

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.

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: _____ Pennsylvania _____
(Name of State/Territory)

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

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

submits the following 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: Robert L. Pratter	Position/Title: Acting Insurance Commissioner
Name: Peter Adams	Position/Title: Deputy Insurance Commissioner
Name:	Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Effective Date:

2 Approval Date:

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

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

1.1.1 Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

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

1.1.3. A combination of both of the above.

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

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

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

Tenth Amendment:

This amendment includes changes to meet options included in the CHIP Reauthorization Act of 2009 and the Patient Protection and Affordable Care Act of 2010 (ACA). Through this SPA, Pennsylvania is:

- Simplifying the application process through the elimination of the requirement for proof of income in those instances that verification can be obtained through various data exchanges (e.g. Income and Eligibility Verification System – IEVS). (Effective 7/1/2010)

Model Application Template for the State Children's Health Insurance Program

- Opening CHIP coverage to children of employees of public agencies within the state if they meet the Hardship Exception included in the ACA. (Effective 7/1/2010)
- Including the template language under Section 4 for expanding coverage to individuals lawfully residing in the United States.
- Providing a more comprehensive explanation of exclusions and limitations of benefits
- Expanding covered dental services (Effective 1/1/2011)
- Attaching a copy of the dental benefit as required annually
- Providing concurrence to meet the dental reporting requirement
- Updating the projected budget for CHIP

Effective Date:

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Approval Date:

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))

Public-Private Health Insurance Program

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Act, 62 P.S. §§ 5001.101 et seq., as amended by Act 68 of 1998, 40 P.S. §§ 991.2301 et seq. (the Children's Health Care Act), and Act 136 of 2006, was originally enacted in December 1992 and implemented in May of 1993 (see **Appendix A** for a copy of the Children's Health Care Act as amended [the "Act"]). The Program provides Free or Subsidized insurance for children in low-income families who are not eligible for Medicaid or not otherwise insured through private or employer-based insurance. The program also allows those that do not meet the income guidelines to purchase the coverage at the state's negotiated rate. (See **Appendix B**, Children's Health Coverage in Pennsylvania). CHIP is administered by the Pennsylvania Insurance Department through individual contracts with ten health insurance companies (hereinafter referred to as Contractors). Under terms of the contract, Pennsylvania requires the Contractors to:

- Conduct outreach
- Utilize CAPS to determine eligibility
- Enroll and renew enrollment for eligible children
- Provide required in-plan services
- Contract with qualified providers to provide primary and preventative health care
- Provide parent health education
- Perform quality assurance tasks (including but not limited to monitoring of quality of care and health outcomes)

CHIP provides free coverage to children from birth through age 18 whose

family income exceeds the Medicaid limit, but is no greater than 200% of the Federal Poverty Level (FPL). Subsidized coverage is provided to children from birth through age 18 in families whose income is greater than 200% but no greater than 300% of the FPL. The free and subsidized programs are funded by State and Federal funds. Families whose income is greater than 300% FPL may purchase the CHIP benefit package at the rate negotiated by the Commonwealth. The buy-in program is not supported through State or Federal funds. Additionally, utilization experience of the buy-in program is not included in rate setting for the free and subsidized programs.

The Program is administered by the Pennsylvania Insurance Department (see **Appendix A**, the Act, Section 2311(G)(1)). In addition, the Act provides for a Children's Health Advisory Council. The Council consists of fourteen voting members, seven (7) of whom are appointed by the Insurance Commissioner. The Council also includes the Secretary of Health, the Insurance Commissioner, the Secretary of Public Welfare, or their respective designees (see **Appendix A**, the Act, Section 2311 (I)). Its primary functions are to review outreach activities; and to review and evaluate the accessibility and availability of services to children enrolled in the program.

Public Insurance Program

Pennsylvania has operated a categorically and medically needy Medicaid program for many years. However, major program expansions have occurred.

In 1988, the State implemented Federally-mandated coverage for pregnant women and qualified children. This coverage was designated as Healthy Beginnings. Healthy Beginnings provides medical coverage to pregnant women and infants up to age one (Income Standard: 185% FPL); children ages one to six (Income Standard: 133% FPL); and children ages six and born after September 30, 1983 (Income Standard: 100% FPL). Early periodic screening, diagnosis and treatment provide comprehensive health services to all persons under age 21 who are receiving Medicaid. These services include check-ups and follow-up care. Pennsylvania has also elected to provide presumptive eligibility to pregnant women thereby encouraging early prenatal care and providing payment for outpatient primary care expenses incurred during pregnancy.

See **Appendix C** for the number of children currently enrolled in CHIP and Medicaid

C. Private Health Insurance Programs for Low-Income Families

Special Care Program

Description: Special Care is a low cost insurance plan offered statewide to low-income residents by Pennsylvania Blue Cross plans and Pennsylvania Blue Shield. Special Care provides basic preventive care services to children and adults ineligible for CHIP and Medicaid who cannot afford private health insurance. Special Care provides protection for families by covering the high cost of hospitalization, surgery, emergency medical care in addition to routine primary care.

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 Commonwealth is committed to providing access to quality health care coverage and to improving the health status of its children. Of particular concern are children of low-income families; families with limited access to care; and families having children with special needs due to chronic or disabling conditions. (Special needs programs include spina bifida, diabetes, asthma, hepatitis B, etc.)

To achieve the goal of providing access to health care, the Commonwealth has brought together a unique consortium of public agencies as well as public advocates from the statewide advocacy community dedicated to increasing awareness and enrollment in both CHIP and Medicaid. Senior and management staffs of the Departments of Insurance, Public Welfare, Health and Education meet to do strategic planning, to monitor progress, and to problem solve. In addition to time and effort, three of these agencies (Insurance, Public Welfare and Health) have also jointly committed funding to a multi-media and multi-faceted public awareness campaign for CHIP, Medicaid and Maternal and Child Health services.

The interagency consortium has increased awareness and enrollment with the following efforts which include but are not limited to:

- Establishing a single statewide toll-free number (1-800-986-KIDS) to provide access to helpline staff who inform, refer, and assist in applying for CHIP and Medicaid, while also providing additional information and referrals to a variety of other social service programs in Pennsylvania.

- Jointly funding a multi-year contract with a media consultant.
- Developing complementary media messages about the availability of healthcare coverage and the importance of preventative care.
- Improving access to enrollment by streamlining eligibility and application practices.
- Conducting studies regarding hard-to-reach populations to increase knowledge on how to achieve better results in outreaching to them.
- Measuring the effectiveness of our joint efforts by gathering and analyzing available data.

The Department's particular efforts to identify and enroll all uncovered children who may be eligible for CHIP include but are not limited to the following:

- Conducting a statewide outreach campaign for CHIP. The campaign includes but is not limited to: paid television, Internet and radio advertisements, posters, brochures, banners and the like.
- Monitoring, measuring and evaluating the effectiveness of the statewide outreach campaign as well as other outreach strategies initiated and implemented by the Department.
- Engaging in collaborative interagency outreach for the purpose of developing and implementing strategies to enroll children in both CHIP and Medicaid. Agencies include but are not limited to: the Department of Education (school- and library-based enrollment), the Department of Health, the Department of Public Welfare, and the Department of Labor and Industry.
- Developing a strategic plan to maximize awareness of CHIP with organizations and associations with existing statewide networks.
- Implementing school-based outreach and/or enrollment.
- Approving and monitoring the outreach and enrollment strategies of CHIP insurance company contractors.
- Approving the use of licensed producers to assist in the outreach and marketing of CHIP.
- Participating in and providing technical assistance for outreach activities initiated by local community organizations.
- Conducting studies which improve the Department's

understanding of issues relating to hard to reach populations and developing outreach strategies recommended by such studies.

