018, has been approved. SPA NE-18-0014 implements mental health parity requirements in section 2103(c)(6) of the Social Security Act (the Act) and regulations at 42 CFR 457.496 to ensure that treatment limitations and financial requirements applied to mental health and substance use disorder benefits are no more restrictive than those applied to medical/surgical benefits. This SPA has an effective date of October 2, 2017.

Section 2103(c)(6)(A) of the Act requires that, to the extent that a state provides both medical/surgical benefits (M/S) and mental health (MH) or substance use disorder benefits (SUD), a state child health plan must ensure 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.

Under this SPA, Nebraska has determined that the benefit package provided to the state's separate CHIP population does not include any MH/SUD benefits and therefore is not subject to mental health parity requirements.

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

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-5480
E-mail: kristin.edwards@cms.hhs.gov

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Official communications regarding program matters should be sent simultaneously to Ms. Edwards and to Mr. James Scott, Associate Regional Administrator (ARA) in our Kansas City Regional Office. Mr. Scott's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
Richard Bolling Federal Building
601 East 12th Street, Room 355
Kansas City, MO 64106-2808

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

We look forward to continuing to work with you and your staff.

Sincerely,

/ Anne Marie Costello /

Anne Marie Costello
Director

Enclosure

cc: Mr. James Scott, ARA, Region VII, Kansas City

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: _____ Nebraska _____
(Name of State/Territory)

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

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

submits the following 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: ~~Matthew Van Patton~~~~Thomas Thompson~~ Position/Title: ~~Interim~~ Director; Div of Medicaid & LTC

Name: ~~Thomas Thompson~~~~Catherine Gekas Steeby~~ Position/Title: ~~Interim~~ Deputy Director; Div of Medicaid & LTC

***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 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, and Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 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)); (42CFR, 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) indicating State

- **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, CHIP and Survey & Certification
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

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. and 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))
Children from conception to birth are reviewed for eligibility under Nebraska’s separate CHIP referred to as 599 CHIP. Children birth up to age 19 will be reviewed for eligibility under Nebraska’s Medicaid expansion program.

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))

- 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. (42CFR 457.130)

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 Plan

On May 13, 1998, Nebraska submitted a Title XXI State Plan, Kids Connection Phase I, to expand Medicaid eligibility for individuals age 15 through 18 to 100 Percent of the Federal Poverty Level (FPL).

Effective Date: May 1, 1998

Implementation Date: May 1, 1998

Amendment

SPA # 1, Purpose: Implement Phase II of Kids Connection, to expand Medicaid eligibility for children through age 18 up to 185 percent of the Federal Poverty Level (FPL).

Effective Date: August 1, 1998

Implementation Date: September 1, 1998

SPA # 2, Purpose: Updates and amends the CHIP State Plan to indicate the State's compliance with the final CHIP regulations.

Effective Date: June 27, 2002

Implementation Date: August 24, 2001

SPA # 3, Purpose: Expand the income eligibility level for children in CHIP from the current income level of 185% of the Federal Poverty Level (FPL) up to and including 200% of the FPL.

Effective Date: October 1, 2009
Implementation Date: October 1, 2009

SPA # 4, Purpose: Obtain Federal matching funds to expand eligibility to uninsured non-citizen, targeted low-income children who have gross family incomes up to and including 200 percent of the Federal poverty level, and who are lawfully residing in the United States, as permitted by section 214 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

Effective Date: July 1, 2010
Implementation Date: July 1, 2010

SPA # 5, Purpose: CMS determined that SPA # 5 was not needed. Nebraska is a Medicaid Expansion state. Nebraska follows the Nebraska Medicaid tribal SPA #11-15 that was approved October 13, 2011 with an effective/implementation date of July 1, 2011.

Effective Date: N/A
Implementation Date: N/A

SPA # 6, Purpose: Provide Federal funding for the Nebraska Regional Poison Center (NRPC) under a health services initiative.

Effective Date: January 1, 2012
Implementation Date: January 1, 2012

SPA # 7, Purpose: Legislative bill 599 instructed Nebraska to create a separate CHIP program for unborn/prenatal coverage. The creation of the new separate CHIP program changed Nebraska from a Medicaid Expansion State to a Combination State.

Effective Date: July 19, 2012
Implementation Date: July 19, 2011

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
NE-13-0008 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS9	Eligibility – Coverage from Conception to Birth	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
NE-13-0009 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
NE-13-0010 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
NE-13-0011 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
NE-13-0012 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17	Residency	Supersedes the current section 4.1.5
		CS18	Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR
		CS19	Social Security Number	Supersedes the current section 4.1.9.1
	General Eligibility	CS27	Continuous Eligibility	Supersedes the current section 4.1.8

SPA # 13, Purpose: Update the State Plan to change the delivery system for the separate CHIP from fee-for-service to managed care.

Effective Date: January 1, 2017

Implementation Date: January 1, 2017

SPA # 14, Purpose: Update the State Plan to comply with Mental Health Parity

Effective Date: October 2, 2017

Implementation Date: October 2, 2017

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.

On April 5, 2018 a tribal notification was sent to the Nebraska tribes with a summary of our intent to comply with the Mental Health Parity Addiction Equity Act.

On March 2, 2017 a tribal notification was sent to the Nebraska tribes with a summary of our intent to amend our 1915(b) waiver and contact information for any questions, comments, or concerns.

Summary of 1915(b) waiver amendment to provide full authority for all Managed Care Delivery Systems under the waiver:

Nebraska Medicaid will be submitting to the Centers for Medicare and Medicaid (CMS) an amendment to the 1915(b) waiver effective January 1, 2017. The amendment will provide full authority for all Managed Care Delivery Systems under the 1915(b) waiver.

The Department plans to implement a full-risk integrated managed care program. This means that Nebraska's physical health, behavioral health, and pharmacy services will be provided statewide by one of three contracted Managed Care Organizations. The new full-risk integrated managed care program will be named Heritage Health and will implement January 1, 2017.

The protections for American Indians/Alaskan Natives (AI/AN), as outlined in the American Recovery and Reinvestment Act of 2009 (ARRA), will apply to the full risk Heritage Health managed care program.

