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State/Territory Name: Tennessee

State Plan Amendments (SPA) #: TN-20-0018

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Children and Adults Health Programs Group

February 24, 2021

Stephen Smith
Director
Division of TennCare
310 Great Circle Road
Nashville, TN 37243

Dear Mr. Smith:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number TN-20-0018, has been approved. Through this SPA, Tennessee has demonstrated compliance with section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. This SPA has an effective date of October 24, 2019.

Section 5022 of the SUPPORT Act added Section 2103(c)(5) to the Social Security Act (the Act) and requires child health and pregnancy related assistance to include coverage of services necessary to prevent, diagnose, and treat a broad range of behavioral health symptoms and disorders. In addition to the behavioral health benefits listed in the CHIP state plan, Tennessee also provides care coordination, and case management through its third party administrator and crisis stabilization through a state funded program under the Department of Mental Health & Substance Abuse Services.

Section 2103(c)(5)(B) of the Act also requires that behavioral health services be delivered in a culturally and linguistically appropriate manner. Tennessee demonstrated compliance by providing the necessary assurances and benefit descriptions that the state covers a range of behavioral health services in a culturally and linguistically appropriate manner.

This amendment also contains updated language of a previously approved disaster provision to clarify that Tennessee will delay acting on changes in circumstances, except for all of the required changes in circumstances as described in 42 CFR 457.342(a), during the COVID-19 public health emergency (PHE). This revised provision is in effect beginning March 18, 2020, through the duration of the federally declared PHE, or at state discretion, a shorter period of time.

Your title XXI project officer is Jack Mirabella. They are available to answer questions concerning this amendment and other CHIP-related issues. Their contact information is as follows:

Page 2 – Mr. Smith

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-2424
E-mail: jack.mirabella@cms.hhs.gov

If you have additional 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 Amy Lutzky/

Amy Lutzky
Deputy Director

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

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

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

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

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

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

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

Name: Stephen Smith	Position/Title: Director, Division of TennCare
Name: Zane Seals	Position/Title: Chief Financial Officer, Division of TennCare

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 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) 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, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Section 1. General Description and Purpose of the State Child Health

Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

- 1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR
- 1.1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX); OR
- 1.1.3. A combination of both of the above.

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

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

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

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

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

State Plan Amendment #4 (Striking dental services for pregnant women)
Effective Date: November 8, 2007
Implementation Date: January 1, 2008

State Plan Amendment #5 (Revising upper income limit, clarifying coverage of unborn children and updating enrollment processes)
Effective Date: January 23, 2008
Implementation Date: February 8, 2008 (unborn children), March 1, 2008 (upper income limit)

State Plan Amendment #6 (Previously submitted on May 22, 2009 and

withdrawn on August 17, 2009.)

Effective Date:

Implementation Date:

State Plan Amendment #7 (Enrollment cap – specified time frame

Effective Date: November 30, 2009

Implementation Date: December 1, 2009 through February 28, 2010

State Plan Amendment #8 (Enhanced dental benefits; prospective payment system; alternative managed care delivery system; citizenship documentation/Social Security Administration; external quality review)

Effective Date: July 1, 2010

Implementation Dates: July 1, 2010 (external quality review); July 1, 2010 (prospective payment system); July 1, 2010 (dental benefit enhancements); September 1, 2010 (managed care delivery system); September 1, 2010 (citizenship documentation/Social Security Administration)

State Plan Amendment #9 (Change method of delivery system from full-risk arrangement to fee-for-service/administrative service only arrangement; phase out alternative delivery system concurrent with the change from managed care to FFS/ASO)

Effective Date: January 1, 2012

Implementation Date: January 1, 2012

State Plan Amendment #10 (Network change from commercial network with commercial rates to TennCare Select Medicaid network with Medicaid rates; SCHIP budget; updated Attachment B Dental Procedure Codes)

Effective Date: October 1, 2013

Implementation Date: October 1, 2013

State Plan Amendment #11 (Submitted June 19, 2014 under a cover letter date June 18, 2014 and withdrawn September 2, 2014)

Effective Date:

Implementation Date:

State Plan Amendment TN 15-0012 (Updated Section 6.2 and Attachment A regarding covered benefits and copays and deleted Attachment B)

Effective Date: September 15, 2014

Implementation Date: September 15, 2014

State Plan Amendment TN 16-0014 (Clarification to Sections 4.3 and 4.4)

Effective Date: July 1, 2015

Implementation Date: July 1, 2015

State Plan Amendment TN 16-0015 (Updated information about covered benefits and copays)

Effective Date: April 1, 2016

Implementation Date: April 1, 2016

State Plan Amendment TN 18-0016 (Updated copays and compliance with MHPAEA)

Effective Date: October 2, 2017

Implementation Date: October 2, 2017

State Plan Amendment 20-0017 (Disaster-related flexibilities)

Effective Date: January 27, 2020

Implementation Date: In the event of a disaster, the State will notify CMS of its intent to provide temporary adjustments to the policies described in Sections 4.3 and 8.2 of this State Plan.