As stated above, the Commonwealth is committed to assuring that children receive the healthcare coverage for which they are eligible (either CHIP or Medicaid). If a parent or guardian applies for CHIP coverage on behalf of a child and it is determined that the child is ineligible (e.g. because the level of family income is within the Medicaid range), the application and documentation submitted by the parent or guardian is automatically forwarded to the local County Assistance Office (CAO) for the determination of Medicaid eligibility. Conversely, if an application for Medicaid is filed and the child is found ineligible, the application and documentation are forwarded to a CHIP contractor. This practice negates the need for the parent or guardian to file separate applications for the two programs and facilitates enrollment of the child. In 2008, this process was automated through the implementation of the "Healthcare Handshake". The healthcare handshake improves efficiencies by removing the need to print applications, to mail or fax applications between agencies, and to reenter data, and significantly reduces the time required for an eligibility decision by the receiving agency.

Additionally, the Department is making a concerted effort to have the CHIP insurance contractors identify children who are potentially eligible for Medicaid due to a serious illness or disabling condition. Again, if a transition is required, the two Departments try to make the transition as seamless as possible.

The Department has worked closely with the Department of Public Welfare to expand access and simplify the application and renewal process for the CHIP and Medicaid programs through the development of an online application and renewal system called COMPASS (Commonwealth of Pennsylvania Access to Social Services). This web portal allows citizens to screen and apply for CHIP as well as many other social service programs across four Commonwealth agencies with one application. Both departments provide administrative funding for a toll-free helpline that can answer citizens' questions about CHIP, Medicaid and various other social service programs, as well as assist callers with completing applications over the phone, utilizing COMPASS.

In 2003, shortly after being sworn into office, Governor Edward G. Rendell created the Governor's Office of Health Care Reform (GOHCR) aimed at improving access, affordability and quality by rejuvenating the

state government's approach to health care. In January 2004, Pennsylvania launched a statewide data collection effort to more accurately define the characteristics of the state's uninsured. This effort was repeated in 2008. In July 2004, the GOHCR was given the lead responsibility to apply for a State Planning Grant through the Health Resources and Services Administration (HRSA). The purpose of the grant was to develop a comprehensive plan to provide access to affordable, quality health care coverage for every Pennsylvanian.

In keeping with that goal, in early 2006, the Governor introduced the Cover All Kids expansion that makes CHIP benefits available to all children in the Commonwealth. Later that year, eligibility was expanded to cover all children in Pennsylvania through either Medicaid or CHIP. Following federal approval in February 2007, enrollment began in the expanded program in March 2007.

Pennsylvania has added a post application screening process to COMPASS. If a family applies for any of the social services accessed by COMPASS other than Medicaid or CHIP, at the end of the application, the family is made aware of the fact that it appears they are eligible for Medicaid or CHIP and asks if they wish to apply. The information is then pulled from the current application into the application for access to health care. COMPASS then requests any additional information from the family, screens for eligibility and routes the application to the appropriate agency for an eligibility determination.

With the approval of this State Plan Amendment, Pennsylvania elects to meet the requirements of Express Lane Eligibility for both simplified eligibility determination and expedited enrollment of eligible children. CHIP will accept eligibility determinations from state agencies that meet the requirements under Section 203 (F) (ii) (I) including:

- Temporary Assistance for Needy Families under Part A of Title IV
- The State Medicaid Plan
 - The CHIP application is an extract of the application used for Medical Assistance and TANF. Therefore, all of the required elements for a determination of CHIP eligibility are included on the Medical Assistance or TANF application.
 - Upon receipt of an application for benefits, the Medicaid or TANF agency processes the application and ensures that the application contains all information required to make an eligibility determination.
 - If additional information is needed, the caseworker contacts the applicant to inform the applicant of the

required information and explains what, if anything, is needed to verify the information.

- The caseworker verifies information such as gross income, household composition, citizenship, identity, and third party insurance.
- After verifying all required information, the caseworker determines if the applicant is eligible for Medical Assistance. If not, the caseworker:
 - Prepares and distributes the determination of ineligibility and
 - Electronically refers the applicant's modified/verified application via the "healthcare handshake" to the appropriate CHIP insurance contractor.
- Upon receipt of a referral from the County Assistance Office, the CHIP contractor will enter all data into the centralized eligibility system (CHIP and adultBasic Processing System – CAPS) and run eligibility. As stated above, all information is considered verified and no additional information is required from the applicant. Eligibility is determined to place the applicant into the category of CHIP for which the applicant is eligible.
- The applicant has the opportunity to appeal any eligibility decision made by the contractor or to request a reassessment. If additional information is provided by the applicant that allows the contractor to determine the applicant is eligible for a lower cost or the free program (different household size, reduction in income since applying, and the like), eligibility is redetermined and the applicant is enrolled in the appropriate category of CHIP.

Other state agencies that have fiscal liability or legal responsibility for the accuracy of data used in eligibility determination findings may be included in the future (i.e. Child Support Enforcement, Daycare, School Lunch Program and the like).

- 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:

CHIP insurance company contractors are mandated by contract to conduct outreach activities.

Each CHIP contractor is required to provide the following outreach information:

- Identification of outreach objectives and activities for the contract period;
- Description of activities to locate potentially eligible children;
- Requirement that outreach materials be linguistically and culturally appropriate, and that outreach services include specific provisions for reaching special populations;
- Indication of whether the contractor will employ a dedicated marketing staff, and if not, submission of a program to assure special efforts are coordinated within overall outreach activities.

Operationally, outreach activities include canvassing local businesses, daycare centers, school districts, CAOs, hospitals/providers, legislative offices, religious organizations and churches, social service agencies, unions and civic groups, and numerous other organizations and groups.

All contractors employ bilingual representatives who are capable of responding to CHIP inquiries in either English or Spanish. TDD lines allow for communication with the hearing impaired and access to multiple language translating services are also available.

- 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))

See Section 2.2.1

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))

CHIP benefits are provided on a statewide basis using a managed care model through ten insurers. The insurers are Blue Cross and/or Blue Shield entities, subsidiaries or affiliates of Blue Cross and/or Blue Shield entities, Health Maintenance Organizations (HMO), or risk-assuming gatekeeper Preferred Provider Organizations (PPO). All enrollees are provided the same Act 68 consumer protections. (Act 68 of 1998 is the state law that outlines requirements for managed care plans in Pennsylvania, many of those mirroring the requirements of Section 403 of CHIPRA.) Enrollees do have the option to terminate enrollment or voluntarily transfer from one contractor to another as required by Section 2103(f)(3) (incorporating section 1932(a)(4) (42 U.S.C. §1396u-2(a)(4)).

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))

CHIP services are provided through a managed care model, in which enrollees select a primary care physician who is responsible for providing basic primary care services and referrals to other specialty care. For those enrollees in counties with a Gatekeeper PPO, a medical home is assigned in lieu of a primary care physician.

