Table of Contents

State/Territory Name: Connecticut

State Plan Amendment (SPA) #: CT-22-0001 & CT-22-0001-CHIP

This file contains the following documents in the order listed:

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

Children and Adults Health Programs Group

October 24, 2022

Gui Woolston
Director of Medicaid and Division of Health Services
State of Connecticut Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Mr. Woolston:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendments (SPAs) CT-22-0001 and CT-22-0001-CHIP, submitted on June 14, 2022 with additional information provided in response to CMS' Request for Additional Information on October 11, 2022, have been approved. These SPAs have an effective date of April 1, 2022.

Through these SPAs, Connecticut extends CHIP eligibility to children from conception to the end of pregnancy (otherwise known as "unborn") whose parents are not otherwise eligible for Medicaid or CHIP with incomes up to and including 258 percent of the federal poverty level (FPL). SPA CT-22-0001 also adds presumptive eligibility for unborn children and CHIP coverage for unborn children of public employees who have access to public employee health coverage. A copy of the approved CS9 template and updated CS28 template are attached and have been incorporated into sections 4.1.2.1-PC and 4.3.2 of Connecticut's CHIP state plan, respectively. The state has also provided the necessary maintenance of agency contribution analysis to demonstrate that the state has consistently contributed to the cost of public employee coverage, with increases for inflation, since 1997.

By providing the same behavioral health benefits to its unborn population that are available to other targeted low-income children in CHIP, Connecticut is in compliance with the mental health parity requirements at section 2107(c)(7)(B) of the Social Security Act (the Act). CMS will work with Connecticut to determine the state's compliance with requirements under section 2105(c)(5) of the Act, added through section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, as they apply to the unborn population through our review of the state's pending CHIP SPA CT-20-0013-CHIP.

Your Project Officer is Tess Hines. Tess is available to answer your questions concerning this amendment and other CHIP-related matters. Tess's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: 410-786-0435
E-mail: Mary.Hines@cms.hhs.gov

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

Sincerely,

/Signed by Sarah deLone/

Sarah deLone
Director

CHIP Eligibility

State Name: Connecticut

OMB Control Number: 0938-1148

Transmittal Number: CT - 22 - 0001

Separate Child Health Insurance Program
General Eligibility - Presumptive Eligibility for Children

CS28

42 CFR 457.355 and 435.1102, 2107(e)(1)(L) and 1920A of the SSA

The CHIP Agency covers children when determined presumptively eligible by a qualified entity. Yes

■ Describe the population of children to whom presumptive eligibility applies:

All children, from birth to the age of nineteen, with incomes above 196% of the FPL and up to and including 318% of the FPL.
All unborn children, with incomes from zero up to and including 258% of the FPL.

■ Describe the duration of the presumptive eligibility period and any limitations:

The date the eligibility determination for CHIP is made, if an application for CHIP is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for CHIP is filed by that date.
No more than two periods within a calendar year.
The above applies to all children, from conception to the age of nineteen.

■ Describe the application process and eligibility determination factors used:

Qualified entities may use either an online portal for presumptive eligibility applications or a simplified, one page presumptive eligibility paper application.
The above applies to all children, from conception to the age of nineteen.

■ The CHIP Agency uses qualified entities, as defined in section 1920A, to determine eligibility presumptively for children.

Separate Child Health Insurance Program
General Eligibility - List of Qualified Entities

CS30

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select the types of entities used to determine presumptive eligibility:

☒ Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan

☒ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

☒ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

☒ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants, and Children (WIC) under section 17 of the Child Nutrition Act of 1966

CHIP Eligibility

- ☒ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☒ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☒ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☒ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☒ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*)
- ☐ Any other entity the state so deems, as approved by the Secretary

- ☑ The CHIP Agency assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

CHIP Eligibility

State Name: Connecticut

OMB Control Number: 0938-1148

Transmittal Number: CT - 22 - 0001

Separate Child Health Insurance Program
Eligibility - Coverage From Conception to Birth **CS9**

42 CFR 457.10

■ **Coverage From Conception to Birth** - Coverage from conception to birth when the mother is not eligible for Medicaid.

☑ The CHIP Agency operates this covered group in accordance with the following provisions:

Age Standard

From conception through birth.

Does the state have an additional age definition or other age-related conditions? No

Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standard

The statewide income standard is: From zero up to 258 % FPL

■ Exempted from requirement of providing or applying for a Social Security Number.

■ Exempted from requirement of verifying citizenship status.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

10/24/22

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: **Connecticut**
(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))

Deidre S. Gifford, MD, MPH, Commissioner, June 14, 2022
(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: Gui Woolston, Ph.D Position/Title: Director of Medicaid and Division of Health Services

Name: Michael Gilbert Position/Title: Deputy Commissioner

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

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

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

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

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

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

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

The template includes the following sections:

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

under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

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

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

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

  Medicaid Expansion- CHIP SPA Requirements
  In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:
  - 1 (General Description)
  - 2 (General Background)

  They will also be required to complete the appropriate program sections, including:
  - 4 (Eligibility Standards and Methodology)
  - 5 (Outreach)
  - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
  - 10 (Annual Reports and Evaluations).

  Medicaid Expansion- Medicaid SPA Requirements
  States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
  - 3 (Methods of Delivery and Utilization Controls)
  - 4 (Eligibility Standards and Methodology)
  - 6 (Coverage Requirements for Children's Health Insurance)
  - 7 (Quality and Appropriateness of Care)
  - 8 (Cost Sharing and Payment)
  - 11 (Program Integrity)
  - 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be

required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

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

Mary T. Hines
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

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

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

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

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

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

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

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

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

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

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

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

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
Date Plan Submitted: January 15, 1998
Date Plan Approved: April 27, 1998
Effective date: HUSKY A (Medicaid Expansion) October 1, 1997
HUSKY B (Separate Child Health) January 1, 1998

Amendment #1:	AI/AN Children Cost Sharing Exempt
Date Submitted:	January 21, 2000
Date Approved:	July 14, 2000
Date Effective:	January 1, 2000

Amendment # 2:	Compliance/Reduce Period of un-insurance from 6 to 2 months
Date Submitted:	July 1, 2002
Date Approved:	October 25, 2005

Amendment #3:	Premium Increase
Date Submitted:	March 25, 2004
Date Approved:	June 21, 2004
Date Effective:	February 1, 2004

Amendment #4:	Premium Rollback
Date Submitted:	June 29, 2004
Date Approved:	September 24, 2004
Date Effective:	February 1, 2004

Amendment #5:	Behavioral Health Carve Out & Eliminates Self-declaration of Income
Date Submitted:	May 8, 2006
Date Approved:	August 1, 2006
Date Effective:	July 18, 2005 and January 1, 2006

Amendment #6: Change from MCOs to PIHPs, four months newborn premium waiving, pharmacy carve-out, expedited newborn application processing, dental carve-out, change from PIHPs to MCOs.

Date Submitted: June 30, 2008
Date Approved: August 18, 2009
Date Effective: January 1, 2008, February 1, 2008, June 11, 2008, August 1, 2008, September 1, 2008

Amendment #7:

Coverage for children under the age of 19 who are qualified aliens and lawfully residing in the United States, regardless of their date of entry into the country. Revision of Appendix 3.1 (HUSKY Plus Physical) to reflect elimination of steering committee.