State Plan Amendment 20-0018 (Documenting coverage of behavioral health services)

Effective Date: October 24, 2019

Implementation Date: October 24, 2019

Superseding Pages of MAGI CHIP State Plan Material

State: Tennessee

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
TN-14-0006 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
		CS9	Eligibility – Coverage From Conception to Birth	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
TN-14-0010 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Incorporate within a separate subsection under section 4
TN-14-0007 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
TN-14-0008 Effective/Implementation Date: January 1, 2014 (Pending RAI)	Eligibility Process	CS24	Single, Streamlined Application Screen and Enroll Process Renewals	Pending RAI

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
TN-14-0009 Effective/Implementation Date: January 1, 2014	Non- Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5
		CS18	Non-Financial – Citizenship	Incorporate within a separate subsection under section 4.1
		CS19	Non-Financial – Social Security Number	Incorporate within a separate subsection under section 4.1.9
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
		CS27	Continuous Eligibility	Supersedes the current section 4.1.8
TN-16-0013 Effective/Implementation Date: January 1, 2016		CS10	Children With Access to Public Employee Coverage	Supersedes the current information on dependents of public employees in sections 4.1.7; 4.4.1

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

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

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

(Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the March 2004 and 2005 Current Population Survey (CPS): Annual Social and Economic Supplements)

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

- 2.2.** Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered

children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

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

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

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

On April 1, 1997, the TennCare Uninsured category was re-opened for children under age 18 who lacked access to health insurance through an employer or family member. Local health departments were key players in conducting outreach for the program. Health Department staff distributed flyers, posters, signs and report card inserts to WIC and Head Start programs, Offices of the Department of Human Services (DHS),

Legal Aid Offices, churches, schools, day care and family resource centers, after-school programs, health fairs, hospital emergency rooms, children's museums, county hospital carnivals, the circus, fast food/grocery/variety stores used by low-income families, child advocacy groups, minority health coalitions, physicians offices, factories, companies not offering health coverage, and bank drive-in windows. Contests were held among clerks at local health departments to see who could enroll the most children. Presentations were made at universities and neighborhood associations, and print and broadcast media were used as well. Local health department personnel personally contacted families who had applied for coverage for uninsured children after the Uninsured category was closed in December 1994 and told them about this new opportunity to enroll their children.

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

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

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

children under age 19 enrolled in TennCare Medicaid who are losing Medicaid coverage *and* are either: 1) a child who lacks access to insurance and has family income below 200 percent of the FPL, or 2) a child who is uninsurable (“medically eligible”) at any income level. The medically eligible category replaces the Uninsurable eligibility category and is determined through a medical underwriting process.

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

- 2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

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

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

The CoverKids program has been working with TennCare to assure coordination of coverage. The 95 county-level Department of Human Services offices that determine eligibility for TennCare will play a role in outreach to the target population, as many children who are not eligible for TennCare may be eligible for CoverKids. Local offices will include information with all *DHS (Medicaid)* denial letters that informs families that CoverKids is another option for health care coverage for their children. DHS will also send files listing the children denied Medicaid eligibility to the CoverKids *Administrative Contractor (AC)* for follow-up. Children who are eligible for TennCare Medicaid and TennCare Standard are not eligible for CoverKids. In addition, TennCare includes information with all TennCare termination letters that informs families

that CoverKids is another option for health care coverage for their children. Eligibility systems for CoverKids have been developed to screen for potential Medicaid eligibility and a process has been established to refer children to the appropriate program. (See Section 4 for further information.)

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

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

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

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

Effective October 1, 2013, the State of Tennessee will provide health insurance benefits through a Fee-For-Service model in which the State will assume the risk of all claims. The associated administrative services (e.g., credentialing and registering providers, claims processing, and related functions) will be provided by a Plan Administrator (PA) with whom the State has contracted on a per member/per month basis. Each enrollee will have access to a list of participating providers in his or her area and will receive all services from CoverKids providers within the network, with medically necessary exceptions permitted if an enrollee requires services from a specific provider that is not currently in the network. The provider network selected for CoverKids will be the TennCare Select Provider network. Providers within the CoverKids network are TennCare providers.

The responsibilities of the PA will include, but are not limited to:

1. All aspects of claims processing, including utilization management and quality assurance targeted to the timely and accurate payment of all properly submitted claims for covered services to enrolled CoverKids members;
2. Recruiting, registering and credentialing an adequate base of physicians, specialists, facilities, pharmacies, and other providers capable of meeting the needs of the CoverKids Program, including Centers of Excellence (Centers of Excellence are locations, usually children's hospitals, where highly specialized procedures are performed;)
3. Furnishing benefits information and ID cards;
4. Responding to inquiries from CoverKids members and providers;
5. Claims certification, investigation, adjudication, and internal appeals process;
6. Maintaining and updating enrollment data;
7. Production of management information that captures claim and utilization experience and trends;
8. Assisting with fraud detection through periodic audits;
9. Meeting specific performance guidelines and guarantees;
10. Encouraging the use of a medical home for each enrollee;
11. Appropriate and accurate fee administration;

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

The CoverKids dental program method of delivery is a Prepaid Ambulatory Health Plan (PAHP).