As a means of determining the level of utilization, managed care plans systematically track the utilization of health services to identify patterns of over and under utilization of health services. In addition, each CHIP Contractor is required to submit specific utilization data to the Department on a quarterly and annual basis. The data includes:

- The number of enrollee visits to primary care physicians, medical

specialists, as well as visits for vision, hearing, dental, and mental health services.

- The number of prescriptions and the ten most utilized drugs; and
- The number of hospital admissions for medical, surgical, maternity, mental health and substance abuse and average length of stay, by age group.

The data collected is analyzed by the Department to identify outliers and potential utilization issues. The Department then works with the plans to further evaluate the outliers and correct problems as necessary during its ongoing utilization review and quality improvement programs.

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: If an application is received by an insurance vendor that does not service the county of residence, the insurance vendor will immediately transfer the application to an insurance vendor that does service the county of residence. This effort improves the timeliness of an eligibility determination and by transferring the application instead of denying the application, a child can be immediately enrolled without reapplying.

4.1.2. Age: CHIP provides coverage to children from birth through 18. (see **Appendix A**, the Act , section 2311 (D))

4.1.3. Income: CHIP provides free coverage to children in families with incomes too high for Medicaid and adjusted gross income at or under 200% of FPL. Subsidized CHIP is provided to children in families with adjusted gross income of greater than 200% of FPL, but not greater than 300% of FPL (i.e., up to and including 300% FPL). “Adjusted gross” income is determined by subtracting from gross earnings:

- A work deduction for each employed family member whose income must be counted in determining eligibility (\$120 monthly/\$1440 annually).
- Day care expense incurred up to \$200 monthly/\$2400 annually for a child under age two; up to \$175 monthly/\$2100 annually for a child over the age of two or for a disabled adult.

After income disregards above are applied and adjusted gross income is determined for eligibility and cost sharing purposes, all income above 200% up to 300% FPL is disregarded.

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

4.1.5. Residency (so long as residency requirement is not based on length of time in state): Must be a resident of the state.

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

- status does not restrict eligibility):
- 4.1.7. Access to or coverage under other health coverage:
Pennsylvania requires that children be totally uninsured or ineligible for Medicaid to be eligible for CHIP. Contractors have the capacity to compare enrollee families to their own company subscribers to verify whether the family has private or employer sponsored coverage. We currently match new applications against a Medicaid data base to ensure the applicants are not already enrolled in Medicaid. The Commonwealth also runs a match through a Third Party Liability contract to assist in the determination that the applicants qualifying for low cost CHIP do not currently have private insurance and that the required period of uninsurance has been met.
- 4.1.8. Duration of eligibility: Enrollment normally begins the first of the month following determination of eligibility and receipt of premium payments, when required. Children are enrolled for a period of 12-months with the following exceptions.
Exceptions to the 12-months of continuous coverage include:
- A child becomes 19 years of age
 - A child is found to have other insurance or is eligible for or receiving Medicaid
 - A child moves out of the household
 - A child moves out of the state
 - A child is deceased
 - Non payment of required premiums
 - A voluntary termination of coverage is requested by the parent or guardian
 - The child was conditionally enrolled pending resolution of inconsistencies with information provided to the SSA for verification of citizenship status. The child will be enrolled for a maximum of 120 days while we attempt to work through the inconsistencies.
 - The child was enrolled in CHIP temporarily pending a Medicaid eligibility determination and Medicaid eligibility is confirmed
 - Misinformation was provided at application or renewal that would have resulted in a determination of ineligibility had the correct information been provided. In this case a child will be retro-terminated to the date of original enrollment. The rationale for this is the child was not eligible for the program and should not have been enrolled based on inaccurate information on the application (e.g. private insurance, not in the household, unreported income, and the like.)

4.1.9. Other standards (identify and describe):

- A child must be a citizen of the United States, a U.S. national, or a qualified alien, consistent with SCHIP regulations defined at 42 CFR 457.320(b)(6). Citizenship of children declaring U.S. citizenship will be verified through a match with the Social Security Administration (SSA). Enrollment of otherwise eligible children will not be delayed pending verification of U.S. citizenship. Children will be conditionally enrolled in CHIP pending final verifications. If citizenship cannot be verified by the SSA, the state will work closely with the family to reconcile any differences for up to 90 days. If the issue cannot be reconciled in the 90-day period, a termination notice will be issued and termination will be effective the first of the next month.
- Citizenship of other applicants may be verified through the Verification Information System – Systematic Alien Verification for Entitlements Program. The Commonwealth elects to provide coverage to children who are lawfully residing in the United States and are otherwise eligible for CHIP including optional targeted low-income children described in section 1905(u)(2)(B) without a five-year delay.
- Pennsylvania CHIP simplified the application process by the elimination of the requirement for proof of income in those instances where verification may be obtained through various data exchanges (e.g., Income and Eligibility Verification System – IEVS). If the self-declared income on the application and the information available through IEVS is within tolerance, the income is considered verified. Within tolerance is defined as resulting in no change to the category of CHIP a child is to receive (Free, Subsidized level, or Full Cost). In this case, no further verification is required. If the income cannot be verified through IEVS or if the information in IEVS is out of tolerance, the application will be treated as incomplete and the appropriate notifications will be generated to request the information from the applicant. As with all eligibility determinations, the family retains the right to appeal any determination and provide additional information to show that the correct determination was not made.
- Pennsylvania state law requires the mother's insurance to cover the newborn from the time of birth through 30 or 31 days. If a child is born to a CHIP enrollee, because the mother is covered by CHIP, full CHIP coverage is extended to the child from the time of birth and CHIP would pay for any claims during this

period. Based upon the new mother's eligibility status, we would naturally assume the newborn will be eligible for either Medical Assistance (MA) or CHIP.

- Children who are born to individuals eligible under the approved State plan are considered by Pennsylvania to be targeted low-income children on the date of the child's birth, to have applied and been determined otherwise eligible for Medicaid or CHIP, as appropriate, on the date of birth, and to remain eligible until attaining the age of 1 unless, after a reasonable opportunity period, the agency fails to obtain evidence to satisfy satisfactory documentation of citizenship under 42 CFR 435.407(c)(1) and (2) and identity under 42 CFR 435.407(e) and (f)
- To ensure no gap in access to health care between the coverage of the child by CHIP under the mother and the coverage of the child by either Medicaid or CHIP under the child's identification number, upon notification of the birth, the insurance contractor will temporarily enroll the newborn in CHIP with an effective date of the first of the month following birth. The child will be assigned its own identification number at that time. Simultaneously, the centralized eligibility system will screen the newborn for potential MA eligibility using the appropriate information on income and family size contained on the mother's existing application.
 - The appropriate information would be directly related to the newborn and the newborn's parent(s) and siblings and their associated income only. The new grandparents and the new mother's siblings and their incomes are not to be counted for the newborn's eligibility determination.
 - In the vast majority of cases, the outcome will be that the newborn is potentially eligible for MA. If potentially eligible for MA, the newborn must be referred to the local county assistance office (CAO) for an eligibility determination.
 - The newborn will remain enrolled in CHIP until an MA eligibility determination is completed. If eligible for MA, the newborn will be terminated from CHIP effective the last day of the month in which MA determined the newborn eligible. This will ensure no gap in access to health care.
 - If not eligible for MA, the newborn will be screened to determine in which category of CHIP the newborn is placed (Free, Low-cost, or Full-cost).