Date Submitted: July1, 2009
Date Approved: December 8, 2009
Date Effective: April 1, 2009

Amendment #8: Cost sharing changes and implementation of presumptive eligibility
Date Submitted: April 29, 2011
Date Approved: August 21, 2015
Date Effective: March 1, 2011

Amendment #9: Technical revision using new State Plan format to the Lawfully Residing Option in accordance with section 214 of CHIPRA previously amended under SPA #7.

Implementation of the HUSKY Health medical administrative services organization (ASO) delivery system for all CHIP medical benefits and the elimination of the medical managed care delivery system model.

Cessation of the Statewide Standard Review Process available through the Connecticut Insurance Department for external appeals of health services matters. Pursuant to 42 CFR 457.1120(a)(1), the Department has developed a program specific review process in which a clinical director at the Department (Medical, Behavioral Health or Dental director) will conduct the appeal of an ASO decision concerning a health services matter.

Date Submitted: June 30, 2012
Date Approved: February 22, 2017
Date Effective: January 1, 2012

CT-17-0010-CHIP (Amendment #10): Describes the new premium bands following ACA/MAGI implementation, incorporates and cross-references the MAGI SPA templates, adds coverage for the coverage of gender dysphoria, and makes certain other technical corrections.

Date Submitted: October 13, 2017
Date Approved: November 15, 2017
Date Effective: July 1, 2017
Proposed Effective date: July 1, 2017

CT-18-0011-CHIP (Amendment #11): Reflects compliance with MHPAEA requirements, adds coverage for Birth to Three services; makes changes to the supplemental program for children with special health care needs.
Date Submitted: June 29, 2018
Date Approved: September 2, 2021
Date Effective: HUSKY Plus changes – July 1, 2017; Birth to Three and MHPAEA – October 1, 2017

CT-20-0012 – Disaster Relief SPA (Amendment #12): Disaster Relief SPA for the COVID-19 Public Health Emergency to implement temporary adjustments to enrollment and redetermination policies and cost sharing requirements.
Date Submitted: June 30, 2020
Date Approved: September 27, 2020
Date Effective: March 18, 2020
Proposed Effective date: March 18, 2020

CT-20-0013-CHIP (Amendment #13): SUPPORT ACT – Behavioral Health Services.

Date Submitted: June 30, 2020
Date Approved:
Date Effective:
Proposed Effective Date: October 24, 2019

CT-22-0001 (Amendment #14): Prenatal Coverage/Unborn Child Option

Date Submitted: June 14, 2022
Date Approved: October 24, 2022
Date Effective: April 1, 2022
Proposed Effective Date: April 1, 2022

CT-22-0005 (Amendment #14): Extended Postpartum Coverage

Date Submitted: June 14, 2022
Date Approved: July 26, 2022
Date Effective: April 1, 2022
Proposed Effective Date: April 1, 2022

1.4 MAGI SPAs

The following MAGI Eligibility plan amendments, CT-14-0001, 14-0003, 14-0004 and 14-0005, replace and supersede the following plan sections, as noted below. Please see Appendix 1.4 for the plan amendments and supporting templates/PDFs. Please note that the effective date for the MAGI eligibility changes was January 1, 2014.
Additional Eligibility changes reflected in CT-22-0001 and 22-0005, are also reflected below.

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
CT-14-0001 Effective/ Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS15 CS7 CS10 CS10	MAGI-Based Income Methodologies Eligibility – Targeted Low Income Children Eligibility – Children Who Have Access to Public Employee Coverage Maintenance of Agency Contribution	Incorporated within a separate subsection under section 4.3 Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Supersedes current section 4.1.7 regarding children of public employees Appendix: Incorporate within a separate appendix
CT-22-0001 **Effective/ Implementation Date: April 1, 2022**	MAGI Eligibility & Methods	CS9 CS10	Eligibility – Coverage from Conception to Birth Maintenance of Agency Contribution	Incorporated within section 4.1.2.1-PC Supersedes current section 4.1.7 regarding

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
				children of public employees
CT-14-0003 Effective/ Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporated within a separate subsection under section 4.1
CT-14-0004 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
CT-14-0005 Effective/ Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS20 CS21 CS28	Non-Financial Eligibility – Residency Non-Financial Eligibility – Citizenship Non-Financial Eligibility – Social Security Number Non-Financial Eligibility – Substitution of Coverage Non-Financial Eligibility – Non-Payment of Premiums General Eligibility – Presumptive Eligibility for Children	Supersedes the current section 4.1.5 Incorporated in new sections 4.1.0; supersedes the current sections 4.1.10 4.1.10.1 Incorporated in new section 4.1.9.1 Supersedes the current section 4.4.4 Supersedes the current section 8.7 Supersedes the current sections , 4.3, 4.3.24.4.3 and 5.1.1 regarding presumptive eligibility
CT-22-0005 **Effective/ Implementation Date: April 1, 2022**	Non-Financial Eligibility	CS27	General Eligibility – Continuous Eligibility	Incorporated in section 4.1.9.2
CT-22-0001	Non-Financial	CS28	General Eligibility –	

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Effective/Implementation Date: April 1, 2022	Eligibility		Presumptive Eligibility for Children	Supersedes the current section 8.7 Supersedes the current sections, 4.3, 4.3.24.4.3 and 5.1.1 regarding presumptive eligibility

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 May 13, 2022, in accordance with the tribal consultation policy, the Department notified the representatives of the two federally recognized tribes of the proposed changes to the HUSKY B program by email. [comments or response, if any].

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))

The State can measure the number of children with creditable health coverage to the extent that they are enrolled in either the HUSKY A or HUSKY B program. Since the start of the HUSKY program and combined HUSKY A and B marketing in July 1998 an additional 51,090 children enrolled in the Medicaid program resulting in their access to creditable health coverage. The increased Medicaid enrollment in addition to the 13,086 HUSKY B members means that an additional 51,090 children now have creditable health coverage in comparison to July 1998.

Please see Appendix 2.1 for a breakdown of HUSKY A (Medicaid) and HUSKY B (CHIP) enrollment by race and ethnicity; a breakdown of HUSKY A and HUSKY B enrollments by county; and HUSKY B enrollment by income level. Please note that we do not have HUSKY A enrollment data broken out by income. The income limit for HUSKY A is 196% of the FPL.

The state currently does not have public-private partnerships.

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 457.10.

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)

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 (IHCIA). 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.
The State seeks advice from the two Connecticut federally-recognized tribes, the Mashantucket Pequot Tribal Nation and The Mohegan Tribe, through periodic meetings with tribal health representatives and by ongoing written and electronic communications.

The State tribal leads for the HUSKY and CHIP programs meet with tribal representatives at least once annually to update the representatives on developments in the Medicaid and CHIP programs. These meetings include a discussion of program changes, including, but not limited to, waivers, demonstration projects and State Plan amendments.

The process that led to the development of this State Plan Amendment included introductory meetings with tribal representatives in May 2010 to describe the State Plan Amendment process and the tribal consultation requirement. The Department's tribal leads described the Medicaid State Plan Amendment and CHIP plan processes and discussed the method of consultation and communication that would best serve the tribal representatives' needs. The tribal representatives agreed to an informal process in which the Department sends copies of the public notice for proposed amendments to the tribes prior to submission to CMS. If the State has not received comments or questions concerning the plan amendment within two weeks, the State determines that the tribe does not have any questions or concerns regarding the proposed amendment. In addition to this informal consultation process, for State Plan Amendments that may have a unique or particular impact on tribal members, for example, a program or plan change that exempts tribal members from some requirement, the State will also arrange for a meeting or teleconference with the tribal representatives to discuss the proposed change.

