OMB #: 0938-0707
Exp. Date:

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

Preamble

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

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

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

Form CMS-R-211

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

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

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

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

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

Patricia Wilson-Coker, Commissioner, CT. Department of Social Services, April 30, 2003

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: David Parrella	Position/Title: Director, Medical Care Administration
Name: Rose Ciarcia	Position/Title: Director, HUSKY Programs
Name: Lee Voghel	Position/Title: Director, Fiscal Analysis

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 *as of 10/1/02* **(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 *through 9/30/02. Effective 10/1/02, the Medicaid expansion was phased out.*

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))**

The state will not claim expenditures for child health assistance prior to the time that the state has legislative authority to operate the state plan amendments as approved by CMS.

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)**

The state complies with all applicable civil rights requirements, including but not necessarily limited to, Title VI of the Civil Rights Act of 1964, Title II of the American with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR ~~P~~part~~s~~ 80,part 84, and part 91, and 28 CFR part 35.

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)**:

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

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

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

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

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

Amendment #5: Pre-paid Inpatient Health Plan
Date Submitted:
Date Approved:
Date Effective: January 1, 2008

Amendment #6: Newborn Premium Waiver
Date Submitted:
Date Approved:
Date Effective: January 1, 2008

Amendment #7: Pharmacy Carve-out
Date Submitted:
Date Approved:
Date Effective: February 1, 2008

Amendment #8: Expedited Newborn Application Processing
Date Submitted:
Date Approved:
Date Effective: June 11, 2008

Amendment #9: Dental Carve-out
Date Submitted:
Date Approved:
Date Effective: July 1, 2008

Amendment #9: Pre-paid Inpatient Health Plan rollback to Managed Care
Date Submitted:
Date Approved:
Date Effective: July 1, 2008

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

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

The state can measure the number of children with creditable health coverage to the extent that they are enrolled in either the HUSKY A or HUSKY B program. Since the start of the HUSKY program and combined HUSKY A and B marketing in July 1998 an additional 51,090 children enrolled in the Medicaid program resulting in their access to creditable health coverage. The increased Medicaid enrollment in addition to the 13,086 HUSKY B members means that an additional 51,090 children now have creditable health coverage in comparison to July 1998.
Please see Appendix 2.1 for a breakdown of HUSKY A (Medicaid & MCHIP) and HUSKY B (SCHIP) enrollment by race and ethnicity; a breakdown of HUSKY A and HUSKY B enrollments by county; and HUSKY B enrollment by income band. Please note that we do not have HUSKY A enrollment data broken out by income. The income limit for HUSKY A is 185% of the FPL.

The state currently does not have public-private partnerships.

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):

*The state currently conducts outreach activities through its contracts with FQHCs and disproportionate share hospitals that assist applicants in completing the application. (**See Section 5.**)*

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:

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

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 HUSKY Plus Physical supplemental plan shares the same steering committee and one of the two Centers for Children with Special Health Care Needs with Title V. Title V refers potential applicants who do not qualify for its program to HUSKY B and HUSKY Plus Physical.* ***(See Appendix 3.1.)***

- *HUSKY B MCOs are required to contract with school-based health clinics.*

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

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))**

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

For children with family income over 185% FPL (Part B of the HUSKY Plan), the state contracts with managed care organizations (MCOs) to administer medical ~~and dental~~ benefits and a behavioral health Administrative Services Organization (ASO) to administer behavioral health services. Effective 2/1/08, ~~.~~pharmacy services are provided through the Department's Medicaid network. Effective 7/1/08, dental services will be provided by an ASO. The state selects ~~MCOsthe~~ MCOs and ~~the~~ ASOs through a competitive bidding process. The state issues an RFP that establishes operational and financial requirements and requires bidders to provide evidence of their ability to meet the requirements. The requirements include but are not limited to: access to care, provider network, member services, utilization management, claims processing, and quality assurance. The state awards the right to negotiate a contract based on a fair evaluation of all proposals submitted in response to the RFP. This method includes evaluation of the following factors: provider network for each service area, efficiency of operation, ability to provide the required services, quality management, ability to perform the necessary administrative tasks, financial viability, and price. The ASO Contracts do~~es~~ not include financial requirements because the ASOs ~~is~~are not capitated and bear~~s~~ no risk.

During the period 1/1/08 through 6/30/08, the state changed its contractual relationship with the existing at-risk MCOs to non-risk pre-paid inpatient health plans (PIHPs). The state returns to at-risk MCO contracts effective 7/1/08.

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

The CCMC's Center for Children with Special HealthCare Needs contracts with a network of providers for the provision of Title V and HUSKY Plus Physical medical services. Care coordination and referrals to medical services are the responsibility of the Center's staff. Reimbursement claims for medical services are billed to and processed by CCMC.

See Appendix 3.1 for additional information on the HUSKY Plus Physical Program.

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))**

As with HUSKY A, the Medicaid definition of medical necessity will prevail for HUSKY B. "Medical Necessity" or " Medically Necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring. Prior authorization decisions are based on the Medicaid definition of medical necessity and medical appropriateness. The state includes a definition of medical necessity and utilization management requirements in the RFP and the contracts with the MCOs and ASOs . The MCOs and ASOs are required to have written utilization management policies and procedures that include the appropriateness criteria for authorization and denial of payment and protocols for prior approval, hospital discharge planning, and retrospective review.