In making payments to FQHCs and RHCs, CoverKids will employ an Alternative Payment Methodology that assures each FQHC and RHC receives an amount that is at least the amount it would have received under the State Comptroller's Medicaid fee schedule for those providers. FQHCs and RHCs will be paid according to the TennCare Select Medicaid provider reimbursement schedule applied by the CoverKids insurance plan. On a quarterly basis, CoverKids and the State, will reconcile payments to FQHCs and RHCs with the PPS rates to identify those providers who would have received a higher amount under the PPS fee schedule. Supplemental payments will be made to these providers to reflect the minimum amount they would have been paid under the PPS schedule. This approach complies with the third methodology stipulated in SHO letter #10-004.

- 3.2.** Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

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

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

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

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

4.1.1. Geographic area served by the Plan: See SPA pages CS7 and CS9 for geographic area served by the State Plan.

4.1.2. Age: See SPA pages CS7 and CS9 for age requirements.

4.1.3. Income: See SPA pages CS7 and CS9 for income requirements.

4.1.4. Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. Residency (so long as residency requirement is not based on length of time in state): See SPA page CS17 for residency requirements.

4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. Access to or coverage under other health coverage: Comprehensive employer-based coverage or other creditable health insurance will preclude enrollment in CoverKids.

For unborn children, this means that the mother is either uninsured, or her coverage does not include prenatal or maternity care.

4.1.8. Duration of eligibility: CoverKids provides 12 months of eligibility.

CoverKids provides continuous eligibility as described by SPA page CS27.

CoverKids may review, redetermine, and extend eligibility for an enrollee during the 12-month coverage period if doing so would align the enrollee’s future redetermination dates with those of other household members. However, CoverKids will not shorten the eligibility period as a result of such a review.

4.1.9. Other standards (identify and describe):

When determining eligibility for the unborn child category, the unborn child or children are counted as if born and living with the mother in determining household size for the unborn child. An unborn child does not count toward the household size of other children in the household.

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

- Children who appear to be eligible for Medicaid (even if not enrolled in Medicaid). This includes children who are eligible for TennCare Standard as uninsured or medically eligible.
- Children who are inmates of a penal facility or residents of an institution for mental diseases.
- Children who are covered under a group health plan or other creditable health insurance coverage.

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

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

4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

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

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

The state's eligibility and enrollment processes operate in a manner consistent with the requirements of 42 CFR 457, subpart C, except where indicated otherwise in Tennessee's mitigation plan approved on May 13, 2016. These processes are applied at the time of initial application and at redetermination, and ensure that eligible targeted low-income children are identified and appropriately enrolled in CoverKids.

Consistent with Tennessee's mitigation plan approved on May 13, 2016, CoverKids accepts applications via the FFM, and it also accepts mailed and faxed applications directly from pregnant applicants (on behalf of unborn children) and newborns. CoverKids contracts with one or more eligibility vendors to process applications and redeterminations using the MAGI-in-the-

Cloud tool. For applications for which the FFM notes an inconsistency in self-reported and electronic data, the state and/or its eligibility vendor(s) will request verification documentation from applicants and process eligibility accordingly. The state's contracted administrative services organization (ASO) and dental benefits manager (DBM) each mail identification cards and member handbooks to enrollees upon receipt of enrollment information (via the 834 process).

Redeterminations of eligibility occur once every 12 months. As noted in Section 4.1.8, CoverKids may review, redetermine, and extend eligibility for an enrollee during the 12-month continuous eligibility period if doing so would align the enrollee's future redetermination dates with those of other household members; however, CoverKids will never shorten the eligibility period as a result of such a review. The effective date for CoverKids coverage is the effective date determined by the FFM or, in instances in which a pregnant woman or newborn applied directly to the State, the date on which the State or its agent received the signed CoverKids application form, or as otherwise agreed to by the State and CMS.

Disaster-related Flexibilities

- At State discretion, requirements related to timely processing of applications may be temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area.
- At State discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area.
- At State discretion, the State may temporarily delay acting on certain changes in circumstances affecting CHIP eligibility for CHIP beneficiaries (other than the required changes in circumstances described at 42 CFR 457.342(a)) who reside and/or work in a State or Federally declared disaster area.

In the event of a disaster, the State will notify CMS of its intent to provide temporary adjustments to its policies as described above.

4.3.1. Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

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

4.4. Describe the procedures that assure that:

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

457.80(c)(3))

Because Tennessee is an FFM determination state currently operating under a mitigation plan approved on May 13, 2016, CoverKids relies largely on the FFM to conduct appropriate screening of applications consistent with the state's eligibility requirements. For applications processed by the state for unborn children and newborns, Tennessee ensures that applicants who appear to be eligible for Medicaid are enrolled in Medicaid, and that eligible targeted low-income children are appropriately enrolled in CoverKids. These screening processes are used both at the time of initial eligibility determinations and at redetermination. As noted in Section 4.3, CoverKids and its eligibility contractors use the MAGI-in-the-Cloud tool to determine eligibility for directly submitted applications and redeterminations.

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

When an applicant (or enrollee subject to redetermination) appears to be eligible for TennCare as determined by CoverKids, its eligibility vendor(s), or the FFM, the applicant is enrolled in TennCare.

- 4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

When a TennCare applicant (or enrollee subject to redetermination) is determined ineligible for TennCare, CoverKids, its eligibility vendor(s), or the FFM enroll the individual in CoverKids, as appropriate.

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

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

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

See SPA page CS20 for substitution of coverage requirements.