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 the CMS Regional Office servicing them for review and approval.

In addition, states may use up to 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. (42 CFR 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) (42 CFR 457.490(a))

The State will utilize the same delivery system and utilization controls as applicable to the rest of the CHIP population.

☐ 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))

As described in the State's Medicaid state plan amendment, under Part A of the HUSKY Plan, the State used Title XXI funds to expand Medicaid eligibility for children 14-18 with family income up to 185% of the FPL. The Title XXI- funded expansion of Medicaid was phased out effective 10/1/02. As of 10/1/02, Title XXI funds are used only for the stand-alone SCHIP program (HUSKY B).

As of 1/1/12, all medical services for Connecticut's Medicaid and CHIP population are coordinated by the statewide HUSKY Health medical Administrative Services Organization (ASO). The State eliminated the managed care organization (MCO) service delivery model on 12/31/11. Medical services for children with family income over 185% of the FPL under the HUSKY Plan, Part B are now obtained through providers in the fee-for-service Connecticut Medical Assistance Program (CMAP) network, the same network through which Connecticut's Medicaid recipients receive their benefits. Behavioral health services have been administered by a behavioral health ASO since 7/1/05 and a dental ASO has provided dental services since 9/1/08. Pharmacy services have been provided through CMAP network providers since 2/1/08.

The State selects ASOs through a competitive bidding process. The State issues a Request for Proposal (RFP) that establishes operational and financial requirements and requires bidders to provide evidence of their ability to meet the requirements. The requirements include but are not limited to: access to care, provider network, member services, utilization management, claims processing, and quality assurance. The State awards the right to negotiate a contract based on a fair evaluation of all proposals submitted in response to the RFP. This method includes evaluation of the following factors: provider network for each service area, efficiency of operation, ability to provide the required services, quality management, and ability to perform the necessary administrative tasks, financial viability, and price. The ASO contracts do not include financial requirements because the ASOs are not capitated and bear no risk.

During the period 1/1/08 through 7/31/08, the state changed its contractual relationship with the existing at-risk MCOs to non-risk pre-paid inpatient health plans (PIHPs). The State returned to at-risk MCO contracts effective 8/1/08.

As of 12/31/11, the Department terminated its MCO contracts.

Following the end of the MCO contracts, the Department implemented a self-insured, managed fee-for-service approach for both Medicaid and CHIP. In support of achieving better heath and care experience outcomes for members, and engagement with providers, the Department has entered into contracts with ASOs for each of the three major service types – Medical, Behavioral Health, and Dental. The structure of each of the ASO contracts supports the Department's desired results. A percentage of each ASO's administrative payments is withheld by the Department pending completion of each fiscal year. To earn back these withholds, each ASO must demonstrate that it has achieved identified benchmarks on health outcomes, healthcare quality, and both member and provider satisfaction measures.

ASO arrangements have substantially improved engagement with both members and providers. Members now have streamlined toll-free and web-based access to clear information and support on how to access and to utilize their benefits. Providers now have a single set of coverage guidelines for each service, and a uniform fee schedule from which to be paid.

In addition, the state, using Title XXI funds, has established a supplemental health insurance program, known as the HUSKY Plus Physical program, for those enrollees in the state subsidized portion of Part B whose medical needs cannot be accommodated within the basic benefit package offered by the Department under the HUSKY Plan, Part B. The HUSKY Plus Physical program supplements HUSKY Plan, Part B coverage for enrollees with intensive physical health needs. Effective 7/1/03, the physical health services are delivered through the Connecticut Children's Medical Center (CCMC)/ Title V network.

Effective 7/1/17, The Department is changing the HUSKY Plus contractor from Connecticut Children's Medical Center to the same administrative services organization (ASO) used for all HUSKY's Medicaid and CHIP programs. Also, providers are reimbursed for HPP services using the same MMIS as for all HUSKY Health programs.

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. (42 CFR 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) (42 CFR 457.490(b))

The state includes a definition of medical necessity and utilization management requirements in the RFP and the contracts with its ASOs. The ASOs are required to have written utilization management policies and procedures that include the medical necessity criteria for authorization and denial of payment and protocols for prior approval. The ASOs are also required to have mechanisms to ensure consistent application of the review criteria. In addition, the MCOs and ASOs must have utilization controls to ensure that only services described in the approved state plan are provided to HUSKY B members.

As discussed in Appendix 3.1 (summarizing HUSKY Plus Physical), utilization is managed through prior authorization based on individual care plans and medical necessity guidelines.

Section 4. Eligibility Standards and Methodology

Guidance: 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:

4.1. ☒ **Separate Program** Check all standards that will apply to the State plan. (42 CFR 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.
See CT-14-0005, CS18, Non-Financial Eligibility - Citizenship.

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

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

Individuals must be under 19 years of age.

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

See CS-22-0001, CS9, Coverage from Conception through Birth.

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

See CT-14-0001, CS7, Eligibility – Targeted Low-Income Children

4.1.3.1-PC ☐ 0% of the FPL (and not eligible for Medicaid) through % 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/resource limit.

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

See CT-14-0005, CS 17 – Non-Financial Eligibility – Residency
To be eligible for the HUSKY Plan, Part B, a child must be a resident of Connecticut.

4.1.6 ☒ Disability Status (so long as any standard relating to disability status does not restrict eligibility):
Measures of disability acuity will apply in HUSKY Plus Physical (See Appendix 3.1).

4.1.7 ☒ Access to or coverage under other health coverage:
See CT-14-0001, CS10 – Eligibility – Children Who Have Access to Public Employee Coverage. Unborn children are also permitted to have access to public employee coverage.

4.1.8 ☒ Duration of eligibility, not to exceed 12 months:

A child who has been determined eligible for the HUSKY B program shall remain eligible for as long as all eligibility criteria are met. Eligibility for HUSKY B is reviewed annually. The renewal period is scheduled to coincide with the yearly anniversary of the initial eligibility determination. The initial eligibility period may include a presumptive eligibility period. Renewal forms are sent during the tenth month of eligibility to allow time for the family to complete and return the form in time for the renewal to be processed before the expiration of the twelfth eligible month.

4.1.9 ☐ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 42 CFR 457.310 and 457.320 that are not addressed above. For instance:

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.

CT-14-0005, CS19, Non-Financial Eligibility – Social Security Number

The Department, at time of initial determination and when determining ongoing eligibility, requires the social security number for any child requesting services under the HUSKY B program. Unborn children are also exempt from the requirement to provide a Social Security Number.

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

4.1.9.2 ☐ Continuous eligibility

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 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 1903(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 least180 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

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.

4.1-**ID** – **Income Disregards** – *See 14-0003, CS14, Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards.*

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)) (42 CFR 457.350)

See CT-14-0001, CS15, MAGI-Based Income Methodologies, CT-14-0004, CS24, Eligibility Process, and CT-22-0005, CS28, General Eligibility – Presumptive Eligibility for Children.