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

Section 4. Eligibility Standards and Methodology. (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: *Statewide*

4.1.2. ☒ Age: *Individuals must be under 19 years of age.*

4.1.3. ☒ Income: *In order to receive a state subsidy under Part B, family income may not exceed 300 percent of the FPL. However, the state will apply the income disregards shown in Appendix 4.1.3. Families with income greater than 300 percent of the FPL may purchase coverage without state subsidy.*

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources): *No asset limit.*

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): *To be eligible for the HUSKY Plan, Part B, a child must be a resident of the State of Connecticut.*

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

4.1.7. ☒ Access to or coverage under other health coverage: *Children who are eligible for Medicaid or covered under a group health plan or under health insurance coverage, and children of any state or municipal employee eligible for employer-sponsored insurance are not eligible for the HUSKY Plan, Part B. However, children of municipal employees are allowed to be eligible for HUSKY Plan, Part B "if dependent coverage was terminated due to extreme economic hardship on the part of the employee" (pursuant to section 18 of Connecticut Public Act 99-279). For other children, an application may be disapproved if it is determined that the child was covered by employer-sponsored insurance within the last two months (this may be extended to 12 months if the commissioner determines that two months is insufficient to deter applicants or employers from discontinuing employer-sponsored dependent coverage). However, an application may be approved if the reason for loss of employer-sponsored insurance is unrelated to the availability of the HUSKY Plan, Part B or otherwise exempt under section 11 of Public Act 97-1 of the October 29, 1997 Special Session. The authorizing legislation (see Appendix 4.1.3) identifies ten reasons that are unrelated to the availability of the HUSKY Plan.*

4.1.8. ☒ Duration of eligibility: *A child who has been determined eligible for the HUSKY B program shall remain eligible for as long as all eligibility criteria are met. Eligibility for HUSKY B is reviewed annually. The renewal period is scheduled to coincide with the yearly anniversary of the initial eligibility determination. Renewal forms are sent during the tenth month of eligibility to allow time for the family to complete and return the form in time for the renewal to be processed before the expiration of the 12th eligible month.*

4.1.9. ☒ Other standards (identify and describe): *The applicant's social security number is required; however verification of the social security number is not required unless the social security number is deemed questionable.*

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 contracts with an entity to be a single point of entry servicer (SPES) for applicants and enrollees under Parts A and B of the HUSKY Plan. The SPES is responsible for making a preliminary determination of eligibility under Part A and a final determination of eligibility under Part B and enrolling eligible children under Parts A and B into an MCO. Eligibility is determined based on information collected on the application form, which includes name, address, date of birth, social security number, residency, family income, employment, and insurance (both current and in the previous two months). The SPES verifies address and income and whether the child is a Medicaid beneficiary. In addition, if an applicant is employed, the SPES contacts the employer for a random sample of cases (10%) for information about employer-sponsored insurance coverage. With the exception of step-parent income, income is calculated in the same manner as for poverty level children under Medicaid with the income disregards provided in section 15 of Public Act 97-1 of the October 29, 1997 Special Session or as may be amended. As described in 4.4.1 (below), as part of the eligibility process, the SPES determines whether a child may be eligible for Medicaid and, if so, sends the application and supporting documents to the Department of Social Services for final eligibility determination. Also, if a child has insurance coverage, he/she will not be enrolled in HUSKY B.

Individuals are able to initiate the application in person or by mail. The SPES uses a simplified mail-in application process. If information is incomplete, the SPES contacts the applicant (by mail or phone) to obtain missing information. If the SPES determines that a child is eligible for HUSKY B, the SPES provides information about participating MCOs. The SPES helps the family select an MCO, and then refers the child to the MCO chosen by the family. If enrolled under HUSKY B, the SPES also provides information about HUSKY Plus Physical. The SPES sends daily rosters of enrollees to the MCOs. The SPES provides choice counseling and enrollment for the HUSKY Program.Effective 6/11/08, families with a newborn child are able to initiate the application process for the newborn at a Connecticut or border hospital. The hospital will fax the application, enrollment form, and other supporting documents to the SPES for eligibility to be determined within one business day of receipt.

Not more than 12 months after determination and annually thereafter, the SPES shall make a preliminary determination under HUSKY A and re-determine eligibility for HUSKY B. The SPES shall mail a form to each HUSKY B family to obtain information to make the eligibility determination. Also, as noted in 4.1.8, applicants will be required to notify the SPES of any change in circumstance that could affect continued eligibility for coverage e.g., attaining age 19, moving out of state, change in income, or having obtained other insurance). If the child is no longer eligible, he/she will be disenrolled from HUSKY B.

Enrollees will be able to change enrollment during an annual, open enrollment period, which will occur at the time of redetermination of eligibility.

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 access to a state health benefits plan) are furnished child health assistance under the state child health

plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

In accordance with Sections 2102(b)(3)(A) and 2110(b)(2)(B) and 42 CFR 457.310(b), 457.350(a)(1) and 457.80(c)(3) the State will screen HUSKY applications through the SPES. Eligibility Specialists at the SPES are trained in the Medicaid (HUSKY A) gross income limits, and applied income limits considering concepts such as, but not limited to, income disregards, and excluded income to ensure that Medicaid children who apply for HUSKY are properly identified and referred to DSS to be granted Medicaid. HUSKY applicants will also be screened by the SPES for potential Medicaid eligibility under spend-down if family income exceeds 185% of the Federal Poverty Level and unpaid medical bills for the family exist sufficient to meet the spend-down. If the family has sufficient medical bills to be eligible for Medicaid under spend-down, the SPES will refer the application to DSS for Medicaid processing. The SPES will retain all other HUSKY applications and process eligibility for HUSKY B (Title XXI). Conversely, if a family contacts DSS first to apply for HUSKY, DSS staff will screen for Medicaid eligibility as they currently do. If the child is not Medicaid eligible, including being eligible for Medicaid as a spend-down, DSS staff will refer the application to the SPES for potential processing for HUSKY B (Title XXI). DSS staff is trained in the HUSKY B (Title XXI) requirements so they can properly identify such applications.

On July 1, 2006 DSS implemented Self-Declaration of income for both HUSKY A and HUSKY B application and renewal processing. Eligibility workers at DSS and the SPES now utilize the Bendex, Social Security Income (SDX), Department of Labor (DOL) and Unemployment Compensation Benefit (UCB) files to check the income information stated on the application/renewal form. If the income on the application/renewal form is reasonable, then the eligibility worker will continue to process the application/renewal form. If the Eligibility Worker has reason to believe that such information is inaccurate or incomplete then the worker will call the client for clarification. If the client is unable to clarify the information, the Eligibility Worker may require verification in order to proceed with processing the application/renewal form. The same screen and refer or screen and enroll process as identified above for a new application is also used at the time of annual renewal.