~~Most Medicaid populations, including American Indians/Alaskan Natives will receive physical health, behavioral health, and pharmacy services through Heritage Health. Long-Term Services and Supports will continue to be carved out of managed care and delivered through the Fee For Service program.~~

~~Additionally, Section D: Cost Effectiveness and accompanying D Appendices will be amended to update cost projections reflecting the addition of Behavior Modification services impacting capitation rates. This amendment will implement in October 2016.~~

TN No: Approval Date _____

Effective Date _____

Section 2. General Background and Description of Approach to Children’s Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified, by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

According to the U.S. Census Bureau, ACS 2015 5-year estimates, found in Table B27016: Health Insurance, Nebraska had 174,000 children below 200% of poverty. Of those, 158,000 had health coverage, and 16,000 did not. Numbers are rounded to the

thousands. There was no state-level data available regarding the nature of coverage.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.1005.

2.2. Health Services Initiatives- Describe if the State will use the health services initiative option as allowed at **42 CFR 457.10**. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

Nebraska will use the health services initiative option allowed at 42 CFR 457.10 to support the Nebraska Regional Poison Center (NRPC). Poison treatment advice and prevention through NRPC will be supported using CHIP funds available under the 10 percent federal administrative expenditures cap. NRPC will not supplant or match CHIP Health Services Initiatives (HSI) Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds. The NRPC provides emergency telephone treatment advice, referral assistance, and information to manage exposure to poisonous and hazardous substances. NRPC operates 24 hours a day, seven days a week at no charge to the public with full information and treatment capabilities. At all times, Specialists in Poison Information (SPIs), Certified Specialists in Poison Information (CSPIs), and toxicologist are available to manage cases. The services are provided via a toll-free telephone number to all communities throughout Nebraska, including underserved, low income, and indigent populations. Services are available by use of an interpreter in over 150 languages and telecommunication devices are used for the deaf and hearing impaired.

NRPC public education programs on poisoning response and prevention direct attention and resources to at-risk children, adolescents and adults living in poverty, including minority and immigrant communities. The NRPC works closely with schools, healthcare organizations, parenting groups, and childcare providers throughout Nebraska to promote poison awareness. It partners with community health programs such as the Nebraska Injury Prevention Coalition and Safe Kids Coalition groups. Each year, the NRPC and its community partners provide education programs to over 30,000 children, parents and caregivers throughout Nebraska. In addition, over 150,000 educational brochures, telephone stickers and magnets are distributed throughout Nebraska each year. Materials have been developed in English and Spanish.

Approximately 17,000 calls from Nebraska are received annually by NRPC. Seventy-two percent of all poisoning exposure calls received by NRPC involve children. Over 27% of

the total calls relate to poisoning exposures of children in families whose annual household incomes are no more than 200% FPL. In addition to calls regarding exposures, the NRPC receives over 10,000 calls each year from Nebraskans requesting poison or drug information. These calls are considered preventive.

NRPC calculated the number of children below 200% by tracking the total number of calls; the ages of the person involved and then estimated the number of children below 200% based on The Kids Count Data Center statistics that estimates 38% of Nebraska children are living in household with incomes no greater than 200% FPL.

NRPC intervention resulted in over 90% of the exposure calls (in children less than six years of age) being handled in the home so the children did not have to use an emergency department or need a 911 call and response. Each call to the NRPC significantly reduces costs in other medical spending. A recent study in the Journal of Medical Toxicology showed a median of 36 dollars in unnecessary healthcare charges were prevented for each dollar spent supporting a poison center.

The NRPC public toll-free number is listed in the emergency section of all Nebraska telephone directories. The number is also included in numerous community directories throughout Nebraska.

NRPC nearly closed in 2003 when their primary sponsoring/funding agency was no longer able to continue to support the service. At that time, several agencies in the state (DHHS Dept. of Health, the University of Nebraska Medical Center, The Nebraska Medical Center, and Creighton University) saw the value that the poison center provides to the state and provided last-minute funding to keep the poison center open. Much of the funding was temporary and many of those revenue sources have either been decreased or eliminated. This left NRPC in an unstable funding situation with a \$900,000 deficit three years ago. During 2008, NRPC was able to begin receiving \$200,000 from the state's healthcare cash fund. In 2009 they started asking other hospitals for support, which helped decreased their deficit, but additional funding was needed to stabilize NRPC. Unfortunately, the federal funding that poison centers receive through HRSA grants was decreased in 2011. Without the CHIP funding, the Nebraska Regional Poison Center will not have the operating funds to continue to provide services to the citizens of Nebraska. The Nebraska Regional Poison Center will retain 100 percent of the total computable funds (State and Federal) made available each year through the Health Services Initiative (up to the administrative funds cap). The funds provided for the Nebraska Regional Poison Center (NRPC) from the Health Services Initiative will only provide funding for costs that are directly related to the provision of services by the NRPC.

Nebraska will only utilize administrative cap money to help fund NRPC through the University of Nebraska Medical Center (UNMC) cash fund. EFMAP will not be claimed for HSI activities that took place prior to the effective date of the SPA or prior to CHIP

funds being incurred for approved costs. These funds will be used to help offset the cost of treatment for low income children. UNMC shall transfer an amount through an Intergovernmental Transfer (IGT), not to exceed \$250,000, to DHHS for the state match so that UNMC can receive the federal CHIP matching funds. When the Department receives the transferred amount (or any portion thereof) and the matching federal funds, the Department shall transfer the combined funds to the UNMC Cash Fund for operation of the NRPC. UNMC is a state entity that qualifies for an intergovernmental transfer agreement under Nebraska State law and is the mechanism currently used in the reimbursement of the upper payment limit to UNMC's physician practice under an amendment to the Nebraska State Medicaid Plan. UNMC and NRPC will not supplant or match CHIP Federal funds with other Federal Funds, nor allow other Federal funds to supplant or match CHIP Federal funds. UNMC shall annually report to the Legislative Fiscal Analyst the amounts transferred, on or before October 1st of every year.

2.3-TC Tribal Consultation Requirements- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3,

issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

Nebraska follows our Medicaid tribal SPA #11-15 approved October 13, 2011. Nebraska will continue to follow the Medicaid tribal SPA for the separate CHIP.

Nebraska regularly holds tribal consultation calls. These calls are used to discuss the state plan amendments, provide additional information, and answer questions. In person meetings are also held with the tribes on a regular basis.

Section 3. Methods of Delivery and Utilization Controls

- 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.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to CMS' Regional Office servicing them for review and approval.