The State uses a single streamline application for its non-elderly/blind/disabled Medicaid coverage groups (parent/ caretakers, single adults and pregnant women and children),CHIP applicants and applicants for Qualified Health Plans through the State Based Marketplace. The application is a variant on the federal single streamlined application. The State encourages the use of online applications, but application may also be made over the phone or on a paper application. Applications may also be made at a number of locations. Once entered, all applicants receive a real-time determination of eligibility. If not all conditions are eligibility are verified at time of application, enrollees will be given 90 days to verify this information. Verification documents are sent to a central post office box, where they are processed by a State contractor.

Effective 6/11/08, families with a newborn child are able to initiate the application process for the newborn at a Connecticut or border hospital. The hospital will fax the

application and other supporting documents to the SPES for eligibility to be determined within one business day of receipt. Effective 4/1/11, families may apply for HUSKY B for a child at any of our certified Qualified Entities available statewide and receive a presumptive eligibility determination. The Qualified Entity will fax the application and other supporting documents to the SPES for eligibility to be entered in the eligibility system within one business day of receipt. The Qualified Entity will provide the family with a payment voucher guaranteeing coverage and payment of services for the child for 10 days in the event there is a need for immediate access to care. The presumptive period will end when a determination for regular HUSKY B is made.

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)(2)) (42 CFR 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)

See 22-0001, CS28, General Eligibility – Presumptive Eligibility for Children. Presumptive eligibility is also permitted for unborn children.

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. 444

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 disregards, or other 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.

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), 42 CFR 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:

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.

See 14-0004, CS24, Eligibility Process.

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)) (42 CFR 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. (Section 2102(b)(3)(C)) (42 CFR, 457.805)

See 14-0005, CS20, Non-Financial Eligibility – Substitution of Coverage

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. (42 CFR 457.810(a)-(c))

4.4.5. ☒ Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

In accordance with Section 2102(b)(3)(D), 42 CFR 457.125(a) the Department met with representatives from both of Connecticut's federally recognized Indian tribes in 1998, during the design phase of the HUSKY plan. The program design was discussed with the tribal representatives and their comments and suggestions were considered in the final design and ongoing operations of the program. In 2000 both tribes provided the Department information required to exempt them from cost sharing. The tribal members provided the Department with the information we need to request of American Indians in order to exempt them from cost sharing.

The Department will continue to meet with the tribes on an annual basis or more often if necessary to discuss programmatic changes to HUSKY and to consider the issues or concerns of the tribal members. The Department also provides

supplies of HUSKY informational materials and applications for distribution to tribal members. HUSKY information has also been available to tribal members via media (Public Service Announcements, T.V. and radio ads and ads in local newspapers) and other outreach efforts.

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) (42 CFR 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):

The State currently conducts outreach activities through its contracts with Federally Qualified Health Centers and disproportionate share hospitals that assist applicants in completing the application.

Effective March 1, 2011 the State implemented the process of presumptive eligibility in accordance with Sec. 2107(e)(1)(L) of the Social Security Act or U.S.C. 1397gg(e)(1)(L). Families may apply for HUSKY B for a child at any of our statewide certified Qualified Entities who make an immediate eligibility determination based on preliminary information provided by the family.

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:
The State currently does not have any programs that involve a public-private partnership. The Healthy Steps program, which existed at the inception of HUSKY B, has been phased out and members of that program were made eligible for HUSKY A or B, according to their family income.

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. (42 CFR 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), 2102(b)(3)(E) and 2102(c)(2)) (42 CFR 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.
*Title V refers potential applicants who do not qualify for its program to HUSKY B and HUSKY Plus Physical. A Department representative monitors services provided by the Connecticut Children's Medical Center, the agent responsible for HUSKY B Children with Special Health Care Needs with Title V. (**See Appendix 3.1.**)*

The Department contracts with school-based health clinics.

HUSKY Plus Physical and the HUSKY Health medical ASO, in conjunction with the Department, also coordinate with the Birth to Three program, which provides services to children with special health care needs.

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.

Guidance: 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.

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.

5.3. **Strategies** 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)) (42 CFR 457.90)

The Department, in partnership with statewide, regional and local health and social service organizations, within available appropriations, regularly conducts public outreach and education to reach families of children likely to be eligible for HUSKY Health, be it Medicaid or CHIP. The Department's HUSKY Outreach program includes:

School based outreach efforts – HUSKY information provided through the free- and reduced-price lunch program in cooperation with the CT Department of Education and school food service directors. HUSKY information and applications are also available through the school nurses and the school-based health centers;

Participation in the CT Department of Labor's Rapid Response Team – provision of HUSKY information and application assistance to laid-off workers;

HUSKY Health medical, dental and behavioral ASOs community-based outreach – The HUSKY ASOs provide information on benefit delivery through periodic mailings, handbooks, its website, and at various community forums including school health promotional fairs; craft shows; country fairs, etc., throughout the state.

Collaboration with Child Support Services;

Collaboration with CT's Covering Kids and Families (CCKF) initiative –C CKF is a Robert Wood Johnson Foundation funded initiative, with Connecticut Voices for Children acting as the lead agency for Connecticut. CCKF funds several local HUSKY outreach projects throughout the state. The initiative supports statewide interventions and supports local projects in Bridgeport and Stratford, Stamford, and in a nine-town area East of the River (Manchester, East Hartford, Vernon, Hebron, Glastonbury, Mansfield, Willington, Coventry and Columbia). The local projects work in their communities to provide application assistance to families and help families through the renewal process, train community-based organizations on HUSKY, build relationships with local Department of Social Services (DSS) offices, train parents and high school students to promote the HUSKY program, develop model projects to enroll immigrant children and families, and work with schools, local businesses and health care providers. All three local projects use an automated tracking system to track their own activities and to identify enrollment and renewal barriers. Statewide initiatives include the coordination and provision of outreach through established groups such as schools, child care providers, pediatric care providers, the business community, and social service providers; and the HUSKY (www.huskyhealth.com) website featuring a downloadable application.

Multi-level campaign

The crux of this campaign has been grass roots, community-based outreach through schools, health centers, community meetings, fairs, events, worksites, and other venues identified by DSS, statewide partners and community contractors. Just as often, HUSKY outreach brings the message to professionals who work with parents through a 'key informant' model--these are the known and trusted people in health, education, human services and other fields who are already in the community and who can vouch for the program and provide follow-up assistance. The emphasis on grass roots, community-based outreach has been acknowledged as especially important in reaching minority communities and newcomer/immigrant populations.

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)); (42 CFR 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 August 5, 1997 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)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

See Appendix 6.1.4, updated on June 29, 2018 to reflect the addition of coverage of Birth to Three Services.

6.1.4.1. ☐ Coverage of all benefits that are provided to children that is the same as the benefits provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic, and Treatment (EPSDT).

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

6.1.4.3. ☐ Coverage 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.

Please note that the HUSKY B benefits combine the most generous benefits offered at the inception of the HUSKY, Part B plan under three state employee options available in 1998 (Blue Cross, MD Health Plan, and Kaiser Permanente), in addition to covered services mandated by the Federal CHIP regulations. In addition, HUSKY B benefits also include a limited supplemental program, HUSKY Plus (which is not available to state employees) for children whose medical needs cannot be fully met by the coverage available under the regular HUSKY B benefits. (See Revised Appendix 3.1) The same benefit package (Secretary approved-benchmark plus) applies to unborn children like other children in CHIP.