- The newborn is guaranteed 1 year of eligibility in CHIP or MA, with the exceptions listed in Section 4.1.8 of the State Plan. The normal renewal process will remain in effect for the new mother. After 1 year, the newborn's renewal due date will be synchronized with the new mother's renewal due date. At the next renewal due date, the normal renewal process will be followed.
- Children born to mothers who are not covered by Medicaid or CHIP and are otherwise eligible for CHIP may be enrolled in CHIP with an effective date of the first of the month following the month of birth, if an application is received during the month of birth or the month following. This allows for a newborn to have continuous access to the health care system with no gap in coverage. If the retroactive enrollment causes duplication of coverage with the mother's insurance during the first 30 days of life, CHIP will be the payer of last resort.
- Children over the age of 2 whose family's net income is greater than 200% of FPL will be subject to a period of uninsurance. The period of uninsurance is defined as six months prior to enrollment, except as specified in 4.4.4.2.
- Pennsylvania CHIP chooses to use the Express Lane option described in Section 2.2.1 above for both initial eligibility determinations and redeterminations. Due to the various categories of CHIP in Pennsylvania, the state will still run eligibility to determine for which category the child is eligible.
 - The Commonwealth simplified its enrollment and renewal processes by reducing the burden on applicants to provide information that has been provided to an Express Lane Agency (listed in Section 2.2.1) within the past 6 months.
 - No CHIP specific application will be required if the applicant indicates on the Express Lane Agency's application that the applicant wishes to enroll in health care or if the applicant affirmatively consents to being enrolled or have enrollment continued through affirmation in writing, by telephone, orally, or through electronic signature
 - Applicants that are determined not eligible for CHIP through the Express Lane process will be redetermined using the regular procedures to include notice requirements for potential eligibility for lower premiums

and utilizing the Screen and Enroll requirements of CHIPRA Section 203 (a)(C)(iii)

- Children will be temporarily enrolled in CHIP pending the outcome of the eligibility determination. No additional verification of information will be required if the information was previously provided by an Express Lane agency unless there is reason to believe the information is erroneous
- Children who are enrolled through the Express Lane process will be assigned codes as the Secretary shall require
- Pennsylvania CHIP chooses to provide coverage to children of employees of a public agency in the state who meet the hardship exception as defined in P.L. 111-148 Section 10203(d)(2)(D)

4.1.10. Check if the state is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

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

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
 - (i). Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
 - (ii). Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), pending applicants for TPS who have been granted employment authorization;
 - (iii). Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
 - (iv). Family Unity beneficiaries pursuant to section 301 of Pub. L 101-649, as amended;
 - (v). Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

- (vi). Aliens currently in deferred action status; or
- (vii). Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA 8 U.S.C. §1158) or for withholding of removal under section 241(b)(3) of the INA 8 U.S.C. §1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;
- (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
- (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. §1806(e); or
- (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

- The State elects the CHIPRA section 214 option for children up to age 19
- The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period

4.1.10.1 The State provides assurance that for individuals whom it enrolls in CHIP under CHIPRA section 214 option that it has verified, both at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.2. 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)

CHIP Contractors enter application data into the Commonwealth's CHIP and adultBasic Processing System (CAPS). CAPS is the automated system developed by the Department for the purpose of determining eligibility for CHIP and adultBasic. Applications for enrollment and re-enrollment are received via: the internet through the Commonwealth of Pennsylvania's Access to Social Services (COMPASS); telephone through calls to the Health and Human Services Helpline; through electronic referrals from the Medicaid agency; or, a mail-in process. Data matches with other agencies, health insurance carriers and employers are conducted after an application is entered into CAPS and prior to a final determination of eligibility.

Through our past SPA, the Commonwealth initiated the verification of citizenship through a match with the Social Security Administration. Pennsylvania assures that it will follow the process outlined in Section 211 of CHIPRA.

To facilitate cross matches between information technology systems, Social Security numbers will be required on applications. If an applicant does not yet have a social security number or fails to include a Social Security Number, the insurance contractor will conduct outreach to the applicant to obtain the number. An application will not be delayed nor denied due to the absence of the Social Security number. The demographic information from the application will be forwarded to the Social Security Administration to try to obtain any number that is not provided by using the enumeration process.

Contractors enroll children on a prospective basis on the first of each month. Contractors are provided with the CHIP Procedures Manual and other forms of instruction (i.e. CHIP Transmittals) which prescribe the method and procedures to be used in the determination of eligibility. Parts I and II of the manual prescribe:

- Basic eligibility requirements relating to income, age, residency, citizenship, and the lawful status of non-citizens
- Verification requirements (required for income if not verifiable through data exchange matches, U.S. citizenship and proof of qualified alien status only unless, in the judgment of the contractor, other verification is needed to clarify incomplete or inconsistent information provided on the application)
- Application processing standards (a decision on eligibility or ineligibility must be made within fifteen calendar days from the receipt of a complete application)

- Notification requirements for notices of eligibility, ineligibility, renewal and termination

4.3.a Process for Express Lane Eligibility

- The Commonwealth simplified its enrollment and renewal processes by reducing the burden on applicants to provide information that has been provided to an Express Lane Agency (listed in Section 2.2.1) within the past 6 months.
- No CHIP specific application will be required if the applicant indicates on the Express Lane Agency's application that the applicant wishes to enroll in health care or if the applicant affirmatively consents to being enrolled or have enrollment continued through affirmation in writing, by telephone, orally, or through electronic signature
- Applicants that are determined not eligible for CHIP through the Express Lane process will be redetermined using the regular procedures to include notice requirements for potential eligibility for lower premiums and utilizing the Screen and Enroll requirements of CHIPRA Section 203 (a)(C)(iii)
- Children will be temporarily enrolled in CHIP pending the outcome of the eligibility determination. No additional verification of information will be required if the information was previously provided by an Express Lane agency unless there is reason to believe the information is erroneous

Children who are enrolled through the Express Lane process will be assigned codes as the Secretary shall require.

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

The Commonwealth would closely monitor expenditures of CHIP funds. If necessary and feasible, we would cap the number of new enrollees in the expanded population (those above 200% of the FPL) and create a waiting list for that population to ensure we do not exceed our CHIP allotment for the year. Prior to implementing a cap and waiting list, the state will provide CMS with appropriate notifications. Other actions at time of decision include:

- Publication in the Pennsylvania Bulletin 60 days prior as public notification
- Include waiting list information on CHIP and COMPASS web sites

New applications would still be accepted through the normal processes. Screen and enroll procedures for Medicaid would remain unchanged. Eligibility would be run on all applications. The applications of individuals that appear to be eligible for Medicaid would be forwarded to the Department of Public Welfare for eligibility determination. Those applicants not eligible for Medicaid would be put on the waitlist with an effective date of the date when the

contractor received a complete enough application to enter into CAPS for an eligibility determination. On at least a monthly basis, the Commonwealth would make an assessment of the number of enrollees against the appropriated funds for the program. As additional funds would become available (either through attrition of enrollees or more funding is identified) applicants on the waitlist would be notified of the availability of coverage through CHIP. A determination would be made as to the number of new enrollees that could be accommodated with the identified funds. Notifications would go out first to those applicants with the earliest completion date; thus a first come, first served process. To update eligibility, applicants would need to attest that there have not been any changes to their family circumstances (e.g. number in household, income, insurance status, and the like). If changes have occurred, the new information would be added into CAPS and eligibility is re-determined. The signing of the attestation or the submission of additional information would be the basis for a new eligibility date and the 12 months of eligibility would begin with the enrollment. It is not expected that enrollees would be affected by any caps or waiting lists that may be implemented.