In addition, states may use up to ten (10) percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive

disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding.

If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

- 3.1. Delivery Standards** 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))

- Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS' Regional Office for review and approval. (Section 2103(f)(3))

Beginning January 1, 2017, integrated physical health, behavioral health, and pharmacy services are delivered by a managed care delivery system. This program will be called Heritage Health. Managed care services will be provided by three Managed Care Organization (MCO), state wide as shown in the chart below.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
<u>Statewide</u> Lancaster, Douglas and Sarpy, Cass, Dodge, Gage, Otoe, Saunders, Seward, Washington Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scottsbluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York counties.	MCO	MCO-United HealthCare of the Midlands, Inc. (plan name: UnitedHealthcare Community Plan) MCO- WellCare, of Nebraska, Inc. MCO-Nebraska Total Care (Centene)

The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5), 1932(b), (c), (d), and (e) of the Act.

All Heritage Health managed care contracts were submitted to CMS and are currently under review.

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are 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.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR, 457.490(b))

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))

A primary goal of Heritage Health is to manage utilization more efficiently and effectively. Nebraska Medicaid, through its partnership with the Heritage Health plans (“the plans”), implement various utilization controls.

The plans must employ the appropriate staff. As part of their care management operations, the plans must employ multidisciplinary clinical staff, care coordinators, and care managers to arrange, assure delivery of, monitor, and evaluate basic and comprehensive care, treatment, and services to members. The plans must ensure an adequate ratio of staff to members to perform all care management functions. Sufficient staff must be available to respond at any time to members, their families/caregivers, or other interested parties calling on behalf of a member. The plans must ensure that only licensed clinical staff operating within the scope of their training and professional licenses make decisions regarding medical necessity.

Along with sufficiently employing staff with adequate knowledge, the plans must provide education materials to both providers and members related to utilization. The plans must educate parents/guardians to assist them in making responsible decisions about preventive health care and appropriate utilization of health care services for their children. The plans are also responsible for educating members on the appropriate utilization of ER services, including behavioral health emergencies. In addition, the plans must educate providers regarding the utilization management requirements, including procedures for service authorizations, concurrent review, extensions of lengths of stay, and retrospective reviews for all covered services.

While the plans are largely responsible for the above-mentioned utilization management methods, the plans must apply partnerships to manage utilization better. The plans must establish an internal utilization management committee that focuses on oversight of clinical service delivery trends across its membership, including evaluating utilization/patterns of care and key utilization indicators. The utilization management committee must be chaired or co-chaired by the Medical Director and must report its findings to the quality assurance and performance improvement committee (QAPIC).

As for the QAPIC, the plan must provide a mechanism for the input and participation of members, families/caretakers, providers, Division of Medicaid and Long-Term Care (MLTC), and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes. The plans must also convene additional committees including a utilization management committee.

Finally, all of these efforts would be futile without applicable utilization data. Data analysis must consider the performance from the previous year, and reported rates must clearly identify the numerator and denominator used to calculate each rate. The data analysis must provide, at a minimum, information about quality of care, service utilization, member and provider satisfaction, and grievances and appeals. The plans must collect the data from administrative systems, medical records, and member and provider surveys. The plans must also collect data on member and provider characteristics as specified by MLTC, and about services furnished to members through the plans' encounter data system. The plans must ensure that data received from providers is accurate and complete by: verifying the accuracy and timeliness of reported data, screening the data for completeness, logicalness, and consistency, collecting service information using MLTC-developed templates.

Section 4. Eligibility Standards and Methodology

Guidance: 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. Included on the template is a list of potential eligibility standards. Please check off the standards that will be used by the state 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, describe how they will be applied and under what circumstances they will be applied.

States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

- 4.0.** **Medicaid Expansion**
4.0.1. Ages of each eligibility group and the income standard for that group:
Birth up to age 19, at or below 200% of the FPL.
- 4.1.** **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))
4.1.0 Describe how the State meets the citizenship verification

requirements. Include whether or not State has opted to use SSA verification option.

Nebraska uses the SSA data match verification option.

4.1.1 Geographic area served by the Plan if less than Statewide: Statewide

4.1.2 Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

4.1.2.1-PC Age: conception through birth (SHO #02-004, issued November 12, 2002)

4.1.3 Income of each separate eligibility group (if applicable):

4.1.3.1-PC 0% of the FPL (and not eligible for Medicaid) through 185 % of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 Resources of each separate eligibility group (including any standards

Relating to spend downs and disposition of resources): No Asset Test

4.1.5 Residency (so long as residency requirement is not based on length of

Time in state): Must be a resident of Nebraska.

4.1.6 Disability Status (so long as any standard relating to disability status

Does not restrict eligibility):

4.1.7 Access to or coverage under other health coverage: The Nebraska application asks for insurance status of the unborn child. Unborn children with existing health insurance are denied eligibility for Nebraska 599 CHIP. Insurance policies that do not offer prenatal care will be reviewed by Policy staff in order to determine if the unborn has creditable insurance prior to any approval.

4.1.8 Duration of eligibility, not to exceed 12 months: Eligible unborn children in 599 CHIP with income at or below 185% FPL will have six months of continuously eligibility beginning with the month of determination through the sixth month or birth, whichever comes first.

4.1.9 Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Must not be a resident of an institution or a patient in an

institution for mental diseases or an inmate living in a public institution.

There is no immigration requirement for the unborn child.

599 CHIP children are not eligible for presumptive, retroactive coverage or spend downs.

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

- 4.1.9.1** States should specify whether Social Security Numbers (SSN) are required.
A SSN will not be required for an unborn child.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

- 4.1.9.2** Continuous eligibility

At initial eligibility all children birth up to age 18 will have 6 months continuous eligibility. Unborn children will have six months of continuously eligibility beginning with the month of determination through the sixth month or birth, whichever comes first.

- 4.1-PW** **Pregnant Women Option** (section 2112) The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of “lawfully residing” children and/or pregnant women. States may elect to cover (1) “lawfully residing” children described at section 2107(e)(1)(J) of the Act; (2) “lawfully residing” pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing

to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In other words, a State that chooses to cover pregnant women under this option must otherwise cover pregnant women under their State plan as described in 4.1.11. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

- 4.1- LR** **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1993(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
 - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
 - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

- (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
- (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
- (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
- (vi) Aliens currently in deferred action status; or
- (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;
- (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
- (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
- (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

- Elected for pregnant women.
- Elected for children under age 19 .