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))**

As noted in 4.4.1, if the SPES makes a preliminary determination that a child is eligible for Medicaid, the SPES sends the application and supporting documents to the Department of Social Services for final determination of eligibility.

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

Applications for children who are determined to be ineligible for Medicaid, due to income, at time of application or renewal are referred to the SPES by DSS staff for HUSKY B eligibility processing. (See Section 4.4.1 above.) Additionally, Medicaid discontinuance notices include a reminder to families so that families may follow-up directly with the SPES to enroll their children in SCHIP. Connecticut and border hospitals are partnering to identify uninsured newborns. Hospitals will assist families to complete the HUSKY application and fax them to the SPES for expedited eligibility processing. A family with a newborn who appears eligible for HUSKY B will be granted coverage within one business day of receipt of the application.

Newborns with family income over 235% FPL will not be required to pay premiums for the first 4 months of coverage.

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.

A two-month crowd-out period is used to discourage families from dropping employer-sponsored insurance for the purposes of qualifying for HUSKY B. The SPES tracks the number of application denials for children whose coverage was dropped within two months from the application date.

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 answer to 4.4.4.1.

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.

See answer to 4.4.4.1.

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))**

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

The Department will continue to meet with the tribes on an annual basis or more often if necessary to discuss programmatic changes to HUSKY and to consider the issues or concerns of the tribal members. The Department also provides supplies of HUSKY informational materials and applications for distribution to tribal members. HUSKY information has also been available to tribal members via media (Public Service Announcements, T.V. and radio ads and ads in local newspapers) and other outreach efforts.

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 Department of Social Services, in partnership with statewide, regional and local health and social service organizations, within available appropriations, regularly conducts public outreach and education to reach families of children likely to be eligible for the HUSKY Plan.

The Department's HUSKY Outreach program includes:

- *Funding HUSKY InfoLine (HIL) – HIL operates a toll free information and referral service for HUSKY applicants and individuals needing information about HUSKY. HIL care coordinators instruct callers on how to apply for HUSKY, provide over the phone application assistance and follow-up to ensure that application process was completed;*

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

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

- *MCO community- based outreach – HUSKY participating plans provide information and application assistance at various community events including school health promotional fairs; craft shows; country fairs, etc;*

- *Collaboration with Child Support Services;*

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

identify enrollment and renewal barriers. Statewide initiatives include the -coordination and provision of outreach through established groups such as schools, child care providers, pediatric care providers, the business community, and social service providers; and

- *HUSKY (www.huskyhealth.com) website featuring downloadable application.*

Multi-level campaign

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

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

Please note that the HUSKY Part B benefits combine the most generous benefits offered at the inception of the HUSKY, Part B plan under three state employee options available in 1998 (Blue Cross, MD Health Plan, and

*Kaiser Permanente), in addition to covered services mandated by the Federal SCHIP regulations. In addition, HUSKY B benefits also include the HUSKY Plus Physical benefit package for Children with Special Health Care Needs, which is not available to state employees. (**See Appendices 3.1 and 6.1**).*

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

100% except for the following conditions:

Mental retardation;
Learning, motor skills, communication and caffeine-related disorders;
Relational problems;
Other conditions that may be the focus of clinical attention that are not defined as mental disorders by the American Psychiatric Association in its "Diagnostic & Statistical Manual of Mental Disorders."

For these above stated conditions, the following applies:

Inpatient hospital benefits will be available for conversion to outpatient services. Up to 35 days may be converted; 25 days will remain as a hospital reserve (they will not be available for conversion). The conversion will be available according to the following schedule:

1 inpatient hospital day = 1 sub-acute day
1 inpatient hospital day = 2 partial hospitalization services
1 inpatient hospital day = 2 intensive outpatient visits
1 inpatient hospital day – 3 outpatient visits
Maximum of 60 days per year.

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

Includes emergency mobile psychiatric and home-based psychiatric services.

100% except for the following conditions:
Mental retardation;
Learning, motor skills, communication and caffeine-related disorders;
Relational problems;
Other conditions that may be the focus of clinical attention that are not defined as mental disorders by the American Psychiatric Association in its "Diagnostic & Statistical Manual of Mental Disorders."

For these above stated conditions, the following applies:
Maximum of 30 visits per year (in addition to allowable substitution of inpatient days)-

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

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

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

6.2.15. ☒ Nursing care services (See instructions) (**Section 2110(a)(15))**

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. ☒ Dental services (**Section 2110(a)(17))**

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

100% except for the following conditions:
Mental retardation;
Learning, motor skills, communication and caffeine-related disorders;
Relational problems;
Other conditions that may be the focus of clinical attention that are not dDefined as mental disorders by the American Psychiatric Association in its "Diagnostic & Statistical Manual of Mental Disorders."
For these above stated conditions, the following applies:
Maximum of 60 days per calendar year for drug abuse and 45 days per yYear for alcohol abuse.

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

100% except for the following conditions:
Mental retardation;
Learning, motor skills, communication and caffeine-related disorders;
Relational problems;
Other conditions that may be the focus of clinical attention that are not defined as mental disorders by the American Psychiatric Association in its "Diagnostic & Statistical Manual of Mental Disorders."
For these above stated conditions, the following applies:
Maximum of 60 visits per year with supplemental coverage available.

6.2.20. ☒ Case management services (**Section 2110(a)(20))**

Case management will be available through HUSKY Plus Physical. (See Appendix 3.1 for additional information on HUSKY Plus Physical.

6.2.21. ☒ Care coordination services (**Section 2110(a)(21))**

Care coordination will be available through HUSKY Plus Physical.- (See Appendix 3.1 for additional information on HUSKY Plus Physical.)

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

Long-term coverage will be available through HUSKY Plus. (See Appendix 3.1 for additional information on HUSKY Plus Physical.)

6.2.23. ☒ Hospice care (**Section 2110(a)(23))**

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

Services of nurse midwives, nurse practitioners, podiatrists, chiropractors, and naturopaths will be covered.