4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

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

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

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

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

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

1) Coordinated Marketing Outreach

Collateral pieces such as brochures, posters and other materials will serve as tools for CoverKids outreach for widespread dissemination. These materials are used by communities to reach the target audience. The available information will include an application form for return mailing. All materials will direct readers to a toll free number for further information or questions. In addition, the state will do a kick-off, press event in one or more media markets. HCFA also will maintain a website with current information regarding the CoverKids program for access by the general public.

2) Outreach through Partner Programs, Agencies, and Organizations

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

Schools: Schools and day care programs will be an important avenue for outreach to families. A contact person at each public school will be responsible for distributing brochures and applications to students. School nurses, Head Start programs, day care providers, private schools and home school organizations will also be provided with information about CoverKids to give to students and families.

Since 2007, CoverKids has partnered with the Tennessee Department of Education to distribute program information and enrollment instructions to every public school student in the state. Now in its fourth year, this campaign has resulted in the enrollment of approximately over 10,000 children and represents the program's strongest and most successful partnership.

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

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

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

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

enrollment assistance from community organizations.

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

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

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

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

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

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

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

6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

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

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

6.1.4.1. Coverage the same as Medicaid State plan

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

- 6.1.4.3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage

Benefits under the CoverKids program will be the same as the benefits for the 2006 HMO option of the State Employee Health Plan; however, it is a fully insured product (the state is at full-risk and TennCare Select Preferred Provider Organization (PPO)) is not an HMO plan. The annual number of visits for outpatient mental health/ substance abuse and PT/OT/SP was increased from 45 to 52 per year per condition. Beginning in January 2008, the benefit package was modified to also include vision services. Beginning in July 2008, the benefit package included dental services. Attachment A is the summary of benefits for CoverKids. Beginning April 2009, outpatient and inpatient mental health/ substance abuse limits were removed pursuant to Section 502 of Children's Health Insurance Program Reauthorization Act of 2009. Effective January 1, 2012, CoverKids began providing coverage through a Fee-For-Service/Administrative Service Only (FFS/ASO) model in which the state assumes the financial risk for the benefits and all operational functions associated with the FFS/ASO model are performed by a contracted PA through a standard Administrative Services Only (ASO) approach.

Benefits under the CoverKids Dental program will be the same as the benefits for the PPO dental option of the State Employee Health Plan; however CoverKids is a PAHP not a PPO plan. CoverKids and the State Employee Dental Plan are consistent with the annual Benefit Limit and the Lifetime Orthodontic Limit. CoverKids has more generous dental benefits than the State employee plan. The State will furnish CMS with a copy of the Dental Benefits Manager contract listing all covered dental codes at any time that contract is amended.

As of July 1, 2010, the six hundred dollar (\$600) dental benefit limit rose to one thousand (\$1,000).

The program also added orthodontia benefits to members. A member must be enrolled in the program for twelve (12) months after the implementation date to obtain orthodontic benefits. The Orthodontia Lifetime Maximum Limit shall not exceed \$1,250 and is not part of \$1,000 annual benefit limit. The CoverKids program elected to mirror the State of Tennessee employee dental program for its benchmark coverage.

6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. Other (Describe)

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

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 prepregnancy family services and supplies (Section 2110(a)(9))

- 6.2.10. 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))

Hearing aids limited to one per ear per year up to age 5; limited to one per ear every two years thereafter.

- 6.2.11. Disposable medical supplies (Section 2110(a)(13))

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

Home Health Services with prior approval. Limited to 125 visits per enrollee per year.

- 6.2.13. Nursing care services (See instructions) (Section 2110(a)(15))

- 6.2.14. 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 consistent with the Hyde Amendment (Section 2110(a)(16))

- 6.2.15. Dental services (Section 2110(a)(17))

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

- Diagnostic services
 - 2 oral examinations per year
- Preventive
 - Fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a year up to age 14
 - Dental sealants for permanent molars
 - 2 cleanings per year
- Emergency Services
 - 2 visits during office hours per year
 - 2 visits after office hours per year
- Restorative services
 - Stainless steel crowns
 - Routine fillings (silver or tooth colored)
- Simple extractions
- Radiographs
 - Bitewing x-rays once per year
 - Full mouth x-rays once every three years
- Therapeutic pulpotomy
- Orthodontic Services
 - Children enrolled in CoverKids prior to July 1, 2010, must

- wait 12 months before they can obtain orthodontic benefits.
- Lifetime maximum limit shall not exceed \$1,250 and is not subject to \$1,000 annual benefit limit.

The maximum annual benefit shall not exceed \$1,000 per child per year.

- 6.2.16. Case management services (Section 2110(a)(20))
- 6.2.17. Care coordination services (Section 2110(a)(21))
- 6.2.18. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

Limited to 52 visits per year per type of therapy.

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

Vision Care which includes the following:

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

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

- 6.2.21. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.22. Medical transportation (Section 2110(a)(26))

Ambulance Service – Air and Ground: When medically necessary.

- 6.2.23. Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.24. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

In addition to the services indicated above, the CoverKids benefit package will also include:

- Emergency Care
- Chiropractic Care: Maintenance visits not covered when no additional progress is apparent or expected to occur.
- Routine Health Assessments and Immunizations in accordance with AAP and ACIP recommendations.
- Skilled Nursing Facility Services. Limited to 100 days per calendar year following an approved hospitalization.