4.1.1-LR The State provides assurance that for an individual whom it enrolls in

Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. Assurances The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 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. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

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

4.2.2-DS 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-DS These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3 Methodology. Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Children from birth through age 18 are eligible for 6 months of continuous medical eligibility from the date of initial eligibility unless:

1. The child turns 19 within the 6 months;
2. The child moves out of state;
3. The worker determines that the original eligibility was based on erroneous or incomplete information;
4. The child dies; or
5. The child enters an ineligible living arrangement.

No income or resource review is required. This policy also applies to 599 CHIP eligible newborns that are found eligible at birth based on a “passive” review of information reported or known to the Department at the time of birth; a new application will not be required.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1 Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(4)) (42CFR, 457.305(b))

Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option.

Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane. *Nebraska noticed the template shows two 4.3.3.3-EL sections.**

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way

that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102)(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4 Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

At time of application and redetermination, staff first determines whether an applicant or recipient is eligible for Medicaid. If the child is not Medicaid eligible, staff assesses eligibility for CHIP or 599 CHIP, if appropriate. In addition there are required questions on the application and review form that ask about the child's health insurance status. The State's MMIS system checks the recipient's history for third party insurance.

At application or review a child applying for, or enrolled in, CHIP will not be eligible for the program if they are covered under a group health plan or have creditable health insurance coverage; or are Medicaid eligible. 599 CHIP unborn child(ren) may have creditable health insurance if verification is provided that they have no prenatal or pregnancy coverage. Medicaid Policy staff will confirm upon review that there is no prenatal care or pregnancy related care before approval of an unborn. Following the birth a 599 CHIP child will be required to meet all eligibility criteria before CHIP will be approved.

- 4.4.1. only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102)(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.
- 4.4.2. children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102)(b)(3)(B)) (42CFR, 457.350(a)(2))
- 4.4.3. children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR, 431.636(b)(4))
- 4.4.4. the insurance provided under the State child health plan does not substitute for coverage under group health plans; states should check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR, 457.805) (42CFR

457.810(a)-(c))

4.4.4.1. (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined.

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)) (42CFR 457.125(a))

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL

The State should designate the option it will be using to carry out screen and enroll requirements:

The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2.

(Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

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

In addition to Medicaid, there are other programs and service delivery systems that (1) provide selected services and/or (2) work toward linking families with health services whether it be Medicaid coverage or other community resources. To promote and provide children and youth with comprehensive services and a full continuum of care through Medicaid, the following direct and indirect outreach efforts are utilized:

- Internal electronic mail and memos are used as a vehicle to notify all staff of changes and updates on eligibility and services.
- Provider bulletins that contain policy changes and clarification and claims processing updates are issued.
- Brochures and other information are distributed to groups when presentations are made to community groups, other agencies, and professional organizations.
- News releases are issued regarding new initiatives and reports as well as when public hearings will be held.
- The Department employs a full-time system advocate accessible through an 800 number to assist individuals with questions or concerns.
- The agency communicates with the Medicaid Medical Care Advisory Committee, client advocacy groups, and other outside agencies during the rulemaking process to address and obtain input regarding policy issues and agency procedures that impact clients and providers. Public hearings are held on all regulation changes.
- The Department has developed a web page that has information about the

various programs and services provided. The web page has information on medical services for children.

- The 800 numbers for agency access for information and for applications are currently listed on Insure Kids Now and CMS' website.
- The Department's Customer Service Centers and local office accept electronic, phone, mail-in, faxed and hand-delivered applications for Medicaid and CHIP eligibility.
- In addition, all Title V grantees in Nebraska are provided state-level support to identify and refer potentially eligible families to the Medicaid program whenever possible. Services for prenatal health care, preventive and primary care for children, health education, lead screening, and adolescent pregnancy prevention and support are all provided to low-income and other at-risk populations in Nebraska through Title V funds. Large proportions of recipients of these services are identified as uninsured and are provided the support necessary to pursue health care coverage.
- Children with special health care needs who do not have health care coverage are often identified through the Medically Handicapped Children's Program (MHCP), which is Nebraska's Title V program dedicated specifically to providing specialty and subspecialty services to this population of children. MHCP services are commonly promoted by communities as a means for getting children with special health care needs into the publicly-funded health care system, particularly Medicaid. All children referred to MHCP clinics or services are screened for Medicaid and CHIP eligibility.
- In addition, the hospitals, schools, and community-based organizations that provide Early Intervention (EI) services to children with special health care needs up to three years of age are an excellent resource for identification and enrollment into Medicaid and CHIP. The EI services coordinators are very familiar with Medicaid rules and regulations, and are able to advocate on behalf of the children with whom they work to get them enrolled.
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- The Medicaid agency, as part of the WIC/Medicaid interagency agreement, provides information on coverage and eligibility to WIC staff as tools for them to outreach to families currently receiving WIC benefits. Through collaborative efforts, Medicaid eligible families are contacted and provided with WIC information.

- Many of the state's schools have been enrolled as Medicaid providers of therapy services (physical, speech, and occupational) and, thus, have become more aware of Medicaid coverable services for their families. School health nurses periodically receive information on the HEALTH CHECK (EPSDT) program, and they often refer youth for assistance. School nurses receive ongoing information from the state's School Health Consultant regarding their role in providing outreach for Medicaid to uninsured children, including updates on rules and regulations, brochures, and information on EPSDT rates for the counties served by their school districts.

- With the support of their state-level grantors, immunization clinics and reproductive health clinics encourage recipients of their services who are potentially eligible to pursue enrollment into Medicaid.

- Staff is also working with tribally-owned and leased clinics to meet the IHS/HCFA (CMS) Memorandum of Agreement terms and provide training and information on services and billing. Presentations and technical assistance have been provided.

- DHHS staff hold quarterly face to face meetings with Tribal representatives, including the Ponca Tribe, the Santee Sioux Tribe, the Omaha Tribe, and the Winnebago Tribe. Monthly phone calls are also held with the tribes. Each of the MCO's also have a fulltime tribal liaison to work directly with each tribe.