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

6.2.26. ☒ Medical transportation (**Section 2110(a)(26))**

Transportation by ambulance will be covered but non-emergency transportation will not. Limited non-emergency transportation will be covered by HUSKY Plus Physical. (See Appendix 3.1 for information on HUSKY Plus Physical.)

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) (**Section 2110(a)(27))**

Translation and outreach services will be available through the ASOs, MCOs and HUSKY Plus. All printed materials must be in English and Spanish and any other languages if more than five percent of the ASO or MCO's enrollees speak the alternative language. Tthe ASOs, MCOs and HUSKY Plus Physical programs must provide translation services. (See Appendix 3.1 for information on HUSKY Plus Physical.)

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

See Appendices 3.1 and 6.1: HUSKY Plus Physical Benefits and HUSKY Part B Benefits

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

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

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

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

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

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

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

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

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

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

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

6.4.2.3. The state assures that the coverage for the family otherwise meet 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))**

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

The MCO contracts include specific standards for quality of care, including the provision of well-baby care, well-child care, and immunizations. MCOs are required to arrange for immunizations and comprehensive screens (and any needed interperiodic screens) in accordance with the schedules recommended by the American Academy of Pediatrics. As described below, MCOs are required to submit semi-annual reports on well-baby care, childcare visits and immunizations. The state has a statewide immunization registry (Connecticut Immunization Registry and Tracking System), and the MCOs are required to report to that registry and use that information to complete their immunization reports to DSS.

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

MCOs and the ASOs are required to meet all standards for quality of care as specified in their contracts with the state. In addition, each MCO must be licensed by the state as a Health Maintenance Organization (HMO) or operate as a Managed Care Organization based on Federally Qualified Health Centers and certified by the Department to participate in the Medicaid Managed Care Program. As an HMO, the MCOs must comply with the managed care bill of 1997, which contains various quality/consumer protection requirements (See Appendix 7.1 for a summary of this bill). The ASOs must be licensed by the State Department of Insurance (DOI) to operate as a utilization review company. The State Department of Insurance (DOI) continuously monitors quality through various mechanisms, including reporting, external reviews, and onsite reviews.

Reporting will include a report on the MCO's and ASO's quality assurance plans (QAP), as required by the Managed Care Bill (Appendix 7.1), which includes information on complaints, prior authorization denials, utilization review (UR) denials, and all data required for HEDIS (or equivalent data for non-NCQA accredited plans). Under the managed care bill, if a plan is NCQA accredited for at least one year, it only needs to submit proof of accreditation and HEDIS. However, DSS requires NCQA accredited plans to submit a report on their QAPs, which must comply with Section 7.1.4. In addition, DSS requires semi-annual reports on compliance with the well-child periodicity schedule and on immunizations, similar to the reports currently prepared by Medicaid MCOs and quarterly provider network reports. The functions of the external quality review organization are described in 7.1.1 In addition, the state conducts periodic onsite reviews to determine ongoing compliance with contract requirements.

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

The state contracts for an external quality review of the HUSKY Plan, Part B. The review includes, but is not limited to, an evaluation of access to care, a satisfaction survey, medical record standards, provider credentialing, and individual care review (see 7.1.3)

7.1.2. ☒ Performance measurement

The state requires MCOs and the ASOs to submit HEDIS reporting measures or equivalent data (which is likely to be HEDIS or a modified version of HEDIS) and semi-annual reports on immunizations and compliance with the well-child periodicity schedule. In addition, as noted in Section 9.7, the state will comply with any national quality measures.

7.1.3. ☒ Information strategies

Both the SPES and the MCOs are required to educate enrollees about their benefits, rights and responsibilities under the HUSKY Plan, Parts A and B, including HUSKY Plus. The MCOs and ASOs also educate enrollees about the importance of preventive services, health promotion activities, and visiting their primary care provider instead of an emergency room.

7.1.4. ☒ Quality improvement strategies

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

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

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))**

The state requires MCOs to submit semi-annual reports on immunizations, and compliance with the well-child periodicity schedule.

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

MCOs are required to ensure that their provider networks provide access to primary care providers (PCPs) within 15 miles of its members' towns of residence. MCOs and ASOs must ensure ~~and~~ access to emergency services on a 24-hour, seven day-a-week basis. Emergency cases must be seen immediately, urgent cases within 48 hours and routine cases within 10 days. An emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant

woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions or serious dysfunction of any body organ or part. The state monitors access requirements through reporting and member satisfaction surveys. For behavioral health services, the ASO will rely on the Connecticut Medical Assistance Program (CMAP) provider network to assure access to covered services.

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 state requires each MCO to contract with a sufficient number and mix of specialists so that the Member population's anticipated specialty care needs can be substantially met within the MCO's network of providers. The MCO is required to have a system to refer Members to out-of-network specialists if appropriate participating specialists are not available. The MCO will make specialist referrals available to its Members when it is medically necessary and medically appropriate and will assume all financial responsibility for such referrals whether they are in-network or out-of-network. The MCO must have policies and written procedures for the coordination of care and the arrangement, tracking and documentation of all referrals to specialty providers.

Behavioral health and dental services are provided through the Department's Medicaid network. HUSKY B members have access to all of the same providers as Medicaid recipients. The behavioral health ~~ASO~~and dental ASOs manage~~s~~ the Department's network, but do~~es~~ not contract with network providers. Dental and Behavioral health claims are processed by the Department's Medicaid management information system.

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

For Members enrolled in HUSKY Plus Physical, the MCO is required to coordinate the specialty care services and specialty provider referral process with the HUSKY Plus Physical program~~s~~ to ensure access to care (See Appendix 3.1).

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

Prior authorization of services covered in the HUSKY, Part B benefit package shall be determined by the MCO or the ASO based on individual care plans, medical necessity and medical appropriateness and in accordance with state law. However, the following services in the benefit package shall not require prior authorization:

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

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

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

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

(3) Emergency ambulance services or emergency care.