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

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))

Families declare on the application form whether their children are receiving Medicaid or some other form of health insurance coverage. Only those children without another source of creditable coverage are enrolled in CHIP. CHIP contractors compare applicants' names against their commercial subscribers to determine if they have health insurance coverage through their companies. Matches are also conducted against Medicaid Client Information System (CIS) files to determine if a child is already enrolled in Medicaid. With the Cover All Kids CHIP expansion in 2007, we included a match of all new applications with household income of greater than 200% of the FPL against the Department of Public Welfare's Third Party Liability database to assist in the determination that applicants do not have creditable private insurance and meet the state's required period of uninsurance. The combination of these efforts gives a high degree of assurance that

coverage is received only by those without another source of coverage.

Screening procedures at initial application and at times of renewal ensure that a child will not be enrolled in CHIP if a child is found eligible for Medicaid.

Pennsylvania is opting for temporary enrollment in CHIP pending screen and enroll as outlined in SHO #10-003 (CHIPRA #14). During the temporary enrollment period, the State will conduct a full eligibility determination. The State will not ask for information from the family that has already been provided to the State or is available to the State from another credible and cooperating source (effective June 2010). **Note:** In June 2010, CHIP obtained connectivity to various data exchanges and uses these exchanges to obtain or verify much of the information that is currently provided by the family.

- If it is determined the child is potentially eligible for Medical Assistance, the child will be referred to the County Assistance Office for a Medicaid eligibility determination; however, the child will remain enrolled in CHIP pending that determination.
- If the child is subsequently enrolled in Medical Assistance, the child's CHIP enrollment will end at the end of the month in which Medical Assistance coverage began.
- If it is determined the child is not eligible for Medical Assistance, the child will be referred back to the insurance contractor and CHIP coverage will continue through the next redetermination.

If the TANF application is marked both Cash and Medical Assistance, the application would have been screened for Medical Assistance eligibility prior to being sent to CHIP. No additional screening for Medicaid would be required. The CHIP insurance contractor would still need to determine eligibility for CHIP to determine in which category of CHIP to enroll the applicant child. An applicant retains the right of appeal or to request a reassessment.

- 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))

A process known as "Any Form is a Good Form" was adopted in February 1999 which facilitates enrollment in both CHIP and Medicaid. Application documents with a common set of data elements are being utilized to accommodate both the CHIP and Medicaid Program. Application materials for children determined ineligible for Medicaid because family income is within the CHIP range are sent to a CHIP

Contractor for a determination of eligibility for CHIP. Application materials for children determined ineligible for CHIP because family income is within the Medicaid range are sent to the appropriate County Assistance Office for a determination of eligibility for Medicaid. We automated the referral process through the “healthcare handshake” to improve efficiency.

Children, who are screened as potentially eligible for Medical Assistance, will be temporarily enrolled in CHIP while awaiting a Medicaid eligibility determination.

- 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))

See Section 4.4.2

- 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.

Pennsylvania has taken a number of steps to guard against and monitor for crowd-out. Questions regarding insurance coverage are contained on the application and renewal forms and cross matches against Medicaid and private insurance files are completed to help determine that only uninsured children are enrolled. Data regarding private insurance coverage is collected and reported in the required annual CHIP report.

Pennsylvania enjoys one of the nation’s highest rates of the persons insured by employer based coverage. The continued stability of the rate of employer based coverage supports the hypothesis that no serious degree of “crowd out” has or is occurring as the result of expansion of publicly funded health care programs.

- 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.

Monitoring: Pennsylvania will continue to monitor the rate of employer based coverage for changes. In addition to using information obtained from the applications, Pennsylvania implemented a cross match through a Third Party Liability contract to determine current and recent health insurance status. This match assists in the determination that the applicant is currently uninsured and has met the required period of uninsurance. This match also provides us a source of data, other than applicant provided information, on the number of individuals who applied for CHIP and had private insurance within the previous six months prior to application. With the addition of this data, we are able to more accurately determine the possibility of substitution among these individuals.

Strategy to limit substitution – children over the age of two: Pennsylvania implemented an uninsured period of six months. Children, over the age of two with a net income of over 200% of FPL, who were covered by a health insurance plan, a self-insurance plan or a self funded plan, are not eligible to enroll in CHIP for a period of six months following the end date of the private insurance except if the child's parent is eligible to receive unemployment compensation or is no longer employed and is ineligible for unemployment compensation, or the child is transferring from one government subsidized health care program to another.

Another disincentive for dropping private coverage is the addition of cost sharing (premiums and copayments) in the CHIP benefit package for families with net incomes greater than 200% of FPL.

Strategy to limit substitution - children under the age of two: In addition to monitoring for overall level of substitution, we will compare the data for the 0 - 2 year olds with data for 2 – 5 year olds to determine if the no period of uninsurance for the 0 – 2 year olds is significantly increasing the rate of substitution in Pennsylvania. If the rate of substitution in the under-2 year olds approaches one and a half times that for 2 – 5

year olds, Pennsylvania will consider implementing a one or two month period of uninsurance. If the rate of substitution continues to grow in the under-2 year olds to a point of twice that of the 2 – 5 year olds, Pennsylvania will consider increasing the period of uninsurance incrementally up to six months.

Cost sharing requirements (premiums and copayments) also apply to the under age two group.

- 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.

Please see 4.4.4.2.

If Pennsylvania finds a significant level of substitution (10% of enrollees dropping or being dropped from private coverage), it will reevaluate the exceptions to the waiting period to determine if they are contributing to substitution and modify them as necessary. We would also consider incrementally increasing the uninsured period up to an additional 6 months to reverse the substitution trend.

Another strategic option that is available is to increase the cost sharing requirements for this target population to deter substitution.

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

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

The minimum employer contribution.

The cost-effectiveness determination.

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

Pennsylvania does not have any American Indian tribes recognized by

the Federal or State government. However, outreach and enrollment strategies outlined in Section 5 include all children, including American Indians and Alaska Natives.

The application form requests information regarding the applicant's racial and ethnic identity, including whether the child is an American Indian or Alaska Native. This information is collected and reported as required.

See **Appendix C**

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 Commonwealth is committed to providing access to quality health care coverage and to improving access to coverage. To achieve this goal, the Commonwealth brought together a unique interagency consortium dedicated to increasing public awareness of and enrollment in both CHIP and Medicaid. Senior Management staff and others in the Departments of Insurance, Public Welfare, Health and Education meet regularly to do strategic planning, to monitor progress, and to problem solve. In addition to time and effort, three of these agencies have also jointly committed funding to a multi-media and multi-faceted public awareness campaign for CHIP, Medicaid and Maternal and Child Health services. This unique consortium has been cited by the Health Care Financing Administration as a best practice to be emulated by other states.

The agenda for increasing awareness and enrollment includes but is not limited to:

- Broad based marketing strategies using television, Internet and radio advertising to increase public awareness of the program and to encourage families to enroll their children.
- Targeted marketing to special populations to address cultural diversity and barriers to participation.
- Strong relationships with other public and private agencies to promote outreach and enrollment activities.
- Utilizing (e.g. on-line application) technology to create optional methodologies for enrollment in CHIP.
- Establishing a single statewide toll-free number (1-800-986-KIDS) to provide access to helpline staff who inform, refer and assist in applying for CHIP and Medicaid, the Special Kids Network and other public programs (e.g. WIC).
- Increasing access to coverage by improving eligibility and enrollment practices.
- Conducting market research to improve targeted marketing and outreach.
- Measuring the effectiveness of all efforts by gathering and analyzing available data.