- In addition to the outreach efforts noted above the MCO's are also required to provide outreach:
 - The Heritage Health plans must have full-time clinical and support staff to conduct daily business in an efficient and effective manner. This includes, but is not limited to, administration; accounting and finance; fraud and abuse; utilization management; quality management and improvement; and, member services, education, and outreach, grievances

- and appeals, provider services, claims processing, and reporting.
- The Heritage Health plans must have effective outreach/education that informs parents/guardians of the benefits of having their children receive EPSDT screening, diagnosis, and treatment services. This includes:
 - Education to parents/guardians to assist them in making responsible decisions about preventive health care and appropriate utilization of health care services for their children.
 - Continuing and comprehensive health care beginning with the screening.
 - Continuing through diagnosis and treatment for any conditions identified during screenings.
 - Assistance to families in making medical appointments and obtaining needed transportation.
 - The monitoring of provided EPSDT services to ensure that all services are delivered within established time frames.
 - The Heritage Health plans must develop and implement a plan detailing the marketing activities it will undertake and materials it will create during the contract period. The Heritage Health plans must submit to MLTC the detailed, proposed plan for review and approval a minimum of 45 calendar days prior to the contract start date.
 - The Heritage Health Plans must develop an outreach program to encourage women to seek prenatal services during their first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include distribution of brochures and/or periodic articles that emphasize the importance of this care to all members.
 - Furthermore, the Heritage Health plans must develop processes and procedures, with designated points of contact, with other entities and programs that serve members including but not limited to:
 - Division of Behavioral Health funded programs.
 - Division of Children and Family Services funded programs that support the safety, permanency, and well-being of children in the care and custody of the State.
 - Division of Developmental Disabilities programs that involve rehabilitative and habilitative services for persons with developmental disabilities.
 - The Nebraska Department of Education Early Development Network.
 - Community agencies including but not limited to the Area Agencies on Aging and League of Human Dignity Waiver Offices.
 - The Office of Probation.
 - Other programs and initiatives within MLTC related to primary care and behavioral health integration/coordination and pharmacy management.
 - Along with these efforts, MLTC's enrollment broker has attended numerous events to advertise Heritage Health, provide information to stakeholders, members, and potential members, and answer any questions. The Heritage Health plans have also attended many such events.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

- 5.1.2.** (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership: Currently there is no public private-partnership providing coverage for Nebraska children.

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

- 5.2.** (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other 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. Section 2102(a)(3) and 2102(c)(2) and 2102(b)(3)(E))(42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts -- particularly new enrollment outreach efforts will be coordinated with and improve upon existing State efforts described in Section 5.2.

Describe the procedures the state uses to accomplish coordination of CHIP 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))

Various amendments have expanded Nebraska eligibility for children through age 18. The outreach efforts currently employed by the agency will be continued.

Promotional materials have been developed and provided to community agencies, schools, Customer Service Centers and local offices to use to outreach to families. Annually a mass mailing is sent to every school district in the state.

Title V/MCH Block Grant community-based grantees plan their programs for the upcoming year with CHIP in mind. As providers of services geared toward low-income

and uninsured families, these grantees want to assure they are able to do their part to recruit uninsured children where they live, play, and go to school and church.

Community Support Specialists employed by the Department provide outreach to community action agencies, child care providers, refugee resettlement sites; human service agencies, homeless/runaway shelters, domestic violence/emergency shelters, family preservation and support teams, reproductive health clinics, faith communities, social security offices, employers, job service offices, employee assistance programs, WIC offices, Early Intervention service coordinators, community mental health providers, food pantries and distribution centers, soup kitchens, immunization clinics, child-serving recreational programs (Boy Scout/Girl Scout, YMCA, etc.), Head Starts and Early Head Starts, Child Care Food Program sponsors, minority advocacy programs, HUD housing authorities, county extension programs, community colleges, technical training programs, GED programs, juvenile court officers, school nurses, and parent/teacher organizations.

Nebraska currently has two Customer Service Centers (CSC) dedicated to Medicaid and CHIP in addition to local offices (LO). Both the CSC's and LO's determine eligibility and are able to answer questions and provide referrals for needed resources. Applications are available via paper, online, phone, or fax. One application is used for both Medicaid and CHIP.

Children with special health care needs will continue to be identified and enrolled in Medicaid or CHIP through the same avenues as are currently being used.

An emphasis is made to reach out to minority groups and organizations representing clients. A list of state and local organizations is available to the Community Support Specialist to be used as a data base for outreach.

Since Nebraska's Title XXI chosen option is a Medicaid expansion for children birth to age 18 and 599 CHIP is a separate CHIP program for unborn children; there are no other state-only or public-private partnership insurance programs enrolling only children, there will be no need for a referral mechanism at this time. Coordination without stationed eligibility services has already been addressed in Section 5.1.1.

Vaccines for Children

Since targeted low income children will be provided coverage through the Medicaid expansions, these children will receive the same benefits as other children receiving

coverage under the Nebraska Medicaid Program. This includes full coverage of Vaccine for Children benefits.

Potential for Substitution

Although Nebraska's Title XXI proposal in 1998 to expand Medicaid to cover all uninsured children age 18 and younger with family incomes at or below 185 percent of the federal poverty level, was not anticipated that there will be a significant crowd-out effect - families substituting Kids Connection coverage for family coverage. Crowd-out is still not anticipated because family coverage for persons in this income group is not affordable. The national rate of family health insurance premiums is estimated to be in excess of \$3,500 annually. It is unlikely that employers provide family health insurance to workers earning wage rates that are consistent with an income of the current 200 percent of FPL, especially given the relatively large number of small businesses in the State. Therefore, substitution is not likely despite the relatively high overall level of health insurance in Nebraska.

Should crowd out ever prove to be an issue that needs to be remedied, the Department will consider appropriate action, such as a three-month or six-month waiting period, premiums, copayments, or tax credits to families who maintain private coverage. These items would have to be authorized in statute.

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

5.3 Strategies

Guidance: Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90) The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

LB 1063 requires each public school district to provide written information to every student describing the availability of services under CHIP. This information is provided by the Department and must be distributed annually, at the beginning of the school year.

LB 1063 requires each hospital to provide written information about CHIP to the mother of every child born in the hospital at the time of birth. The written information is to be provided by DHHS and DHHS Finance & Support and will describe the availability of health services under CHIP.