Section 8. Cost Sharing and Payment (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, *with the exception of low-income children in the state who are American Indians and Alaska Natives (AI/NA) who are members of a federally recognized tribe. (As defined in section 4 (c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). These AI/NA children will be exempt from any cost sharing (e.g., copayments and premiums).*

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:

Effective February 1, 2004, children with family income up to 235 percent of the FPL will not be required to pay a premium. Children with family income that exceeds 235 percent of the FPL but which does not exceed 300 percent of the FPL will be required to pay a premium of $30.00 per child per month, up to a maximum of $50.00 per family per month. Children with family income over 300 percent of the FPL will be required to contribute the entire premium. Effective October 1, 2007, newborns with family income over 235% FPL will not be required to pay premiums for the first 4 months of coverage, provided they were born in a Connecticut hospital or designated border hospital.Note enrollment of children with family income over 300 percent of the FPL does not come under Title XXI funding as it is offered as a full buy-in program. Private organizations may subsidize premiums.

8.2.2. Deductibles: *Not applicable*

8.2.3 Coinsurance or copayments: *Coinsurance is not applicable***.**

Copayments: For children in families with income over 185 percent of FPL, the state has established a schedule of reasonable copayments for services other than the following: preventive care and services, inpatient physician and hospital, outpatient surgical, ambulance, skilled nursing, home health, hospice and short-term rehabilitation and physical therapy, occupational and speech therapies, lab and X-ray, preadmission testing, prosthetics, durable medical equipment, behavioral health services, and dental exams (See Appendix 6.1) There are no co-payment requirements for children enrolled in HUSKY Plus Physical.

8.2.4. Other:

The maximum annual aggregate cost sharing (premiums and co-payments) for a family with income that exceeds 185 percent of the FPL (before disregards) but does not exceed 235 percent will be no more than $760.00. The $760.00 represents the maximum amount of co-payments that a family in this income range will be required to contribute. The $760.00 also represents the maximum cost sharing, as there is no premium requirement, for families whose income does not exceed 235% FPL. The maximum annual aggregate cost sharing for a family

whose income exceeds 235 percent of the FPL but does not exceed 300 percent will be no more than $1,360. The $1,360.00 is composed of the annual co-payment maximum of $760.00 plus an annual premium maximum of $600.00 ($50.00/month X 12 months). Annual cost sharing, including premiums, deductibles, and co-payments cannot exceed 5% of the family's gross income.

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))**

Information about cost sharing is included in the outreach materials and both the SPES and the MCO provide information on cost sharing requirements. The MCO provides information on cost sharing requirements through the introductory Welcome Call as well as in the Member Handbook, in which the MCO is required to include a summary of the cost sharing requirements end maximum. The information is also available via MCO Member Services Departments and through outreach materials such as newsletters. The SPES makes information about cost sharing available through its toll free phone number (1-877-CT-HUSKY, a variety of outreach materials, and through letters sent to the applicant that provide notification of eligibility for HUSKY B. Enrollees and providers are informed by the MCO when a client has reached the maximum annual aggregate cost-sharing limit for copayments so that the client is not charged for further copayments by the provider.

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

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

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

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

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

The family share of premium payments and co-payment caps were calculated to not exceed 5% of the lowest qualifying family income within each of the two income bands for subsidized benefits (eg. 5% of 185% FPL and 5% of 235% FPL). Co-payments are tracked by the MCOs and ASOs as applicable and reported to the SPES. The ~~MCOs are~~SPES is required to ensure that the co-pays do not exceed $760 per year. If a family exceeds $760 per year in co-payments, the MCOs and ASOs ~~is~~are required to reimburse the excess above $760 to the family. There is no premium requirement for families in Income Band 1. And co-payments are capped at $760 per year, therefore the maximum cost share for which a family in Income Band 1 can be liable is $760, which is less than 5% of the 185% FPL. The maximum premium, which can be paid by a family in Income Band 2, is $600 ($50 per month x 12 months). Co-payments are capped at $760 per year, therefore the maximum cost share for which a family in Income Band 2 can be liable is $1,360, which is less than 5% of 235% FPL.

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

When a family reaches the maximum annual aggregate cost-sharing limit for copayments, the SPES will inform the MCOs and ASOs. The MCOs and ASOs must inform~~s~~ the providers, subcontractors and family that the copayment limit has been met, that the providers and subcontractors cannot charge further copayments within the annual period, and the date when the annual period ends.

If the family believes it has reached the maximum annual aggregate cost-sharing limit for copayments, it may request, in writing, that the ~~MCO~~ SPES review the copayments that have been paid by the family. The ~~MCO~~ SPES will then review the copayments made by the family and respond to the family, in writing, within three weeks of the date of the family's written request. If the family disagrees with the ~~MCO's~~ SPES's determination, the family may request, in writing, a review by the DEPARTMENT. The MCOs ~~is~~ are required to include a summary of this right and the appropriate procedures to request the review in its Member Handbook.

There are no cost-sharing requirements for children enrolled in HUSKY Plus Physical.

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)**

Families of American Indian/Alaskan Native (AI/AN) children who are members of a ~~F~~federally organized tribe and who are in Income Band 1 or 2 are exempted from paying HUSKY, Part B premiums or copayments. Income Band 1 represents those enrollees whose income falls between 185 percent and 235 percent of the federal poverty level. Income Band 2 represents those enrollees whose income falls between 235 percent and 300 percent of the federal poverty level.

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

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

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

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))**

Nonpayment of premiums results in a disenrollment effective the end of the month for which the premium was not paid, and a three-month lockout period.

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

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
Reminder notices are sent to enrollees, prior to dis-enrollment, which inform enrollees of the consequences of nonpayment and instruct them to call the SPES if their family income has decreased so that eligibility can be re-evaluated. Based on the reduced family income the SPES will either refer the children to Medicaid or transfer HUSKY B eligibility to Income Band 1 for which there is no premium requirement. If an enrollee becomes disenrolled due to nonpayment of premiums, they may appeal through the Department's administrative hearing division. Enrollment will continue during the appeal process for individuals who have filed their appeal within the allowable timeframe. Please see section 12.1 for more information.