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only in New York, Pennsylvania or Florida. (under 42 CFR 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 coverage under one of the benchmark plans specified in 457.420, through the 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)

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)) (42 CFR, 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)) (42 CFR 457.490)

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

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

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

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

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

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

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

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

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

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

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))

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

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 (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))

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)

6.2.18. ☒ Vision screenings and services (Section 2110(a)(24))

6.2.19. ☒ Hearing screenings and services (Section 2110(a)(24))

6.2.20. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

6.2.21. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))

6.2.22. ☒ Case management services (Section 2110(a)(20))

Case management is available through the medical and behavioral ASOs, depending on the member's needs.

6.2.23. ☒ Care coordination services (Section 2110(a)(21))

Care coordination is available to members who are part of the Primary Care Medical Home initiative .

6.2.24. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
Short term rehabilitation is covered under HUSKY B and long-term coverage is available through HUSKY Plus. See Appendix 3.1 for additional information on HUSKY Plus Physical

6.2.25. ☒ Hospice care (Section 2110(a)(23))

Guidance: See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.

6.2.26. ☐ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

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.

6.2.27. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))
Services of nurse midwives, nurse practitioners, podiatrists, chiropractors, and naturopaths will be covered.

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

6.2.29. ☐ Medical transportation (Section 2110(a)(26))

Transportation by ambulance will be covered but non-emergency

transportation will not.

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.

6.2.30. ☐ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))
Translation and outreach services will be available through the HUSKY ASOs. All printed materials must be in English and Spanish and any other languages if more than five percent of the ASO enrollees speak the alternative language.

6.2.31. ☐ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))
See Appendices 3.1 and 6.1: HUSKY Plus Benefits and HUSKY B Benefits

6.2- UNBORN CHILDREN – The state provides the same scope of benefits to unborn children as it does to other Targeted Low-Income Children. This includes comprehensive prenatal care with no cost sharing. When comprehensive prenatal care is rendered by the same provider or provider group, the provider/group bills with a comprehensive bundle code that includes all routine prenatal, delivery and post-partum care and thus all the services are covered under the unborn children option. If a different provider or provider group renders the delivery, the delivery will be covered by Emergency Medicaid since the comprehensive bundle code cannot be billed.

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 (CDT[1]) 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)

Current Dental Terminology, © 2010 American Dental Association. All rights reserved.

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 CDT[2] 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)

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 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

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.

Current Dental Terminology, © 2010 American Dental Association. All rights reserved.

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. (Formerly 8.6.)

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)

☒ State guidelines (Describe:
The state developed a behavioral health indicator designed to flag services on the claims submission end with the behavioral health indicator prior to upload into the data warehouse based on the following criteria:

- All claims submitted by a substance abuse treatment facility, behavioral health clinic, and psychologist, licensed clinical social worker, behavioral health FQHC (this is listed on the T1015 level), licensed marital and family therapist, board certified behavior analyst, and alcohol & drug counselor. With the exception of the evaluation and management procedure codes and autism services, the other services that these providers perform are limited to behavioral health/substance abuse services by nature of the code description.

- Claims submitted by a psychiatrist, pediatric & adolescent psychiatrist, and psychiatric APRN will depend on the service detail. Behavioral health services (identified via the procedure code description such as psychiatric diagnostic interview) will always be flagged with the BHI. If other services are submitted on the same claim that are not by nature of the code description behavioral health and therefore not flagged with the BHI, the primary diagnosis on the claim will determine whether or not the claim is flagged with the BHI. ICD 9 primary diagnosis of 291-316 will populate the BHI (please note effective for 10/1/2015 – the comparable ICD 10 for the ICD 9 series of 291-316 will drive the BHI). These diagnosis codes are contained in a special list in the claims system that automatically drives population of the BHI.
- Medical FQHC – the claim will be flagged as BHI if the claim includes a primary ICD 9 diagnosis of 291-316 (please note effective for 10/1/2015 – the comparable ICD 10 for the ICD 9 series of 291-316 will drive the BHI). These diagnosis codes are contained in a special list in the claims system that automatically drives population of the BHI.
- For services that require a registration or prior authorization (PA): the BHI will be assigned to any service that was provided a PA through the Behavioral Health ASO.
- Inpatient claims – claims submitted with a BH inpatient RCC will be flagged with the BH indicator

☐ Other (Describe:)

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

☒ Yes ☐ No

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

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

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

☐ Yes

☒ No

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

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

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐ All children covered under the State child health plan.

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

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

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

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

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

☐ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services,

whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

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

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

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

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

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

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

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

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

Populations

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

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

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

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

The state used existing regulatory definitions (Medicaid) and grouped the services in such a way as to ensure that they were put into only one category. The Department conducted this process without regard to whether the service or facility at issue was a mental health/SUD service or a medical/surgical service. The resulting categorization of the benefits is below:

Inpatient and Outpatient: The state used the federal Medicaid regulatory definitions of inpatient and outpatient (42 C.F.R. § 440.2(a)) to place benefits into classifications for inpatient and outpatient.
Emergency: The state used its state Medicaid definition of hospital emergency services to classify the benefit into emergency classification, specifically for health care claims billed and paid by the hospital emergency department, which is defined in section 17b-262-968(22) of the DSS operational policy for outpatient hospital services, which has the force of state regulation under Conn. Gen. Stat. § 17b-10, which provides as follows: "'Emergency department' means an organized department or facility of a hospital that provides unscheduled episodic services to individuals who present to the hospital for immediate medical attention, regardless of whether it is located on or off the main hospital campus". The criteria for hospital emergency department services are further defined in section 17b-262-970(i) of the DSS operational policy for outpatient hospital services.
Pharmacy: The state included its entire pharmacy benefit (consistent with federal Medicaid regulation definition of outpatient prescription drug in 42 C.F.R. § 440.120) as the basis for including the benefit in the prescription drug classification.

Please see Appendix 6.2.3.

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.

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 - *The State uses a self-insured, managed fee-for-service approach for both Medicaid and its CHIP Program. As part of this approach, the Department has entered into contracts with Administrative Service Organizations (ASO) for major service types, including Behavioral Health. The State's behavioral health ASO administers the Behavioral Health Partnership. The Partnership maintains a very detailed website, which includes very specific descriptions of medical necessity guidelines and criteria.*

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 *The State uses a self-insured, managed fee-for-service approach for both Medicaid and its CHIP Program. As part of this approach, the Department has entered into contracts with Administrative Service Organizations (ASO) for major service types, including Behavioral Health. The State's behavioral health ASO administers the Behavioral Health Partnership. The Partnership maintains a very detailed website, which includes very specific descriptions of reasons for denial, processes to appeal denials, etc.*

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

6.3. The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42 CFR 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. (Formerly 8.6.) (Section 2103(f)) Describe:

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)) (42 CFR 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 percent 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)) (42 CFR 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)) (42 CFR 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 percent 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 percent 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. (42 CFR, 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)) (42 CFR 457.1005(a))

Guidance: Check 6.4.2.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)) (42 CFR 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)) (42 CFR 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)) (42 CFR 457.1010(b))

6.4.2.3. The State assures that the coverage for the family otherwise meets title XXI requirements. (42 CFR 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, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42 CFR 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)) (42 CFR 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.)

The methods that are used to assure quality and appropriateness of care include contracting standards, licensing, reporting requirements, external reviews, and onsite reviews.