LB 1063 requires the Director of the Department of Health and Human Services and the Director of Finance and Support to develop and implement other activities designed to increase public awareness of the availability of health services under CHIP. These activities may include public service announcements, the development and distribution of printed materials describing the program, periodically locating agency staff at public health sites outside the HHSS offices to receive applications for the program, contracting with organizations to assist the public in applying for Kids Connection benefits and to receive referrals for medical services as deemed necessary, and other activities deemed appropriate by the Directors. These activities will include materials and efforts designed to increase participation in the program by minority populations.

LB 1063 required the Department to establish a toll-free help line for this program. Nebraska does have a toll-free number that is operational.

LB 1070 provides funding that may be used for hiring school nurses by educational service units, school districts, public health entities, or partnerships between schools and public health entities, with one purpose being to identify children for Medicaid eligibility.

LB 1070 authorized DHHS to contract with health clinics of Nebraska's federally recognized Native American tribes, Indian health organizations, or other public health organizations that have a substantial Native American clientele, to provide educational and public health services targeted to Native American populations. The activities include identifying and enrolling children in state and federal programs providing access to health insurance and health care, including Medicaid and CHIP.

Outreach efforts will continue. These include:

1. Single application for Medicaid and CHIP.

2. Allowing on-line, phone, and mail-in application forms;
3. Established two Customer Service Centers dedicated to Medicaid and CHIP to provide better access;
- 4.
5. Working with advocacy agencies in disseminating information on eligibility, the application process, etc. to the low income community; and
6. Written and on-line information is available.

For additional information on outreach efforts, please refer to sections 2.2.1 and 2.3.

LB 603, which was passed by the 2009 Nebraska Legislature and signed into law by Governor Heineman on May 22, 2009, contained a provision to include as eligible for Medical Assistance under Title XXI, children under nineteen years of age with a family income equal to or less than two hundred percent (200%) of the OMB Income Poverty Guideline. LB603 became effective October 1, 2009, and will be codified at Nebraska Revised Statutes Sec. 68-915.

LB 599, which was passed into law on April 18, 2012, contained a provision to establish a separate CHIP program for unborn children of otherwise ineligible pregnant women with family income equal to or less than one hundred eighty-five percent (185%) of the OMB Income Poverty Guideline. LB 599 becomes effective July 19, 2012, and will be codified at Nebraska Revised Statutes Sec. 68-915.

Section 6. Coverage Requirements for Children’s Health Insurance

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 proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

- 6.1.** The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

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

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

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

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

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.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:
▪ the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:

- dental services
- inpatient and outpatient hospital services,
- physicians' services,
- surgical and medical services,
- laboratory and x-ray services,
- well-baby and well-child care, including age-appropriate immunizations, and

- emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
 - coverage of prescription drugs,
 - mental health services,
 - vision services and
 - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

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. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

- 6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, 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.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

- 6.1.4. Secretary-approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**
Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth. Services not covered under include medical issues separate to the mother and unrelated to pregnancy.

- 6.1.4.1. Coverage the same as Medicaid State plan
6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver
6.1.4.3. Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark

coverage, as specified in §457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

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 applicable only New York, Pennsylvania, or Florida (under §457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in §457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in §457.431 to determine actuarial equivalence.

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 (Provide a sample of how the comparison will be done)

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. Other (Describe)

No alterations are being made to Nebraska's current ability to provide expanded eligibility under the state's Medicaid plan to CHIP children.

The state elects to provide pregnancy related benefits covered under Title XXI through the 599 CHIP (separate

CHIP) program. Professional services, antepartum care and delivery services including associated tests and procedures such as ultrasounds, non-stress tests, amniocentesis and other pregnancy specific tests, procedures and services as covered under Title XIX are provided as medically necessary to support optimal pregnancy outcomes, and are billed using the appropriate CPT/HCPC codes. In addition, visits with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes.

Services not covered include medical issues separate to the mother and unrelated to pregnancy.

Under Heritage Health the MCO's are required to provide all Medicaid and CHIP covered services. However, the MCO's can provide additional services at their discretion with Departmental approval.

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

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

6.2.1. Inpatient services (Section 2110(a)(1))
Inpatient services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child

throughout the pregnancy and birth.

- 6.2.2.** Outpatient services (Section 2110(a)(2))
Outpatient services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.
- 6.2.3.** Physician services (Section 2110(a)(3))
Physician services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth. Professional services, antepartum care and delivery services (including associated tests and procedures such as ultrasounds, non-stress tests, amniocentesis and other pregnancy specific tests, procedures and services as covered under Title XIX) are provided as medically necessary to support optimal pregnancy outcomes, and are billed using the appropriate CPT/HCPC codes. In addition, visits with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes.
- 6.2.4.** Surgical services (Section 2110(a)(4))
Surgical services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.
- 6.2.5.** Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
Clinic services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.
- 6.2.6.** Prescription drugs (Section 2110(a)(6))
Prescription drug coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

- 6.2.7.** Over-the-counter medications (Section 2110(a)(7))
Over-the-counter medications for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.
- 6.2.8.** Laboratory and radiological services (Section 2110(a)(8))
Laboratory and radiological services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.
- 6.2.9.** Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
Prenatal care services and supplies coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth. Professional services, antepartum care and delivery services (including associated tests and procedures such as ultrasounds, non-stress tests, amniocentesis and other pregnancy specific tests, procedures and services as covered under Title XIX) are provided as medically necessary to support optimal pregnancy outcomes, and are billed using the appropriate CPT/HCPC codes. In addition, visits with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes. Eligible Unborn Children will receive the services described in 6.1.4.7 and 6.2 with fee-for-service reimbursement.
- 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))
- 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))
- 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))
DME coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

- 6.2.13.** Disposable medical supplies (Section 2110(a)(13))
Disposable medical supplies coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

Guidance: Home and community based services may include 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.

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

Guidance: Nursing services may include 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.

- 6.2.15.** Nursing care services (Section 2110(a)(15))
Nursing care services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth. This service remains fee-for-service and is not covered by the MCO's.

- 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)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
Emergency Dental Services covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth. Dental services are carved out of Heritage Health.

- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))
- 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))
Coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.
- 6.2.23. Hospice care (Section 2110(a)(23))
- Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) 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.
- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
Other services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth. Services not covered include medical issues separate to the mother and unrelated to pregnancy.
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))

Coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.27. Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
Non-emergency transportation will be covered as medically necessary and only when the services benefit the health of the unborn child throughout the pregnancy and birth.