Based on the request of several of our insurance contractors, Pennsylvania has authorized the use of licensed producers to assist with the marketing of CHIP, as long as the CHIP insurance contractors and the licensed producers follow CMS regulations for the Medicare Advantage and Medicare Part D programs, abide by all applicable laws, and do not increase the administrative costs for which these insurance contractors seek compensation from the CHIP program.

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

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

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

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

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

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

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

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

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

A. Benefits Package: See **Appendix D**, Benefits Chart. Also, note Section 6.2. which denotes benefits provided by Contractors beyond the minimums required by the Act.

B. Administration: CHIP is administered by the Insurance Department (see **Appendix A**, Section 2311 (G)(1)). The Insurance Department is required by statute to:

(1) Review all bids and approve and execute all contracts

for the purpose of expanding access to health care services for eligible children (See **Appendix A**, Section 2311 (G)(2)):

(2) Conduct monitoring and oversight of contracts entered into (See **Appendix A**, Section 2311 (G)(3)):

(3) Issue an annual report to the Governor, the General Assembly, and the Public for each fiscal year outlining primary health services funded for the year, detailing the outreach and enrollment efforts, and reporting by county the number of children receiving health care services from the fund, and the projected number of eligible children (see **Appendix A**, Section 2311 (G)(4)):

(4) In consultation with other Commonwealth agencies (e.g. the Departments of Health, Welfare and Education), monitor, review and evaluate the adequacy, accessibility and availability of services delivered to enrolled children (see **Appendix A**, Section 2311 (G)(6)):

(5) Promulgate regulations necessary for the administration of the program (see **Appendix A**, Section 2311 (H)):

(6) Establish the Children's Health Insurance Advisory Council (see **Appendix A**, Section 2311 (I)):

(7) Solicit bids and award contracts through a competitive procurement process (see **Appendix A**, Section 2311 (J)):

(8) In consultation with appropriate Commonwealth agencies, review enrollment patterns for the program (see **Appendix A**, Section 2311 (N)): and

(9) In consultation with appropriate Commonwealth agencies, coordinate the development of an outreach plan to inform potential contractors, providers and enrollees regarding eligibility and available benefits (see **Appendix A**, Section 2312).

C. Program Enactment and Effective Date: The Children's Health Insurance Act, 62 P.S. §§ 5001.101, et seq., was enacted in December 1992 and implemented in May of 1993. The Act

was amended on June 17, 1998 by Act 68 of 1998, 40 P.S. §§ 991.2301 et seq., and on November 2, 2006 by Act 136 of 2006 (see **Appendix A**).

D. Fiscal year 1996 state expenditures for CHIP are as follows:

CHIP expenditures in fiscal year 1996 totaled \$31,611,373, including an expenditure of \$30,685,814 for its Free Program, and \$915,559 for its Subsidized Program.

- 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
 - 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))
Inpatient benefits for medical and mental health hospitalizations, medically related inpatient rehabilitation, and skilled nursing facility services are limited to a total of 90 days per year combined. Inpatient medically related rehabilitation therapy stays are limited to no more than 45 days per year. Inpatient days may be exchanged for mental health related partial hospitalization (PH) or intensive outpatient (IOP) mental health services if the member's outpatient mental health benefit has

been exhausted. Each inpatient day is considered the equivalent of 2 days of PH or IOP. Up to 10 inpatient days may be exchanged for this purpose.

- 6.2.2. Outpatient services (Section 2110(a)(2))
Outpatient physical health visits combined with 6.2.3, 6.2.4, 6.2.5, and 6.2.9 related services are limited to 50 visits per year. Preventive, well-baby, well-child, prenatal, emergency, and urgent care visits are not included in the count for the annual maximums.

Placing a maximum on physical health outpatient visits brings PA CHIP in compliance with the requirements for mental health parity listed in Section 502 of CHIPRA.
- 6.2.3. Physician services (Section 2110(a)(3))
Physician services combined with 6.2.2, 6.2.4, 6.2.5, and 6.2.9 related services are limited to 50 visits per year. Preventive, well-baby, well-child, prenatal, emergency, and urgent care visits are not included in the count for the annual maximums.
- 6.2.4. Surgical services (Section 2110(a)(4))
Subject to the existing inpatient and outpatient services limits depending on where the services are rendered.
- 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
Clinic services combined with 6.2.2, 6.2.3, 6.2.4, and 6.2.9 related services are limited to 50 visits per year. Preventive, well-baby, well-child, prenatal, emergency, and urgent care visits are not included in the count for the annual maximums.
- 6.2.6. Prescription drugs (Section 2110(a)(6))
A generic drug will be automatically substituted for a brand-name drug whenever a generic formulation is available unless the physician indicates that the brand-name version of the drug is medically necessary.
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
Covered when the drug is a part of the formulary, the member has a prescription for the drug, and a documented medical condition that indicates the drug is medically necessary.
- 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))
Pregpregnancy family services combined with 6.2.2, 6.2.3, 6.2.4, and 6.2.5 related services are limited to 50 visits per year. Preventive, well-baby, well-child, prenatal, emergency, and urgent care visits are not included in the count for the annual maximums.
- Includes counseling, education and related services to prevent and address the consequences of at-risk behaviors related to sexually transmitted diseases (STDs) and pregnancy.
- 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))
Inpatient benefits for medical and mental health hospitalizations, medically related inpatient rehabilitation, and skilled nursing facility services are limited to a total of 90 days per year combined. Inpatient medically related rehabilitation therapy stays are limited to no more than 45 days per year. Inpatient days may be exchanged for mental health related partial hospitalization (PH) or intensive outpatient (IOP) mental health services if the member's outpatient mental health benefit has been exhausted. Each inpatient day is considered the equivalent of 2 days of PH or IOP. Up to 10 inpatient days may be exchanged for this purpose.
- 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))
Outpatient mental health services are limited to 50 visits per year. Covered services include psychological testing; consultations; individual, group, or family therapy; targeted mental health case management and resource coordination; and prescription drugs
- 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
Durable medical equipment is covered with monetary caps based on each Insurer's experience and subject to PID review and approval.

One hearing aid or device per ear every two years. Purchase of hearing aids or devices is subject to a monetary cap based on each insurer's experience and subject to PID review and approval.

The vision benefit is limited to one frame in any 12 month period unless a second frame is medically necessary. Lenses are limited to once every six months and a prescription change must be documented for a second set of lenses to be covered within a 12 month period of time. Contact lenses are only covered when medically necessary. Frames and lenses are subject to monetary caps based on each Insurer's experience and subject to PID review and approval.

Prosthetic dental devices are covered as a part of a member's dental benefit and subject to an annual dental benefit limit of \$1,500 as detailed in section 6.2.17.

- 6.2.13. Disposable medical supplies (Section 2110(a)(13))
Ostomy supplies are only available to members who have had a surgical procedure which resulted in the creation of a stoma.

Urological supplies are covered only for members with a diagnosis of permanent urinary incontinence or permanent urinary retention.

With the exception of prosthesis prescribed as a result of a mastectomy and foot orthoses for diabetics, durable medical equipment, prosthetics, orthotics, ostomy and urological supplies are subject to a combined monetary caps based on each Insurer's experience and subject to PID review and approval.