Mothers of eligible unborn children who are over age 19 receive all benefits available under the CoverKids program, except for chiropractic services, routine dental services, and vision services.

6.2- BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

6.2.1-BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

- State-developed schedule
- American Academy of Pediatrics/ Bright Futures
- Other Nationally recognized periodicity schedule (please specify: _____)
- Other (please describe: _____)

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, the state should only check off the applicable benefits. It

does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

6.3.1-BH Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

6.3.1.1-BH The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

6.3.1.2-BH The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

The state contracts with its plan administrator in several ways to facilitate the use of validated screening tools. These include providing online resources (also known as the online toolkit) that include clinical practice guidelines for commonly diagnosed behavioral health conditions, including appropriate, validated screening tools for each condition. These online resources are updated at least annually; providers are advised in the program's provider manual to refer to these online resources for the most current information. In addition, the state and its plan administrator partner with the Tennessee Chapter of the American Academy of Pediatrics to provide online, self-paced educational modules for providers that specifically address the use of behavioral health screening tools and related issues (e.g., appropriate codes for reimbursement). These modules offer free CME credit for participants. In addition to these online modules, the state's plan administrator also offers regional large group and provider office-based trainings to train pediatricians and physician extenders on the importance of addressing behavioral health in primary care settings and the use of screening tools.

6.3.2-BH Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

6.3.2.1- BH Psychosocial treatment

Provided for:

- Mental Health
- Substance Use Disorder

Psychosocial treatment is a community-based treatment that promotes recovery, community integration, and improved quality of life for members who have been diagnosed with a behavioral health condition that significantly impairs their ability to lead meaningful lives.

Psychosocial treatment is covered as medically necessary (no limits).

6.3.2.2-BH Tobacco cessation

Provided for:

Substance Use Disorder

Tobacco cessation consists of counseling and products intended to help members discontinue the use of tobacco products, including all indicated FDA-approved medications and nicotine replacement therapy (smoking deterrents).

Tobacco cessation is covered as medically necessary (no limits).

6.3.2.3-BH Medication Assisted Treatment

Provided for:

Substance Use Disorder

6.3.2.3.1-BH Opioid Use Disorder

6.3.2.3.2-BH Alcohol Use Disorder

6.3.2.3.3-BH Other

Medication assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, for treatment of substance use disorders. Covered MAT medications include naltrexone, buprenorphine, and methadone.

Medication assisted treatment is covered as medically necessary (no limits).

6.3.2.4-BH Peer Support

Provided for:

Mental Health

Substance Use Disorder

6.3.2.5-BH Caregiver Support

Provided for:

Mental Health

Substance Use Disorder

6.3.2.6-BH Respite Care

Provided for:

- Mental Health
- Substance Use Disorder

6.3.2.7-BH Intensive in-home services

Provided for:

- Mental Health
- Substance Use Disorder

Intensive in-home services provide frequent and comprehensive support to individuals with a focus on recovery and resilience. Intensive in-home services are provided through a team approach which includes a therapist and care coordinator who work under the direct clinical supervision of a licensed behavioral health professional.

Intensive in-home services are covered as medically necessary (no limits).

6.3.2.8-BH Intensive outpatient

Provided for:

- Mental Health
- Substance Use Disorder

Intensive outpatient services are outpatient treatment services consisting of meetings, classes, and/or counseling for treatment of behavioral health conditions multiple times per week. Intensive outpatient programs provide a minimum of three hours per day of treatment, two to five days per week.

Intensive outpatient services are covered as medically necessary (no limits).

6.3.2.9-BH Psychosocial rehabilitation

Provided for:

- Mental Health
- Substance Use Disorder

6.3.3-BH Day Treatment

Provided for:

- Mental Health
- Substance Use Disorder

6.3.3.1-BH Partial Hospitalization

Provided for:

- Mental Health
- Substance Use Disorder

Partial hospitalization is short-term, intensive treatment for the diagnosis or active treatment of serious behavioral health conditions. Partial hospitalization services include physician services. Partial hospitalization programming typically occurs five to seven days per week for five or more hours per day.

Partial hospitalization is covered as medically necessary (no limits).

6.3.4-BH Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for:

- Mental Health
- Substance Use Disorder

Inpatient services are services delivered by a provider or institution at a 24-hour facility, including those at an inpatient hospital or residential setting.

Inpatient services are covered as medically necessary (no limits).

6.3.4.1-BH Residential Treatment

Provided for:

- Mental Health
- Substance Use Disorder

Residential treatment services include development of an individualized treatment plan, evaluation for medications and prescribing of medications, daily therapeutic activities including group therapy, recreational therapy, individual and family counseling, and grade-appropriate school.

Residential treatment is covered as medically necessary (no limits).

6.3.4.2-BH Detoxification

Provided for:

- Substance Use Disorder

Detoxification consists of admission into a hospital, residential treatment facility, or outpatient program where

the member receives a clinically appropriate detoxification from drugs and/or alcohol.

Detoxification is covered as medically necessary (no limits).

6.3.5-BH Emergency services

Provided for:

- Mental Health
- Substance Use Disorder

Services needed to evaluate or stabilize an emergency medical condition.