The HUSKY Health medical ASO contract includes specific standards for quality of care, including the provision of well-baby care, well-child care, and immunizations. The HUSKY Health medical ASO is required to arrange for immunizations and comprehensive screens (and any needed interperiodic screens) in accordance with the schedules recommended by the American Academy of Pediatrics. As described below, The HUSKY Health medical ASO is required to submit reports on well-baby care, childcare visits and immunizations. The Connecticut Department of Public Health has a statewide immunization registry (Connecticut Immunization Registry and Tracking System), to which providers report directly.

The behavioral health and dental ASO contracts will include specific standards for quality of care, including the provision of behavioral health and dental health intensive care management and service coordination. In addition, the behavioral health and dental ASOs will be required to submit to the Department periodic reports on utilization of dental health services and behavioral health services, including inpatient and outpatient services.

The HUSKY Health ASOs are required to meet all standards for quality of care as specified in their contracts with the State. The ASOs must be licensed by the Connecticut Insurance Department (CID) to operate as a utilization review company. CID continuously monitors quality through various mechanisms, including reporting, external reviews, and onsite reviews.

Reporting will include a report on each ASO's quality assurance plan (QAP), complaints, prior authorization denials, utilization review (UR) denials, and all data required for HEDIS (or equivalent data for non-NCQA accredited plans). In addition, the Department requires reports on compliance with the well-child periodicity schedule and on immunization. The State conducts periodic onsite reviews to determine ongoing compliance with contract requirements.

The unborn children covered under this coverage will be included in all current methods to assure quality and appropriateness of care.

7.1.1. ☒ Quality standards

7.1.2. ☐ Performance measurement

7.1.2 (a) ☒ CHIPRA Quality Core Set

7.1.2 (b) ☒ Other

7.1.3. ☒ Information strategies

The HUSKY ASOs are required to educate enrollees about their benefits, rights and responsibilities under the HUSKY B. including HUSKY Plus. The HUSKY ASOs also educate enrollees about the importance of preventive services including medical and dental services, health promotion activities, and visiting their primary care provider instead of an emergency room. The unborn population will be included under these processes.

7.1.4. ☒ Quality improvement strategies

The State includes specific standards for quality of care in the contracts with its ASOs. These standards are monitored by the State through reporting requirements, onsite reviews, and external reviews.

In particular, the HUSKY ASOs are required to establish an internal QAP, which will be in writing and available to the public. The written description shall include detailed goals and annually developed objectives; address the quality of clinical care and non-clinical aspects of services for the entire range of care provided by each ASO; specify quality of care studies and related activities; provide for continuous performance of activities, including tracking of issues over time; and provide for review and feedback by physicians and other health professionals.

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)) (42 CFR 457.495)

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

The State requires the HUSKY Health medical ASO to submit reports on immunizations, and compliance with the well-child periodicity schedule.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42 CFR 457.495(b))

The State monitors access requirements through reporting and member satisfaction surveys. For medical, dental, pharmacy, and behavioral health services, the ASO will

rely on the Connecticut Medical Assistance Program (CMAP) provider network to assure access to covered services. HUSKY Health ASO is required to monitor the CMAP provider network to ensure providers who fail to reenroll do so and also to recruit additional providers to make the network more robust.

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)) (42 CFR 457.495(c))

All HUSKY Health services (medical, behavioral health and dental) are provided through the CMAP network. HUSKY B members and members covered under the unborn coverage have access to all of the same providers as Medicaid recipients. The HUSKY Health medical, behavioral health and dental ASOs assist in managing the Department's network, but do not contract directly with network providers. All claims are processed by the Department's MMIS.

Pharmacy services are provided utilizing the Department's Preferred Drug List (PDL).

For members enrolled in HUSKY Plus, the HUSKY Health medical ASO now administers that program. This allows for more streamlined and efficient coordination of services for members eligible for HUSKY Plus, allowing members to receive supplemental services to the fullest extent possible in the least restrictive setting. (See Appendix 3.1).

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)) (42 CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Prior authorization of services covered in the HUSKY B benefit package shall be determined by the appropriate ASO based on the Department's individual care plans, medical necessity and in accordance with State law. However, the following services in the benefit package shall not require prior authorization:

(1) Preventive care, including:
- *(a) Periodic and well-child visits;*
- *(b) Immunizations; and*
- *(c) Prenatal care;*

(2) Preventive family planning services, including:
- *(a) Reproductive health exams;*
- *(b) Member counseling;*
- *(c) Member education;*

(d) Lab tests to detect the presence of conditions affecting reproductive health; and

(e) Screening, testing and treatment of pre and post-test counseling for sexually transmitted diseases and HIV, and

(3) Emergency ambulance services or emergency care.

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? (42 CFR 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 percent 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 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent 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)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (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)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. ☐ Premiums:

Effective July1, 2014, children with family income up to 249% of the FPL will not be required to pay a premium. Children with family income that exceeds 250% of the FPL but which does not exceed 318% of the FPL will be required to pay a premium of $30.00 per child per month, up to a maximum of $50.00 per family per month. Effective July 1, 2014, newborns with family income over 249% of the FPL will not be required to pay premiums for the first four months of coverage, provided they were born in a Connecticut hospital or designated border hospital. Effective August 1, 2015, pursuant to a change in state law, enrollment of children over 318% of the FPL will not be permitted. Private organizations may subsidize premiums. For unborn children with family income up to 258% FPL, no premiums are required.

8.2.2. ☐ Deductibles:

Not applicable.

None..

8.2.3. ☒ Coinsurance or copayments:

Copayments: For children in families with income over 196% of the FPL, the State has established a schedule of reasonable copayments for services other than the following: preventive care and services, inpatient physician and hospital, outpatient surgical, ambulance, skilled nursing, home health, hospice and short-term rehabilitation and physical therapy, occupational and speech therapies, lab and X-ray, preadmission testing, prosthetics, and durable medical equipment, and pregnancy related services, including medications prescribed during pregnancy. (See Appendix 6.1). Both targeted low income children and beneficiaries in the unborn child group will receive pregnancy-related services (including prescription medications) with no copayments. Due to the parity analysis under MHPAEA, the State will no longer charge copayments for outpatient behavioral health visits and outpatient substance abuse treatment. The State will implement that change as soon as practicable.

8.2.4. ☒ Other:

$725 lifetime limit on orthodontic benefit and $100 towards the purchase of eyeglass frames and lenses per two-year period.

Effective March 1, 2011, the maximum annual aggregate cost sharing (premiums, if applicable, dental co-insurance and co-payments) will be calculated using the lowest qualifying income according to income level which is based on FPL and household size. Income Level 1 includes children with family income that exceeds 196% of the FPL but does not exceed 249% of the FPL. There is no premium. Income Level 2 includes children with family income that is 250% or more of the FPL but does not exceed 318% FPL. The premium is $30 per month for one child or $50 for two or more children per month. Annual cost sharing including premiums, dental co-insurance, and co-payments cannot exceed 5% of the family's gross income per eligibility year. Maximums will be adjusted yearly to reflect the most current FPL's.

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)) (42 CFR 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)) (42 CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 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)) (42 CFR 457.515(f))

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

8.4.2- MHPAEA ☐ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A)) Not applicable.