☒ 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 would 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, cop~~e~~sayments, 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))**

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

9.1.2 To maximize participation in HUSKY, Parts A and B through outreach, a single point of entry servicer (SPES), a simplified application process.

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

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

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

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

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

9.2.2 To maximize participation in HUSKY Parts A & B.

- *Expand Medicaid (HUSKY Part A) enrollment of uninsured children 18 years old who are under 185% of the FPL.*
- *Increase the number of insured children 18 or under who are between 185% and 300% of the federal poverty level.*

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

- *Match or exceed the statewide average of the percentage of children in HUSKY Parts A and B who receive immunizations by age two, meet or exceed state standards for well-child care, with a goal of at least 80% of children receiving all recommended well-child visits.*

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

- *Ninety percent of referrals to HUSKY Plus Physical will have eligibility determination made within 21 days.*
- *Track the percentage of referrals to HUSKY Plus Physical accepted or denied.*
- *100% of children with the following conditions will receive care according to individual needs and professional guidelines:*

- *Children with intensive physical needs with a diagnosis of cystic fibrosis under ICD 9 CM 277.0.*
- *Children with intensive physical needs with a diagnosis of cerebral palsy under ICD 9 CM 343.*

9.2.5 To maximize coordination between HUSKY Part B and HUSKY Plus Physical

- *100% of children in HUSKY Plus Physical have an assigned HUSKY B case manager/liaison within 30 days of their enrollment into HUSKY Plus Physical.*
- *100% of children in HUSKY Plus Physical have an assigned HUSKY Plus Physical case manager/coordinator.*
- *85% of children in HUSKY Plus have a global plan of care within 30 days of enrollment*
- *85% of children in HUSKY Plus Physical have a revised global plan of care at least semi-annually.*
- *85% of children in HUSKY Plus Physical have had evidence of coordination between HUSKY B, and HUSKY Plus Physical at least quarterly as documented in the progress notes, and if additional revision is indicated, in the Global Plan of Care.*

9.2.6 To assure that children with behavioral health needs receive appropriate care

- *70% of children who are discharged from inpatient care for mental health or substance abuse will receive follow-up care 30 days following discharge.*
- *75% of children will receive a clinical assessment within14 days following referral for treatment*

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 state, through a contract with an external quality review entity, with the exception of calendar year 2003, conducts an annual evaluation based on an analysis of the program measures and a patient satisfaction survey.

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.
Or modified measures that are based on HEDIS.

9.3.6. ☒ Other child appropriate measurement set. List or describe the set used.
Well-child periodicity compliance.

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:

- *Ambulatory Services*
- *Follow-up After Mental Health Hospitalization*
- *Follow-up After Chemical Dependency Hospitalization*

See Appendix 9.3 for complete listing of reporting measures.

9.3.8. ☐ Performance measures for special targeted populations.

See Appendix 9.3 for complete listing of reporting measures.

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

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

The State, through a contract with an external quality review entity and through the use of internal eligibility and enrollment data and utilization reporting from the MCOs and the ASOs, will conduct an annual evaluation based on an analysis of the program measure. The analysis will include a sampling of patient charts, utilization data and a patient satisfaction survey. Please note that with the exception of calendar year 2003, the report will include the findings from the audit conducted by an external quality review entity.

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

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

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

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

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

The Medicaid Managed Care Council (MMCC) plays an advisory role to the Department for both the HUSKY A and HUSKY B programs. The council is comprised of legislators, clients and representatives from the managed care organizations, the medical provider community, advocacy groups, the Department of Social Services and other State agencies such as the Departments of Children and Families and Public Health. The council meets once a month during which time the Department provides program updates. The council also has several subcommittees which act as workgroups for important issues that require additional study and follow-up. The subcommittees are as follows: Public Health; Quality Assurance; Behavioral Health and Consumer Access. Additionally public input is obtained through a public notice process whereby proposed changes are published in the Connecticut Law Journal and the Department's website and undergo a 15 day public comment period.

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

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

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

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

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

Amendments relating to either eligibility, such as the reduction of the crowd-out period from six to two months, or benefits, such as mental health parity or the carve-out of behavioral health services to the ASO, have been the result of legislative changes; therefore the prior public notice requirement was provided through the legislative process. Based on additional comments received subsequent to the 2/1/04 implementation from clients, advocates and other stakeholders, it was decided to repeal the premium increases, retroactive to the 2/1/04 implementation. The co-payment maximum remains at $760.00.

The amendment relating to the change from at-risk MCO contracts to non-risk PIHPs was due to a directive from the Governor.

The amendment relating to expediting eligibility processing and waiving premium payments for the first 4 months of managed care enrollment for a newborn child born in a Connecticut or designated border hospital with family income greater than 235% FPL was a result of a legislative change. In addition, the amendments relating to the carve-out of dental and pharmacy services as well as the return to at-risk MCO contracts were also a result of legislatve changes. The prior public notice requirement was provided through the legislative process.

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.

The SCHIP budget, as provided in Appendix 9.1.0 is based upon the following assumptions:

- *A budget period of October 1, 2002 through September 30, 2003.*
- *A 3% rate increase was included for July 1, 2002.*
- *For the time period of October 1, 2002 through June 2003, an average PMPM cost of $147.04 for Band 1 clients. For the time period of July 1, 2003 through September 30, 2003, an average PMPM cost of $151.45 for Band 1 clients.*
- *For the time period of October 1, 2002 through June 2003, an average PMPM cost of $128.75 for Band 2 clients. For the time period of July 1, 2002 through September 30, 2003, an average PMPM cost of $133.16 for Band 2 clients.*
- *The average net enrollment increase was estimated at 260 clients per month. This enrollment variance was based upon the variance over the last three state fiscal years.*
- *HUSKY B (SCHIP) enrollment as of September 30, 2003 is estimated at 16,200 with 11,400 clients under Band 1 and 4,800 clients under Band 2.*
- *Reduction in crowd-out period from 6 to 2 months was projected to have little, if any impact on enrollment levels. A review of the number of cases denied due to "crowd-out" shows that the reduction in the crowd-out period has not had an impact on enrollment levels. The number of cases denied pre and post implementation of the two-month crowd-out period has remained level.*
- *The elimination of continuous eligibility was projected to have minimal impact on enrollment. This was based on experience since the inception of the program, which has been that reported changes in income or household size usually result in either a lower income band or eligibility for Medicaid and not loss of coverage.*