Emergency services are covered as medically necessary (no limits).

6.3.5.1-BH Crisis Intervention and Stabilization

Provided for:

- Mental Health
- Substance Use Disorder

6.3.6- BH Continuing care services

Provided for:

- Mental Health
- Substance Use Disorder

6.3.7-BH Care Coordination

Provided for:

- Mental Health
- Substance Use Disorder

6.3.7.1-BH Intensive wraparound

Provided for:

- Mental Health
- Substance Use Disorder

6.3.7.2-BH Care transition services

Provided for:

- Mental Health
- Substance Use Disorder

6.3.8-BH Case Management

Provided for:

- Mental Health
- Substance Use Disorder

6.3.9- BH Other: Applied behavioral analysis (ABA)

Provided for:

- Mental Health
- Substance Use Disorder

ABA is a widely used strategy for addressing behavior problems among individuals with certain disorders, which considers antecedents (environmental factors that appear to trigger unwanted behavior), the behaviors themselves, and consequences that either increase or decrease future occurrences of that behavior.

ABA is covered as medically necessary (no limits).

6.4- BH Assessment Tools

6.4.1-BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

- ASAM Criteria (American Society Addiction Medicine)
 - Mental Health
 - Substance Use Disorders
- InterQual
 - Mental Health
 - Substance Use Disorders
- MCG Care Guidelines
 - Mental Health
 - Substance Use Disorders
- CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
 - Mental Health
 - Substance Use Disorders
- CASII (Child and Adolescent Service Intensity Instrument)
 - Mental Health
 - Substance Use Disorders
- CANS (Child and Adolescent Needs and Strengths)
 - Mental Health
 - Substance Use Disorders
- State-specific criteria (e.g. state law or policies) (please describe)
 - Mental Health
 - Substance Use Disorders

- Plan-specific criteria (please describe)
 - Mental Health
 - Substance Use Disorders

The state's plan administrator develops medical policies to supplement MCG guidelines for specific treatment modalities or care not sufficiently addressed by MCG.

- Other (please describe)
 - Mental Health
 - Substance Use Disorders

- No specific criteria or tools are required
 - Mental Health
 - Substance Use Disorders

6.4.2-BH Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

The state partners with its plan administrator in several ways to facilitate the use of validated assessment tools. These include providing online resources (also known as the online toolkit) that include clinical practice guidelines for commonly diagnosed behavioral health conditions with examples of appropriate assessment tools. These online resources are updated at least annually; providers are advised in the program's provider manual to refer to these online resources for the most current information. In addition, the state and its contracted plan administrator conduct annual treatment record audits for a sample of providers. The evaluation tool used during these audits specifically addresses the use of appropriate assessment tools. If a deficit is identified in this area, the provider in question is placed on a corrective action plan and re-audited after six months of operation under the corrective action plan.

6.2.5-BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

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: _____)
- Other (Describe: _____)

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

- Yes
- No

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

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.

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))

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.

Tennessee classifies covered benefits according to the following standards:

Classification	Description
Inpatient	All covered services delivered by a provider or institution at a 24-hour facility, including those at an inpatient hospital, residential, and/or SNF setting with a corresponding place of service code
Outpatient	All covered services delivered at an outpatient office, clinic, or community setting with a corresponding place of service code
Emergency	All covered services or items delivered in an emergency department with a corresponding place of service code
Prescription Drugs	Covered medications and drugs requiring a prescription

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).

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.

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

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

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.

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

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.

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

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

Yes

No

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))

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

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))

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.

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

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.

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 Administrative Services Organization (ASO) contracted with the state.

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 Administrative Services Organization (ASO) contracted with the state.

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

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

6.3.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to

provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

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

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

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

Effective January 1, 2012, concurrent with the change from a full-risk (Preferred Provider Organization) to a Fee-for-Service/Administrative Service Only (FFS/ASO) model, CoverKids will no longer provide an Alternative Delivery System to children and pregnant women.

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

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

Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

- 6.4.2. Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)
- 6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))
 - 6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))
 - 6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

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

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

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

Effective January 1, 2010, CoverKids has engaged an External Quality Review Organization (EQRO) to conduct a range of quality assurance activities. However, this step has been taken to promote quality outcomes in the program in general and not specifically in relation to oversight of a Managed Care Organization (MCO) as required in CHIPRA because CoverKids does not use an MCO model.

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

7.1.1. Quality standards

7.1.2. Performance measurement

The State ensures quality through contracted performance measures.

7.1.3. Information strategies

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

7.1.4. Quality improvement strategies

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

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

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

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

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

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

The geographic access standard for children's primary care practitioners (pediatricians, general medicine and family practice physicians), at a minimum, will be a physician within 30 miles in rural area and 20 miles in urban area. The standard for acute care hospitals will be at least 1 facility within 30 miles. The standard for specialists assures that enrollees will, at a minimum, have access to a children's hospital where they may access specialty care. The CoverKids program will meet all geographic access standards for children's coverage within the new TennCare Select network.