- 6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))
Limited to a maximum of 60 visits per year. Home infusion therapy does not include blood or blood products. Private duty nursing and custodial services are not covered.

- 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))
The incident of rape or incest must have been reported to law

enforcement authorities or child protective services, unless the treating physician certifies that in his or her professional judgment, the member is physically or psychologically unable to comply with the reporting requirement.

- 6.2.17. Dental services (Section 2110(a)(17))
Non-emergent dental services are limited to an annual maximum dental benefit expenditure of \$1,500 per member with the exception of comprehensive medically necessary orthodontic services which are limited to a lifetime maximum of \$5,200 per member. Services include diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, oral and maxillary surgery, orthodontic, and adjunctive dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions as mandated by law. Cosmetic related services are not covered.

- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
Inpatient detoxification is limited to seven (7) days per admission, with no annual or lifetime maximum.

Non-hospital residential alcohol and substance abuse treatment is limited to a total of 90 days per year. Substance abuse outpatient sessions may be exchanged for additional non-hospital residential alcohol and substance abuse treatment if the member's outpatient substance abuse benefit has not been exhausted. Two outpatient sessions are considered the equivalent of one non-hospital residential treatment day. Up to 60 substance abuse outpatient sessions may be exchanged for this purpose.

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

Substance abuse outpatient visits are limited to 90 visits per calendar year. Substance abuse outpatient sessions may be exchanged for additional non-hospital residential alcohol and substance abuse treatment if the member's outpatient substance abuse benefit has not been exhausted. Two outpatient sessions are considered the equivalent of one non-hospital residential treatment day. Up to 60 substance abuse outpatient sessions may be exchanged for this purpose.

- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
Speech, occupational, and physical therapy are limited to 60 outpatient visits per year per type of therapy.
- 6.2.23. Hospice care (Section 2110(a)(23))
Requires a certification by a physician stating that the member has a terminal illness and has six months or less to live. Respite care may not exceed 10 consecutive days per admission. A maximum of 30 days is available for continuous and/or inpatient hospice care services. All hospice care services combined are limited to a total of 180 days per lifetime.
- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
Outpatient medical therapy services (chemotherapy, radiation therapy, dialysis, and respiratory therapy) are unlimited.

In accordance with the Pennsylvania Autism Insurance Act (Act 62), prescription drug coverage, services of a psychiatrist and/or psychologist, and rehabilitative and therapeutic care for the purposes of treating a confirmed diagnosis of autism are limited to a maximum benefit of \$36,000 per member per year. These services do not count toward any other physical or mental health related limits.
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
Transportation services by land, air, or water ambulance are covered only in response to an emergency or when determined to be medically necessary.
- 6.2.27. Enabling services (such as transportation, translation, and outreach services) (See instructions) (Section 2110(a)(27))
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this section (Section

2110(a)(28))

6.2.D The State will provide dental coverage to children through one of the following. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children. (Section 2103(2)(5))

6.2.1.-D State specific Dental Benefit Package. The state assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999 (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.2-D Periodicity Schedule. The State has adopted the following periodicity schedule:

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

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

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

6.2.2.2-D State employee coverage: (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes.)

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

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

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

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

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

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

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross

reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

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

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

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

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

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

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

Section 7. Quality and Appropriateness of Care

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

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

CHIP provides services to enrolled children through a managed care model. By state law and regulation, all of the CHIP Contractor delivery systems are state licensed managed care organizations (predominantly HMOs, though one of them uses gatekeeper PPO delivery systems in limited counties) which, as a condition of licensure, must undergo periodic external reviews of their quality assurance systems and the quality of care provided to their members. These reviews are required within one year of licensure and again at three-year intervals or for cause. The reviews are performed by the National Committee for Quality Assurance ("NCQA") with Health Department participation. The scope of review includes a detailed examination of the plan's quality assurance/improvement program including access, availability, continuity of care, and preventive and health maintenance services to members, including CHIP-enrolled children. NCQA staff also independently assess managed care compliance with current state regulations on a periodic basis. The Department independently identifies opportunities for improvement for the CHIP program and institutes quality improvement performance measures via its contracted external quality review organization, as appropriate.

CHIP enrollees also have access to a complaint and grievance resolution process through their managed care plans. This process is mandated by state law (Act 1998-68) for all managed care organizations and requires members to go through a two-step process at the HMO level, with the second level including one-third member representation in the decision-making process. If the member is still dissatisfied, he or she has the right to appeal the plan's decision to the Department of Health (grievances) or the Insurance Department (complaints). The Contractor is required to have a data system in place capable of tracking and trending all complaints and grievances. In addition to assuring that appropriate care is accessible to members, this process also enables the Department to track and identify patterns of inappropriate care or service.

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 Department has established Quality Management and Utilization Management requirements to which the insurer is contractually bound. See **Appendix E** (Provided in the original State Plan) which contains requirements as specified in the Department's Request for Procurement.

- 7.1.2. Performance measurement
- In addition to evaluating contractors based on their overall NCQA accreditation ratings, the program also conducts Healthcare Effectiveness Data Information Set (HEDIS) reviews which compare the CHIP population with the commercial subscribers of the insurer. In addition, the program has been doing direct comparisons of its HEDIS data with medical assistance programs regionally and nationally. The results from HEDIS reviews are used to investigate potential problem areas and institute quality improvement activities, as appropriate.

During FY 2000 the Department, for the first time, began collecting HEDIS data and continues to do so annually.

Since these initial efforts, the Insurance Department has joined with the Department of Public Welfare in its contract with IPRO to develop standardized, clinically relevant and evidence-based performance measures to facilitate evaluation of care provided by the health plans.

- 7.1.3. Information strategies

All CHIP enrollees receive membership handbooks (see **Appendix F (provided with the original State Plan submission)**, sample handbook which describes the benefits provided to enrollees under the Program). These materials also describe members' rights and responsibilities and the specific steps to appeal any medical or service issue to the plan and to the Department of Health. All service denials or reduction in benefits must also contain information about how to appeal the decision through the member grievance process. Managed care plan providers have developed a multitude of member educational materials and informational items that encourage CHIP enrollees to obtain age-appropriate health services and preventive care. These are distributed widely by the plans.

CHIP collects information from all CHIP Contractors on a quarterly and annual basis. This reporting provides information

on CHIP enrollment, demographic and ethnic characteristics, outreach efforts, use of medical and dental services, member grievance information, and data on financial expenditures. Information is used by Program managers to document performance and promote adequate Program accountability. The data elements are updated on specific needs as identified.

7.1.4. ☒ Quality improvement strategies

Several key initiatives mentioned herein are the basis for individual and collective quality improvement activities.

- Based on the clinical standards adopted and the data obtained from external reviews, each of the ten contractors have been required to identify appropriate mechanisms for improving the provision of preventative and health maintenance services for children enrolled in CHIP.
- The Department and the contractors work together to implement interventions that will raise the rates of preventative services to conform with established CHIP goals. Such intervention includes:
 - patient information on the availability and necessity of services;
 - parent education
 - a system of patient reminders;
 - member satisfaction surveys to detect barriers to accessing care;
 - community-based education;
 - physician education;
 - immunization registries which follow children across providers and insurance programs.