6.2.28. Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

6.2-DC Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)

9. Emergency Dental Services

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific
- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

6.2.2-DC Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes) Page - 11 – State Health Official

6.2.2.3-DC HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

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)

Diagnostic and Statistical Manual of Mental Disorders (DSM)
~~————~~ Behavioral health only

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.

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.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. Previously 8.6

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 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Describe: Previously 8.6

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

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))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10% limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is 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 Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10% limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan

for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

- 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))

Guidance: Check 6.6.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR, 457.1010)

- 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. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

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))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

- Yes
 No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan.

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA: Purchasing Pool- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

Yes
 No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one

employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA Notice of Availability of Premium Assistance- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

Section 7. Quality and Appropriateness of Care

Guidance: **Methods for Evaluating and Monitoring Quality-** Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies. Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance. Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan. Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries). Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

- 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.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCOA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

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. (Section 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.)

Pertaining to 7.1.1 through 7.2.4 below.

The Heritage Health plans must develop a Quality Assurance and Performance Improvement (QAPI) program that, at a minimum, must comply with State and Federal requirements (including 42 CFR 438.330) and UM program requirements described in 42 CFR 456. The QAPI program must:

- Ensure continuous evaluation of the plan's operations. The plan must be able to incorporate relevant variables as defined by MLTC.
- At a minimum, assess the quality and appropriateness of care furnished to members.
- Provide for the maintenance of sufficient encounter data to identify each practitioner providing services to members, specifically including the unique physician identifier for each physician.
- Maintain a health information system that can support the QAPI program. The plan's information system must support the QAPI process by collecting, analyzing, integrating,

and reporting data required by the State's Quality Strategy. All collected data must be available to the plan and MLTC.

- Make available to its members and providers information about the QAPI program and a report on the plan's progress in meeting its goals annually. The plan must submit the information or reports to MLTC for review and approval prior to distribution.
- Solicit feedback and recommendations from key stakeholders, providers, subcontractors, members, and families/caregivers, and use the feedback and recommendations to improve the quality of care and system performance.

Furthermore, the plan must develop, operationalize, and implement the outcome and quality performance measures with the Quality Assurance and Performance Improvement Committee (QAPIC), with appropriate input from, and the participation of, MLTC, members, family members, providers, and other stakeholders.

The plan must form their QAPIC no later than one month following the contract's start date. The plan's Medical Director must serve as either the chairperson or co-chairperson of the QAPIC.

The plan must include, at a minimum, the following as members of the committee:

- The plan's QM Coordinator.
- The plan's Performance and Quality Improvement Coordinator.
- The plan's Medical Management Coordinator.
- The plan's Member Services Manager.
- The plan's Provider Services Manager.
- Family members/guardians of children or youth who are Medicaid members.
- Adult Medicaid members.
- Network providers, including PCPs, specialists, pharmacists, and providers knowledgeable about disability, mental health and substance use disorder treatment of children, adolescents, and adults in the State. The provider representatives should have experience caring for the Medicaid population, including a variety of ages and races/ethnicities, and rural and urban populations.

Furthermore, the plan's QAPIC must:

- Review and approve the MCO's QAPI Program Description, Work Plan, and Program Evaluation prior to submission to MLTC.
- Review the Cultural Competency Plan.
- Require the MCO to study and evaluate issues that the MLTC or the QAPIC may identify.
- Establish annual performance targets.
- Review and approve all member and provider surveys prior to their submission to MLTC.
- Define the role, goals, and guidelines for the QAPIC, set agendas, and produce meeting summaries.

- Provide training; participation stipends; and reimbursement for travel, childcare, or other reasonable participation costs for members or their family members. The plans should only provide participation stipends if the individuals are not otherwise paid for their participation as staff of an advocacy or other organization.
- Annually, and as requested, provide data to MLTC's Quality Committee, which meets annually to review data and information relevant to the Quality Strategy. The MCO must incorporate recommendations from all staff and MCO committees, the results of PIPs, other studies, improvement goals, and other interventions into the QAPI Program, the QAPI Program Description, the QAPI Work Plan, and the QAPI Program Evaluation.

The plan must include Quality Management (QM) processes in its operations to assess, measure, and improve the quality of care provided to and the health outcomes of its members. The plan's QM functions must comply with all State and Federal regulatory requirements, as well as those requirements identified in this RFP, any other applicable law, and any resulting contract. The plan must support and comply with MLTC's Quality Strategy, including all reporting requirements in formats and using data definitions provided by MLTC after contract award. MLTC is in process of revising its Quality Strategy to reflect changes in the managed care delivery system. MLTC will provide the plans with the final Quality Strategy when CMS approves it. The plan must have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities. The plan's QM program must include:

- A quality assurance and performance improvement (QAPI) program.
- Performance improvement projects (PIPs).
- Quality performance measurement and evaluation.
- Member and provider surveys.
- MCO accreditation requirements, including a comprehensive provider credentialing and re-credentialing program, as described in Sections IV.C Business Requirements and IV.I Provider Network Requirements of this RFP.

The plan must ensure that the QM unit within the organizational structure is separate and distinct from other units, such as Utilization Management and Care Management. MLTC expects the plan to integrate QM processes, such as tracking and trending of issues, throughout all areas of the organization. The plan must provide a mechanism for the input and participation of members, families/caretakers, providers, MLTC, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.

Finally, MLTC and CMS may inspect and audit any records of the MCO or its subcontractors. There is no restriction on the right of MLTC or the Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness, or timeliness of services, and reasonableness of costs.

7.1.1. Quality standards
Refer to section 7.1.

7.1.2. Performance measurement
7.1.2 (a) CHIPRA Quality Core Set
7.1.2 (b) Other
Refer to section 7.1.

7.1.3. Information strategies
Refer to section 7.1.

7.1.4. Quality improvement strategies
Refer to section 7.1.

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495) Refer to section 7.1.

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))
Refer to section 7.1.

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))
Refer to section 7.1.

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))

Refer to section 7.1.

- 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)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

The state assures that prior authorization of health services are completed in a timely manner and in accordance with state law. The state takes into consideration the urgency of care in responding to prior authorization requests.

Section 8. Cost-Sharing and Payment

- 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) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

- 8.1.1.** Yes
8.1.2. No, skip to question 8.8.
- 8.1.1-PW** Yes
8.1.2-PW No, skip to question 8.8.