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

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

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

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

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

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

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

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

8.1.1. YES

8.1.2. NO, skip to question 8.8.

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

8.2.1. Premiums: None

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments: Children will be subject to copayments for most services provided under the plan; however, no copayments will be charged for well-child visits, immunizations, or lab and x-ray services. There is also no copayment for ambulance services when deemed medically necessary by the health plan. For children in families with income at or below 200 percent of the FPL, co-payments will not exceed \$5.00, except the copayment for non-emergency use of the emergency room will be \$10. Copayments for children in families with income above 200 percent of the FPL will vary by service. Children receiving hospice services and pregnant enrollees are exempt from all copay requirements. Attachment A details the copayments for each income group.

At State discretion, cost sharing may be temporarily waived for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or Federally declared disaster area. In the event of a disaster, the State will notify CMS of its intent to provide temporary adjustments to cost sharing policies.

8.2.4. Other: None

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

Families of applicants and enrollees, providers, and the public will be informed of the cost-sharing requirements (including the cumulative maximum) in the CoverKids application and enrollment materials. Copayments are listed in the benefits booklet. Outreach workers and administrative staff who answer phone inquiries are trained to discuss with families the co-payments required and the annual out-of-pocket limit. The CoverKids eligibility and enrollment AC will notify the health plan of the families' annual income within the enrollment eligibility file. The health plan will determine the dollar amount of their out-of-pocket limit based on 5% of their annual income and include this information in the enrollees Explanation of Benefit correspondence. The health plan will electronically accumulate the money spent (including dental services) for cost sharing for eligible children in a family and notify the family via a letter when the dollar amount is met. The health plan's electronic claims system will annotate the child's file to notify providers that no further cost sharing is required.

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

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

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

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

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

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

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

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

of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

Yes (Specify)

The State applies financial requirements (copays) to mental health and SUD benefits in the inpatient and outpatient benefit classifications.

No

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

Yes

No

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))

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

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))

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

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

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

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

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

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

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

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

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

- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
- In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

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

- 8.8.1. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2. No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)
- 8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above).
(Section 2105)(c)(7)(A)) (42CFR 457.475)

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

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

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

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

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

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

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

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

Performance Goals:

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

Measure: Percentage of eligible children enrolled.

- 1B. Decrease the number of low-income ($\leq 250\%$ FPL) children who are uninsured by 1% each year.

Measure: Percentage of uninsured low-income children based on CPS three-year average.

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

Performance Goals:

- 2A. Outreach/marketing will have a visible campaign to repeatedly inform and educate families.

Measure: Percent of eligible children enrolled by outreach strategy.

- 2B. Outreach/marketing will target ethnic and rural populations identified as historically underserved.

Measure: Number of persons contacted by media and events for ethnic and rural populations.

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

Performance Goals:

- 3A. Increase the percentage of children with a regular source of care.

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

- 3B. Decrease the percentage of children who use the emergency room.

Measure: Percent of enrollees whose families report that their children have used a hospital emergency room since enrollment in CoverKids as compared to before enrollment.

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

Performance Goals:

- 4A. Increase preventative care for children.

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

- 4B. Increase appropriate care for children with asthma and children with diabetes.

Measures: 1) Percent of enrollees ages 5 – 17 with persistent asthma who were prescribed appropriate medications for long-term control of asthma. 2) Number of primary care visits for children with asthma. 3) Emergency room visits for children with asthma. 4) Hospitalizations for

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

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:

(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

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

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

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

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

- 9.3.6. Other child appropriate measurement set. List or describe the set used.

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

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

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

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

- 9.3.7.1. Immunizations
9.3.7.2. Well 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, please list:

- 9.3.8. Performance measures for special targeted populations.

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

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

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

- 9.6.** The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)
- 9.7.** The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))
- 9.8.** The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)
- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1132 (relating to periods within which claims must be filed)
- 9.9.** Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

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

- Vanderbilt Children's Hospital - CEO, administrators, and hospitalists - 7/20
- Nashville area community pediatric providers - 7/20
- T.C. Thompson Children's Hospital (Chattanooga) - CEO, administrators, and hospitalists - 7/25
- Chattanooga area community pediatric providers - 7/25
- East Tennessee Children's Hospital (Knoxville) - CEO, administrators, and hospitalists - 7/26
- Knoxville area community pediatric providers - 7/26
- LeBonheur Children's Hospital (Memphis) - CEO, administrators, and hospitalists - 7/28
- Memphis area community pediatric providers - 7/28

- Governor's Office of Children's Care Coordination Steering Committee (advocacy groups) - 8/5
- TN Commission on Children and Youth - convening of children's advocacy groups - 8/25

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

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

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

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

Public notice of the change in eligibility rules (Amendment #7) was provided by publishing Emergency Public Necessity Rules in accordance with State law. The Emergency Public Necessity Rules were published on October 12, 2009.