The non-Federal share of the budget is funded through appropriations from the State's general fund. Please see attached Appendix 9.10, which includes the budget for FFY 2003

Section 10. Annual Reports and Evaluations (Section 2108)

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

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

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

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

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

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

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

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

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

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

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

Eligibility and Enrollment Matters

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

In accordance with 42CFR Sec 457 part(s), 1120, 1130(a), 1130(c), 1140, 1150(a), 1160(a), 1170 and 1180, an applicant has the right to request an administrative review of eligibility and enrollment decisions described below. However, the State will not provide an opportunity for review of a matter if the sole basis for the decision is a provision in this plan or in federal or State law requiring automatic change in eligibility or enrollment that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances. The Department has a two level process to review appeals related to HUSKY B eligibility and enrollment. The level one review is conducted by the Department's agent (SPES) and the Department's Administrative Review Unit conducts the level two review.

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

Eligibility

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

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

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

At the second level review, the DSS administrative reviewer, who was not involved in the prior decisions, evaluates all factors related to the SPES' eligibility decision or failure to make a timely decision of eligibility. The level two review is a desk review unless the applicant requests a personal

conference with the administrative reviewer as part of the review process. The personal conference may be conducted in person, by telephone or video conferencing.

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

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

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

Enrollment

Enrollment decisions, which can be appealed, include any suspension or termination of enrollment, such as disenrollment due to non-payment of premiums, denial of good cause for early re-enrollment, and denial of plan change.

When a HUSKY B client's enrollment is suspended or terminated, a notice, described above, is sent to the client informing him of this decision. The denial notice also informs the client of his right to request an administrative review of the decision within ten business days from the date the denial notice was sent by the SPES.

An agent at the SPES, who was not involved in the original decision, conducts the initial level one administrative review and notifies the applicant in writing of its level one review decision not more than ten business days from receipt of a request for administrative level one review.

If the applicant is not satisfied with the level one review decision, the applicant may request a level two administrative review within ten business days following the date on the notice of the level one administrative decision.

The Department's administrative reviewer, who was not involved in the previous decisions, shall evaluate all factors related to the agent's enrollment decision and shall offer the applicant the opportunity to have a personal conference with the administrative reviewer as part of the review process. Such personal conference maybe conducted in person, by telephone or video conferencing.

Enrollment continues pending both levels of review and final decision from the level two appeal. Enrollment decisions are not subject to expedited appeals.

Health Services Matters

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

The State, pursuant to 42 CFR 457.1120(a)(2) has elected to comply with existing grievance and appeal requirements in effect for the MCOs with which it contracts. The same or more stringent requirements will be imposed on the ASO for decisions related to denial of behavioral health services and dental services. These existing requirements provide, in accordance with applicable state law, for internal reviews within the MCO and the ASOs and external reviews with the State of Connecticut, Department of Insurance ("DOI"), the state agency that regulates MCOs. In addition, pursuant to the Department's contract with the MCOs and the ASOs, the MCO's and ASO's internal appeals process for HUSKY B Enrollees must allow for expedited review in certain circumstances described below.

In the State of Connecticut, MCOs, as HMOs must comply with various quality consumer protection requirements by state law. (see appendix 7.1 for a summary or this law.)

The MCO and ASO must clearly specify in its Enrollee handbook/packet(s) the procedural steps and timeframes for each level of its internal appeals process and for filing an external appeal through the DOI. The enrollee handbook that describes the appeals process and enrollee rights is provided to enrollees at the time of enrollment and at least annually thereafter. An independent external review is conducted as part of this appeals process which is the statewide standard review, and also complies with the State review requirements in place for all health insurance companies.

When a requested good or service is denied, the MCO or ASO must provide a written denial notice to the Enrollee, which includes the MCO's or ASO's denial decision as well as notice of the Enrollee's appeal rights. The notice must clearly state or explain what goods and/or services are being denied; the reasons for the denial; the contract section that supports the denial; the address and toll-free number of their Member Services Department; the Enrollee's right to challenge the denial by filing an internal appeal with the MCO or ASO; the procedure and timeframe for commencing each level of the MCO's or ASO's internal appeals process, including the address to which any written request for appeal may be mailed; the availability of expedited internal appeals; specifications and assistance as to the format in which the Enrollee may request an internal appeal; that the Enrollee will lose his or her right to challenge the denial with the MCO or ASO within 60 days from the date the MCO mailed the denial notice; that for each level of its appeals process, the MCO or ASO must issue a decision regarding an appeal no more than 30 days following the date that the MCO receives the request for review; that the MCO or ASO must be responsive to questions which the Enrollee may have about the denial; that the Enrollee may submit additional documentation or written material for the MCO's or ASO's consideration; and that the MCO's or ASO's review may be based solely on information available to the MCO or ASO and its providers, unless the Member requests a meeting or the opportunity to submit additional information.

Internal appeal process

Enrollees must have the opportunity to request an internal appeal with the MCO or ASO of a decision made by the MCO or ASO regarding the denial of goods and services covered in the basic benefit package. The MCO is required to have a timely and organized internal appeal process for receiving and acting upon these requests. This internal appeals process, may, at the MCO's or ASO's option, consist of more than one level of review. The internal appeals process shall be available for resolution of disputes between the MCO/ASO or MCO/ASO subcontractors and Enrollees concerning the denial of a request for goods and services covered under the HUSKY B benefit package. The MCO/ASO is responsible for ensuring compliance with the internal appeals process, whether the MCO or one of its subcontractors denies the goods or services.