Guidance: It is important to note that for families below 150% of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50-.59). For families with incomes of 150% of poverty and above, cost sharing for all children in the family cannot exceed 5% of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

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 by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other:

8.2-DS **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

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)(A)) (42CFR 457.505(b))

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

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

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

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

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

457.515(f)

- 8.5** Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))
- 8.6** Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)
- 8.7** Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Guidance: Section 8.8.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide 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 that is coordinated with other sources of health benefits coverage for children.

- 8.7.1** Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (42CFR 457.570(a))

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

- In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

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

- 8.8.1.** No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2.** No cost-sharing (including premiums, deductibles, copayments, 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

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

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))

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

The strategic objective of Heritage Health is to promote better health outcomes by being a smart purchaser of services that focuses on an efficient and thoughtful delivery of benefits. The Heritage Health plans report specific performance measures including Adult Core Measures, Child Core Measures, and HEDIS Measures. MLTC acknowledges that these measures are only a starting point that require further analytics to provide a deeper understanding the effectiveness of the plans' care management strategies. As such, MLTC requires the plans to implement an analysis of whether there have been demonstrated improvements in members' health outcomes, the quality of clinical care, quality of service to members, and overall effectiveness of the QM program. MLTC continually evaluates the reporting measures and evaluations in pursuit of maximizing health benefits coverage.

Some examples of specific projects related to pregnant women and the health of unborns include:

1. **17-alpha-hydroxyprogesterone (17P)** – The focus is on pregnant women with previous preterm births with an emphasis on variance in sub populations.
 - a. Numerator - # of pregnant women with a history of premature birth who receive 17P
 - b. Denominator - # of pregnant women with a history of premature birth who deliver at >23 weeks gestation.
2. **Tdap in pregnancy** – The focus is on increasing the Tdap immunization rate in pregnant women between 27-36 weeks gestation. Immunizations administered in the post-partum period will not count.
 - a. Numerator - # of pregnant women who receive Tdap in pregnancy between 27-36 weeks gestation
 - b. Denominator - # of delivered babies

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

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic

minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

As noted in 9.1 the goal is to increase health babies by increasing the use of 17P and TDAP immunizations in pregnant women. Also noted the Heritage Health plans will report specific performance measures including Adult Core Measures, Child Core Measures, and HEDIS Measures. MLTC acknowledges that these measures are only a starting point that require further analytics to provide a deeper understanding the effectiveness of the plans' care management strategies.

- 9.3.** Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

The Heritage Health plans must promote and facilitate the capacity of its providers to provide patient-centered care by using systematic, patient-centered medical home (PCMH) management processes and health information technology to deliver improved quality of care, health outcomes, and patient compliance and satisfaction. The plans provided with their proposals a methodology for evaluating the level of provider participation and the health outcomes achieved. MLTC will work with the plans to develop a common evaluation methodology. The findings from these evaluations shall be included in the plans' annual quality evaluation report.

Finally, the Heritage Health plans must develop processes and procedures and designate points of contact for collaboration with the Division of Children and Family Services funded programs that support the safety, permanency, and well-being of children in the care and custody of the State. The plans must collaborate with these entities when serving members and identifying and

responding to members' behavioral and physical health needs. The plans must provide effective outreach and education to parents/guardians of children regarding covered services and the benefits of making responsible decisions about preventative health care and appropriate utilization of health care services for their children.

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

- 9.3.1.** The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2.** The reduction in the percentage of uninsured children.
- 9.3.3.** The increase in the percentage of children with a usual source of care.
- 9.3.4.** The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5.** HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6.** Other child appropriate measurement set. List or describe the set used.
- CMS child core measures
 - CAHPS 5.0H.is used to measure the following:
 - Children with chronic conditions measuring satisfaction with the respective health plans.
 - Parents measuring their children's care satisfaction
- These measures are reported on annually.
- 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 childcare
 - 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, 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)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

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)

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)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

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)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

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))

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. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

All federally recognized tribes, Tribal Clinics, Tribal Health Departments, Indian Health Service Hospital, Indian Health Service contracts and the Nebraska Urban Indian Health Coalition within the State are notified of proposed State Plan Amendments (SPA) regardless of the assumed impact to the Tribal entities. Tribal entities have 30 days from the date of the notice to provide comment back to the Department. If no comment is received during the 30 day period, the Department submits the SPA.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR457.65(b) through (d).

Regulations will be developed to implement this change and a public hearing will be held during the regulation development process. Public notice will be provided 30 days prior to the hearing, as required by Nebraska state statutes.

9.9.3 Describe the State’s interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

Nebraska has not implemented Express Lane eligibility.

9.10 Provide a 1-year projected budget. A suggested financial form for the budget is below. 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 expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc. All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.

- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
 - Total 1-year cost of adding prenatal coverage
 - Estimate of unborn children covered in year 1

CHIP SPA Budget		
STATE:	FFY Budget	FFY Budget
Federal Fiscal Year	2012	2013
State's enhanced FMAP rate	69.65%	69.03%
Benefit Costs		
Insurance payments		
Managed care		
<i>per member/per month rate</i>		
Fee for Service		
Health Services Initiatives		
Cost of Proposed SPA changes		
	1,245,040	6,294,465
Total Benefit Costs	1,245,040	6,294,465
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs		
Administration Costs		
Personnel	22,736	90,944
General administration		
Contractors/Brokers		
Claims Processing	4,083	16,332
Outreach/marketing costs		
Other		

Total Administration Costs	26,819	107,276
10% Administrative Cap	138,338	699,385
Federal Share	885,850	4,419,122
State Share	386,009	1,982,619
Total Costs of Approved CHIP Plan	1,271,859	6,401,741
NOTE: Include the costs associated with the current SPA.		
The Source of State Share Funds: Legislative Appropriation		

NE 18-0014 CHIP SPA has no budgetary impact and therefore a budget submission is not necessary.

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP’s website at <http://www.nashp.org>. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

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 uninsured 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.

- 10.3-DC** Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

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.

- 12.1. Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane

option when determining eligibility. Nebraska will follow the review and appeal process used by Medicaid.

Guidance: “Health services matters” refers to grievances relating to the provision of health care.

12.2. Health Services Matters- Describe the review process for health services matters that comply with 42 CFR 457.1120. Nebraska will follow the review and appeal process used by Medicaid.

12.3. Premium Assistance Programs- If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, 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.

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.mcgregal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
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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
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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(l)(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.