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

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

CHIP Budget

STATE: Tennessee Federal Fiscal Year 2018	Current Budget	With SPA 18-0016
State's enhanced FMAP rate	99.07%	99.07%
Benefit Costs		
Insurance payments	16,965,297	16,965,297
Managed care	54,000,000	54,000,000
Fee for Service	141,626,969	141,656,969
Total Benefit Costs	212,592,266	212,622,266
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs	212,592,266	212,622,266
Administration Costs		
Personnel	0	0
General administration	57,478	57,478
Contractors/Brokers (e.g., enrollment contractors)	316,953	316,953
Administrative Services	10,795,114	10,795,114
Outreach/marketing costs	50,000	50,000
Other (e.g., indirect costs)	9,611,982	9,611,982
Health Services Initiatives		
Total Administration Costs	20,831,527	20,831,527
10% Administrative Cap	23,621,363	23,624,696
Federal Title XXI Share	231,252,952	231,282,673
State Share	2,170,841	2,171,120
Total Costs of Approved CHIP Plan	233,423,793	233,453,793

The Source of State Share Funds: The State share funds come from revenue generated by the State and are appropriated through the budgeting process. None of the State share of the funds are provided by the enrollees.

Section 10. Annual Reports and Evaluations (Section 2108)

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

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

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

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

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

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

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

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

11.2.1. 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. Section 1124 (relating to disclosure of ownership and related information)

11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. Section 1128A (relating to civil monetary penalties)

11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

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

12.1. Eligibility and Enrollment Matters

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

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

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

Reviews of general eligibility and enrollment matters will be completed within a 90-day timeframe. Expedited reviews will be completed within 10 days from the initial receipt of the request for review. The appropriate notices will be issued

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

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

12.2. Health Services Matters

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

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

After the insurer's internal review is completed, the parent of an enrollee who disagrees with the decision may request further review by submitting a letter or form to Benefits Administration. The Appeals Coordinator within Benefits Administration will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator may also request review by the by state's independent medical consultant. Reviews generally are completed within 16 days and the member will be notified in writing of the decision. It is anticipated that most appeals will be resolved either through the insurer's internal process or at this level.

If the appeal is not resolved, the request will be scheduled for impartial review by the CoverKids Review Committee. The Committee will meet once per month

to consider any appeals and will be composed of five members, including Benefits Administration staff and at least one licensed medical professional, selected by the Commissioner or his designee. The parent will be given the opportunity to review the file, provide supplemental information and appear in person. The parent will receive written notification of the final decision, normally within one week from the date of the Committee meeting. The decision of the CoverKids Review Committee is the final recourse available to the member.

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

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

12.3. Premium Assistance Programs

If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Attachment A – CoverKids Cost Sharing

Benefit	Family Income Less Than 200% FPL	Family Income Between 200% and 250% FPL
Annual Deductible	None	
Preexisting Condition Requirement	None	
Physician Office Visit	\$5 copay (primary care physician or specialist)	\$15 copay (primary care physician); \$20 copay (specialist)
Inpatient Care	\$5 per admission (waived if readmitted within 48 hours for same episode)	\$100 per admission (waived if readmitted within 48 hours for same episode)
Prescription Drug Copay	\$1 generic; \$3 preferred brand; \$5 non-preferred brand	\$5 generic; \$20 preferred brand; \$40 non-preferred brand
Maternity	No copay for prenatal visits or for hospital admission for the birth of a child	No copay for prenatal visits or for hospital admission for the birth of a child
Routine Health Assessment and Immunizations	No copays for services rendered under American Academy of Pediatrics guidelines	
Emergency Room	\$10 copay per use for non-emergency	\$50 copay per use for non-emergency
Chiropractic Care	\$5 copay (maintenance visits not covered when no additional progress is apparent or expected to occur)	\$15 copay (maintenance visits not covered when no additional progress is apparent or expected to occur)
Ambulance Service (air and ground)	No copay (100% of reasonable charges when deemed medically necessary by claims administrator)	
Lab and X-ray	No copay - 100% benefit	
Physical, Speech and Occupational Therapy	\$5 copay per visit (limit of 52 visits per year per type of therapy)	\$15 copay per visit (limit of 52 visits per year per type of therapy)
Inpatient Mental Health Treatment	\$5 copay per admission (waived if readmitted within 48 hours for same episode)	\$100 copay per admission (waived if readmitted within 48 hours for same episode)
Inpatient Substance Abuse Treatment	\$5 copay per admission (waived if readmitted within 48 hours for same episode)	\$100 copay per admission (waived if readmitted within 48 hours for same episode)
Outpatient Mental Health and Substance Treatment	\$5 copay per session	\$15 copay per session
Dental	\$5 copay per visit; no copay for routine preventive oral exam, x-rays, cleaning and fluoride application)	\$15 copay per visit; no copay for routine preventive oral exam, x-rays, cleaning and fluoride application
<ul style="list-style-type: none"> Annual Benefit Maximum Per Child 	\$1,000	

Attachment A – CoverKids Cost Sharing - continued

Benefit	Family Income Less Than 200% FPL	Family Income Between 200% and 250% FPL
Orthodontic Services (as of July 1, 2010) <ul style="list-style-type: none"> • 12-month waiting period* 	\$5 copay	\$15 copay
<ul style="list-style-type: none"> • Lifetime Maximum Per Child** 	\$1,250	
Vision Care	\$5 copay for prescription lenses and frames OR contact lenses; no copay for preventive annual exam and glaucoma testing	\$15 copay for prescription lenses and frames OR contact lenses; no copay for preventive annual exam and glaucoma testing
Annual Out-of-Pocket Maximums	5% of annual family income	

*There is a 12-month waiting period before orthodontic benefits are paid.

**The lifetime orthodontics maximum limit does not apply to the family annual out-of-pocket maximum.