The MCO and the ASO must develop and make available to Enrollees and potential Enrollees appropriate alternative language versions of internal appeal materials, including but not limited to, the standard information contained in denial notices. Such materials shall be made available in Spanish, English and any other language(s) if more than five percent of the MCO's or ASO's Enrollees in the State of Connecticut served by the MCO or ASO speak the alternative language. The MCO/ASO must submit such alternative language materials to the DEPARTMENT and the DEPARTMENT must approve any such materials in writing prior to use by the MCO or ASO.

The MCO and ASO must develop written policies and procedures for each component of its internal appeals process, which must be approved by the Department in writing. The MCO and the ASO are required to maintain a record keeping system for each level of its appeal process, which shall include a copy of the Enrollee's request for review, the response, and the resolution, which the MCO or ASO shall make available to the Department upon request.

An individual or individuals having final decision-making authority shall conduct the final level of the MCO's or ASO's review. One or more physicians who were not involved in the denial determination must decide any appeal arising from an action based on a determination of medical necessity.

The MCO and ASO may decide an appeal on the basis of written documentation available to the MCO or ASO at the time of the request, unless the Enrollee requests an opportunity to meet with the individual or individuals conducting the internal appeal on behalf of the MCO or ASO and/or requests the opportunity to submit additional written documentation or other written material. The MCO/ASO shall inform the Enrollee that the MCO's or ASO's review may be based solely on information available to the MCO or ASO and its providers, unless the Enrollee requests a meeting or the opportunity to submit additional information.

The MCO or ASO shall issue a written decision for each level of its internal appeals process. Each decision shall be sent to the Member by certified mail. The MCO/ASO shall send a copy of each decision to the DEPARTMENT. The appeal decision shall be sent no later than 30 days from the date on which the MCO or ASO received the appeal.

If the MCO or ASO fails to issue a decision within 30 days, the DEPARTMENT will deem the decision to be a denial and the Enrollee may file an external appeal with the DOI.

The MCO's and ASO's written decision must include the Member's name and address; the provider's name and address; the MCO or ASO name and address; a complete statement of the MCO's or ASO's findings and conclusions, including the section number and text of any statute or regulation that supports the decision; a clear statement of the MCO's or ASO's disposition of the appeal; a statement that the Member has exhausted the MCO's/ASO's internal appeal procedure concerning the denial at issue; and relevant information concerning the external appeals process available through the DOI.

The MCO and the ASO shall have also an internal appeal process through which a health care provider may grieve the MCO or ASO decision on behalf of a Member. The MCO/ASO shall provide information on the availability of this process to the providers in the MCO's or ASO's network. The health care provider appeal process does not include any appeal rights to the DEPARTMENT or any rights to an external appeal through the DOI.

Expedited internal appeal process

Pursuant to the Department's contract with the MCO's and ASO, the MCO's/ASO's internal appeals process for HUSKY B Enrollees must allow for expedited review. If an Enrollee requests an expedited review, the MCO or ASO must determine within one business day of receipt of the request, whether to expedite the review or whether to perform the review according to the standard timeframes.

The MCO and the ASO must include the following information concerning the DOI external appeal process in the Enrollee's member handbook: that if the Member has exhausted the MCO's or ASO's internal appeals process and has received a final written decision from the MCO or ASO upholding the MCO's/ASO's original denial of the good or service, the Member may file an external appeal with the DOI within 30 days of receiving the final written appeal decision; that the Member may be required to pay a filing fee for the DOI appeal; that the Enrollee will be asked to submit certain information in support of the appeal request, including a copy of his or her HUSKY B enrollment card and a release of medical records; that the DOI will assign the appeal to an outside, independent entity, which will conduct a preliminary review and determine whether the appeal meets eligibility for review; that the Enrollee will be notified within five business days of the DOI's receipt of the request whether the appeal has been accepted or denied for full review; and that Enrollees may obtain information about the external review process and request a form from the DOI and provide the DOI's address and phone

number; a copy of the DOI External Appeal Consumer Guide; and that the MCO or ASO shall be bound by the DOI's external appeal decision.

The DEPARTMENT shall pay the filing fee on behalf of any Enrollee whose family income exceeds 185 percent of the federal poverty level but does not exceed 300 percent of the federal poverty level (Members in Income Bands 1 and 2).

HUSKY PLUS: The HUSKY Plus Physical program has its own separate appeals process that addresses issues specific to the services covered by HUSKY Plus Physical. The HUSKY Plus Physical appeals process has three levels. The first level is an informal appeal that is addressed by the participating HUSKY Plus Center. If the enrollee wishes to pursue the matter further, a written request is submitted to the HUSKY Plus Appeals Subcommittee. The subcommittee in HUSKY Plus Physical consists of impartial representatives from the Department of Social Services, the Department of Public Health, and each of the contracting Title V Centers. The appeals subcommittee hears appeals for both HPP and Title V. If the enrollee is still dissatisfied, the appeal subcommittee's decision may be further appealed through the Commissioner of the Department of Social Services. A detailed description of this appeals process is included in Appendix 3.1.

Premium Assistance Programs

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

SCHIP Budget Plan

	Federal Fiscal Year Costs FFY 2008	Federal Fiscal Year Costs FFY 2009
Enhanced FMAP rate		
Benefit Costs		
Insurance payments		
Managed care	$24,209,379.36	$32,089,871.50
per member/per month rate @ # of eligibles		
Fee for Service	$6,909,426.48	$9,938,357.52
Total Benefit Costs	$31,118,805.83	$42,028,229.03
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs		
Administration Costs		
Personnel	$448,274.48	$463,966.88
General administration	$2,692,380.07	$680,697.18
Contractors/Brokers (e.g., enrollment contractors)	$237,294.60	$245,601.39
Claims Processing	$27,466.85	$28,428.36
Outreach/marketing costs	$0.00	$0.00
Other	$383,997.40	$397,439.70
Total Administration Costs	$3,789,413.40	$1,816,133.50
10% Administrative Cost Ceiling	$3,457,645.09	$4,669,803.23
Federal Share (multiplied by enh-FMAP rate)	$22,690,342.50	$28,498,835.64
State Share	$12,217,876.73	$15,345,526.88
TOTAL PROGRAM COSTS	$34,908,219.23	$43,844,362.53

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