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

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

☐ Yes (Specify:)

☒ No

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

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

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

☒ Yes

☐ No

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

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

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

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

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

☐ Yes

☒ No

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

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

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

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

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

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

The family share of premium payments, copayments and dental co-insurance payments were calculated to not exceed 5% of the lowest qualifying family income within each of the two income levels for subsidized benefits (e.g. 5% of 196% of FPL and 5% of 250% of the FPL) for the applicable household size. Cost sharing is tracked by the

Department's Medicaid Management Information System (MMIS) as applicable and reported to the SPES. The SPES compiles the cost sharing amounts with premiums it has collected and reports back to the Department's MMIS vendor and the ASOs. When cost sharing maximums have been met, the ASOs will issue new member identification cards. If a family exceeds the maximum, the Department is required to reimburse the excess above the maximum amount to the family.

It is the responsibility of the SPES to review the member accounts at a minimum on a monthly basis to determine which families have reached their maximum annual cost sharing limit. The review must be completed no later than 15 days after the end of each review period. If, due to claims' time-lag, the family has paid more than the allowed limits for cost sharing, it is the responsibility of the Department to repay the overpayment to the family within three months of the SPES's determination that the maximum annual aggregate cost sharing limit for copayments had been met. The SPES is required to establish and maintain a system to track the copayments incurred by each family in Income Levels 1 and 2 in order to adhere to the requirements of the maximum annual aggregate cost sharing. The ASOs and the Department also must require their providers and subcontractors to verify whether a family has reached the maximum annual aggregate cost sharing limit for copayments and co-insurance before charging a copayment or co-insurance amount.

When a family reaches the maximum annual aggregate cost sharing limit, the SPES will inform the Department. The ASOs will inform the providers, subcontractors and family that the limit has been met, that the providers and subcontractors cannot charge further cost sharing within the annual eligibility period.

If the family believes it has reached the maximum annual aggregate cost sharing limit, it may request, in writing, that the Department review the cost sharing amounts paid by the family. The Department will then review the cost sharing amounts paid by the family and respond to the family, in writing, within three weeks of the date of the family's written request. If the family disagrees with the determination, the family may request, in writing, a review by the Department. The ASOs are required to include a summary of this right and the appropriate procedures to request the review in their Member Handbooks.

There are no cost sharing requirements for covered HUSKY Plus Physical services.

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)) (42 CFR 457.535)

Families of American Indian/Alaskan Native (AI/AN) children who are members of a federally organized tribe and who are in Income Level 1 or 2 are exempted from paying HUSKY B premiums or copayments. Income Level 1 represents those enrollees whose income falls between 196 percent and 249 percent of the federal poverty level. Income

Level 2 represents those enrollees whose income falls between 250 percent and 318 percent of the federal poverty level.

The Department of Social Services staff informed representatives of the Mashantucket Pequots and the Mohegans, the two federally recognized tribes within the State of Connecticut, that federal requirements do not permit cost sharing for AI/AN children in the HUSKY B program. Staff also consulted with them about the best way to identify AI/AN children.

Based on recommendations made by both tribes, it was decided that applicants would be asked to verify their tribal membership at time of application. The HUSKY application was modified to ask if the child for whom application is made is a member of a federally recognized tribe. If the answer is "yes", the applicant will need to provide the name of the tribe and verification of membership. HUSKY informational materials were also revised to include information about the cost sharing exemption for AI/AN children. The SPES, under contract with the Department to determine eligibility for HUSKY B applicants, will notify the ASOs when a new enrollee is qualified for exemption from cost-sharing due to AI/AN status. The ASOs will not charge the family for any partial premium payment and will issue the enrollee a membership card that specifies "no copayments"

American Indian/Alaskan Native children enrolled in HUSKY Plus Physical will not be charged premiums or copayments as there are no cost sharing requirements.

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42 CFR 457.570 and 457.505(c))

See CT14-0005, CS21, Non-Financial Eligibility – Substitution of Coverage). Enrollees are permitted up to 90 (days) to pay their initial premium and their premium for annual re-enrollment. Failure to do so will result preclude the enrollee from receiving initial coverage or having their coverage renewed, as applicable. Once the enrollee has coverage however, as of January 1, 2014, the Department no longer disenrolls enrollees for failure to pay the monthly premium.

Guidance: Section 8.7.1 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. (Section 2103(e)(3)(C))

8.7.1.1. ☐ 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. (42 CFR 457.570(a))

8.7.1.2. ☐ 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. (42 CFR 457.570(b))

8.7.1.3. ☐ 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. (42 CFR 457.570(b))

8.7.1.4 ☐ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42 CFR 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)) (42 CFR 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) (42 CFR 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)) (42 CFR 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)) (42 CFR 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)) (42 CFR 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)) (42 CFR 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)) (42 CFR 457.710(b))

To increase the number of children in Connecticut with health insurance through the expansion of the HUSKY program.

To maximize participation in HUSKY B through outreach, a simplified application process

To promote the health of children through an improved health benefit package tailored to the health care needs of children, which includes comprehensive preventive services.

To assist those children enrolled in HUSKY B who have special physical health care needs, to receive appropriate care through a supplemental plan (HUSKY Plus Physical).

To maximize coordination between the HUSKY Health ASOs and HUSKY Plus Physical by integrating basic health care needs into the care provided for intensive health care needs, and, whenever possible, building upon existing therapeutic relationships with Title V providers.

To promote the health of children covered under the unborn option by promoting optimal pregnancy outcomes.

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

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

To increase the number of children covered by health insurance within Connecticut.

To maximize participation in HUSKY B.

• Expand Medicaid (HUSKY Part A) enrollment of uninsured children 18 years old who are under 196% of the FPL.

• Increase the number of insured children 18 or under who are between 196% and 318% of the federal poverty level.

To promote the health of children through a comprehensive health benefits package.

• Match or exceed the statewide average of the percentage of children in HUSKY B who receive immunizations by age two, meet or exceed state standards for well-

child care, with a goal of at least 80% of children receiving all recommended well-child visits.

To assist children with special physical health needs through HUSKY Plus.

• Ninety percent of referrals to HUSKY Plus will have eligibility determination made within 21 days.

• Track the percentage of referrals to HUSKY Plus accepted or denied.

To maximize coordination between HUSKY B and HUSKY Plus:

- *The HUSKY Health ASO is now coordinating health care for HUSKY Plus members. The ASO is also pre-authorizing all HUSKY Plus covered services. Families now have a single entity to assist them and ensure that supplemental services are authorized when the child's medical needs surpass the regular HUSKY B package.*

• 100% of HUSKY Plus children's needs will be assess and referred for Intensive Care Management.

To assure that children with behavioral health needs receive appropriate care

• 70% of children who are discharged from inpatient care for mental health or substance abuse will receive follow-up care 30 days following discharge.

To promote the health of children covered under the unborn option by promoting optimal pregnancy outcomes.

- Track and monitor the following pregnancy outcomes:
  - overall c-section measures, NTSV c-section measures, adverse maternal measures, vaginal delivery (39 wks. and above) measures, NICU utilization, preterm deliveries, NAS - neonatal abstinence syndrome measures.

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.

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)) (42 CFR 457.710(d))

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

9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☐ The reduction in the percentage of uninsured children.
9.3.3. ☐ The increase in the percentage of children with a usual source of care.
9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☒ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- **9.3.7.1.** ☐ Immunizations
- **9.3.7.2.** ☐ Well 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:
  - *Ambulatory Services*
  - *Follow-up After Mental Health Hospitalization*
  - *Follow-up After Chemical Dependency Hospitalization*

See Appendix 9.3 for complete listing of reporting measures.

9.3.8. ☒ Performance measures for special targeted populations.

See Appendix 9.3 for complete listing of reporting measures

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)) (42 CFR 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)) (42 CFR 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 or audit. (Section 2107(b)(3)) (42 CFR 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. (42 CFR 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)) (42 CFR 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 ensuring ongoing public involvement. (Section 2107(c)) (42 CFR 457.120(a) and (b))

The Medical Assistance Oversight Council (MAPOC) and the Behavioral Health Partnership Oversight Council (BHPOC) serves in an advisory role to the Department for the behavioral health services as managed by the medical and behavioral health ASOs. The MAPOC and BHPOC are comprised of legislators, clients, advocacy groups, DSS, and other state agencies such as the Department of Children and Families and the Department of Mental Health and Addiction Services. The MAPOC and BHPOC meet once a month during which time the Department provides program updates. The MAPOC and BHPOC also have several subcommittees that provide a forum for important issues to assure the viability of the medical and behavioral health service delivery system. The subcommittees include: Transition, Provider Advisory, Quality Management, Consumer Access, and the Department of Children and Families Subcommittee.

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)) (42 CFR 457.120(c))
In accordance with 42 CFR 457.125, Section 2107 (c) and 42 CFR 457.120 (c) The Department met with representatives from both of Connecticut's federally recognized Indian tribes, during the design phase of the HUSKY plan. The program design was discussed with the tribal representatives and their comments and suggestions were considered in the final design and ongoing operations of the program. The Department met with both tribes again in 2000 to discuss American Indian's being exempt from cost sharing. The tribal members provided the Department with the information needed to request of American Indians in order to exempt them from cost sharing.

The Department continues to consult with both tribes on an annual basis to discuss any changes to the HUSKY Plan as well as address any concerns or questions the tribal representatives may have. The consultation will either be conducted by phone or in person depending on the issues to be discussed.

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 CFR 457.65(b) through (d).

Amendments relating to either eligibility, such as the reduction of the crowd-out period from six to two months, or benefits, such as mental health parity or the carve-out of behavioral health services to the ASO, have been the result of legislative changes; therefore the prior public notice requirement was provided through the legislative

process. Based on additional comments received subsequent to the 2/1/04 implementation from clients, advocates and other stakeholders, it was decided to repeal the premium increases, retroactive to the 2/1/04 implementation. The copayment maximum remained at $760.00.

The amendment relating to the change from at-risk MCO contracts to non-risk PIHPs was due to a directive from the Governor. The amendment relating to expediting eligibility processing and waiving premium payments for the first four months of managed care enrollment for a newborn child born in a Connecticut or designated border hospital with family income greater than 235% FPL was a result of a legislative change. In addition, the amendments relating to the carve-out of dental and pharmacy services as well as the return to at-risk MCO contracts were also a result of legislative changes. The prior public notice requirement was provided through the legislative process.

The amendment relating to the increase in cost sharing including copayments and co-insurance effective 3/1/11 were the result of legislative change. Prior public notice was provided in the Connecticut Law Journal and on the Department's website.

The amendment relating to the elimination of the managed care delivery service model for HUSKY B benefits effective 1/1/12 was the result of legislative change.

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.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42 CFR 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 1 700

CHIP Budget

STATE: CT	**FFY Budget**
Federal Fiscal Year	**2023**
State's enhanced FMAP rate	**65%**
Benefit Costs	
Insurance payments	
Managed care	
per member/per month rate	
Fee for Service	$5,136,975
Total Benefit Costs	
(Offsetting beneficiary cost sharing payments)	(205,479)
Net Benefit Costs	**$4,931,496**
Cost of Proposed SPA Changes – Benefit	**$4,931,496**
Administration Costs	
Personnel	$32,193
General administration	
Contractors/Brokers	
Claims Processing	$72,807
Outreach/marketing costs	
Health Services Initiatives	
Other	
Total Administration Costs	**105,000**
10% Administrative Cap	$493,150
Cost of Proposed SPA Changes	$5,036,496

STATE: CT	FFY Budget
Federal Share	$3,278,280
State Share	$1,758,217
Total Costs of Approved CHIP Plan	**$49,324,166**

NOTE: Include the costs associated with the current SPA.
$4,931,496
The Source of State Share Funds: The CT General Fund plus beneficiary cost-sharing

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)) (42 CFR 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. (42 CFR 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 ☒ 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)) (42 CFR 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)) (42 CFR 457.935(b)) (The items below were moved from section 9.8. Previously 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.

Eligibility decisions, which can be appealed, include denials, failure to make a timely determination of eligibility, discontinuances and income level assignment changes. When HUSKY B eligibility is denied, terminated, transferred to a higher premium level, or the State fails to make a timely determination of eligibility, a notice, described above, is sent to the applicant informing him of this decision. The notice also informs the applicant of his right to request an administrative review of this decision within ten business days from the date the notice was sent to the applicant. A supervisory level employee, who was not involved in the original decision, conducts the level one administrative review of the initial eligibility decision.

The SPES notifies the applicant in writing of its level one review decision not more than ten business days from receipt of a request for administrative level one review. Decisions related to expedited requests shall be made within five business days.

If the applicant is not satisfied with the SPES's level one review decision, the applicant may request a level two administrative review within ten business days following the date on the notice of the level one decision. The level one decision notice contains information on how to request a second level review and information related to expedited review.

At the second level review, the DSS administrative reviewer, who was not involved in the prior decisions, evaluates all factors related to the SPES's eligibility decision or failure to make a timely decision of eligibility. The level two review is a desk review unless the applicant requests a personal conference with the administrative reviewer as part of the review process. The personal conference may be conducted in person, by telephone or video conferencing.

The DSS administrative reviewer renders a decision in writing to the applicant not more than 45 calendar days following the date of receipt of the applicant's written request for the level two administrative review. Decisions related to expedited requests shall be made within 20 days.

The Commissioner may waive any of the time limits as provided for above as may become necessary.

To the extent that an applicant has coverage, coverage continues pending both levels of review and final decision from the level two appeal.

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 complies with 42 CFR 457.1120.

"Health services matters" refers to grievances relating to the provision of health care.

In accordance with 42 CFR Sections 457, 1120, 1130(a), 1130(c), 1140, 1150(a), 1160(a), 1170 and 1180, an applicant has the right to request an administrative review of eligibility and enrollment decisions described below. However, the State will not provide an opportunity for review of a matter if the sole basis for the decision is a provision in this plan or in federal or state law requiring automatic change in eligibility or enrollment that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances. The Department has a two level process to

review appeals related to HUSKY B eligibility and enrollment. The Department's agent (SPES) conducts the level one review and the Department's Office of Legal Counsel, Regulations and Administrative Hearings conducts the level two review.

The State ensures that all enrollees and applicants receive timely written notice of any eligibility or enrollment decisions subject to review, as outlined below. All notices issued during the appeals process include the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames (if any) for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review. Additionally, the State will ensure that applicants and enrollees have opportunities to represent themselves or have representatives of their choosing in the review process, to timely review their files and other applicable information relevant to the review of the decision, and to fully participate in the review process.

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.

N?A

Key for Newly Incorporated Templates

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

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

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

GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

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

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

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

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

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