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

State-licensed HMOs are the principal contractor health service provider entities for CHIP enrollees. Under Pennsylvania statute, these entities are subject to oversight and regulation by the Department of Health and the Insurance Department, which also have joint licensing authority of these entities (see 40 P.S. 1551, et seq. and 31 Pa. Code, Chapters 301-303) The Insurance Department is primarily responsible for monitoring initial

capitalization and financial solvency. The Department of Health is charged with monitoring quality of care and assuring the availability of and accessibility to health services.

To obtain licensure, certain requirements regarding availability and access must be satisfied by an HMO. These requirements are:

- coverage for basic health services, including emergency services;
- provisions for access to a primary care physician for each subscriber;
- evidence of arrangements for the ten most commonly used specialties;
- policies on obtaining referrals for specialty care;
- professional staff standards (for example, there must be at least one full-time primary care physician per 1600 members);
- physician and provider network capacities.

Many of these requirements are evaluated initially upon licensure; upon request for service area expansion; and periodically through complaint and grievance monitoring, on-site visits by Department of Health staff, external reviews by NCQA, and various quarterly and annual reports addressing the provider delivery systems of the CHIP Contractors.

As part of the annual re-contracting process, Contractor health service delivery system information is assessed to assure an adequate number and distribution of providers and facilities of all types.

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))

Primary care, including well-child care is provided in accordance with the schedule established by the American Academy of Pediatrics. Services related to those visits, include, but are not limited to, immunizations, health education, tuberculosis testing and developmental screening in accordance with routine schedule of well-child visits. Care must also include a comprehensive physical examination, including X-rays if necessary, for any child exhibiting symptoms of possible child abuse.

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))

Contractors must establish and maintain adequate provider networks as determined by the Department of Health to serve all eligible children

who are or may be enrolled, to include, but not be limited to: hospitals, children's tertiary care hospitals, specialty clinics, trauma centers, pediatricians, specialists, physicians, pharmacies, dentists, substance abuse treatment facilities, emergency transportation services, rehab facilities, home health agencies and DME suppliers in sufficient numbers and geographic dispersions to make available all services in a timely manner. Covered services must be provided out-of-network if such services are not available in a timely and accessible manner through in-network providers. In accordance with Article XXI Section 2111, of Act 1998-68, and 28 Pa. Code Sections 9.679(D) and 9.679(E), the contractor must have adequate health care available in a timely and accessible manner through its network providers.

Contractors cannot discriminate against CHIP enrollees by offering them access to physician services which differ from the access offered commercial enrollees. For example, a plan may not specifically close a practice to CHIP enrollees if the practice is open to commercial enrollees.

- 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))

See response to 7.2.2

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

Decisions related to the prior authorization of health services are made in accordance with State law (Act 1998-68). Contractors must establish and maintain written policies and procedures relating to prior authorization of health services that must be submitted for review and comment by the Department. Contractors must individually identify service(s), medical item(s), and/or therapeutic categories of drugs to be prior authorized. In addition, the list and scope of services to be prior authorized must be approved by the Department.

The policies and procedures must include an expedited review process to address situations when an item or service must be provided in an urgent basis.

Contractors must demonstrate how written policies and procedures for requests for prior authorization comply and are integrated with the enrollee notification requirements and enrollee grievance and appeal procedures.

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

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

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

8.1.1. YES

8.1.2. NO, skip to question 8.8.

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

Children with a family net income of 200% of FPL or less are not subject to any cost sharing requirements.

8.2.1. Premiums: If the family net income is determined to be above 200% FPL, the family will be required to share in the cost of the coverage. The negotiated rate for calendar year 2010 is expected to average approximately \$176 statewide. The per child monthly premiums are:

Percent FPL	Per Child Per Month
>200 – 250	25 percent of the state negotiated rate (approx \$44.00 for 2010)
>250 – 275	35 percent of the state negotiated rate (approx \$61.60 for 2010)
>275 – 300	40 percent of the state negotiated rate (approx \$70.40 for 2010)
>300	Full cost of coverage as negotiated by the Commonwealth with each of the contractors. This (>300% coverage) is a full payment program and is not included in any Title XXI funding.

Premiums are due to the contractors on an established date prior to the first of the month for which premiums are paid.

8.2.2. Deductibles: Not applicable

8.2.3. Coinsurance or copayments: Coinsurance is not applicable

Copayments: For children in families with net income greater than 200% FPL, but less than 300% FPL, the Commonwealth has established reasonable copayments for services other than the

following: well-baby; well-child; immunizations; pregnancy related services; or emergency care that results in admissions.

Copayments are as follows:

Primary Care visits	\$5
Specialists	\$10
Emergency Care	\$25 (waived if admitted)
Prescriptions	\$6 for generic and \$9 for brand names

Copayments are limited to physical health and do not include routine preventive and diagnostic dental services or vision services. Copayments will be due at the point of service.

8.2.4. Other: None

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

Notice of the initial premiums and the cost sharing requirements were published in the Pennsylvania Bulletin prior to the requested effective date of the state plan amendment. Premiums, copayments, and the benefit plan were all included in statewide public hearings regarding the Cover All Kids initiative to expand Pennsylvania's CHIP. Adequate time was allotted for anyone to provide comment on any aspect of the expansion. This information was also shared at the following meetings in October 2006:

- **Medical Assistance Advisory Committee (MAAC) Presentation** – The Commonwealth presented the plan and program design at a MAAC meeting, which is a monthly meeting conducted by DPW for the purpose of presenting and gaining input from stakeholders on issues of policy development and program administration. MAAC is open to the public and is composed of Commonwealth citizens who have experience, knowledge, and interest in the delivery of health care services to low-income citizens and medically vulnerable groups. Members include physicians and other providers, representatives of managed care organizations under contract with the Department, representatives of consumer and provider organizations, current Medicaid recipients and parents of minor child recipients. The Commonwealth provides copies of the SPA it submits to CMS to committee members upon request.
- **Consumer Subcommittee of MAAC** – The Commonwealth presented the plan and program design at a Consumer Subcommittee meeting, which is

a monthly subcommittee meeting conducted by DPW for the purpose of reviewing and advising the MAAC on policy development and program administration of publicly funded medical assistance (MA) programs. The Consumer Subcommittee's mission is to be a resource to the MAAC, enabling the committee to advise the Department of Public Welfare on issues regarding access to service and quality of service. A majority of the members of the Consumer Subcommittee are current MA recipients and may also include representatives of: low-income groups whose membership is primarily medical assistance recipients; advisory groups advocating on health care issues for low-income Pennsylvanians; aging or elderly consumer groups advocating on health care issues for low-income Pennsylvanians; disease or health care condition specific groups; Hispanic or other ethnic groups advocating on health care issues for low-income Pennsylvanians; former recipients (within past year); parents of minor child recipients; families of recipients; and others knowledgeable and interested in matters that come before the Subcommittee. At least one, but no more than two, members of the Consumer Subcommittee may serve on other subcommittees.

- **Income Maintenance Advisory Committee (IMAC)** - The Commonwealth presented the proposed waiver and program design at an IMAC meeting, which is a bi-monthly meeting conducted by DPW for the purpose of advising the Department on the development and implementation of policies and procedures relating to cash assistance, food stamps, the Low-Income Energy Assistance Program (LIHEAP) and eligibility for Medicaid. The IMAC is composed of 17 members: 12 Medicaid recipients, four advocates and an Executive Director of a County Assistance Office. The Committee Members meet every other month with Department staff in Harrisburg, Pennsylvania. The Commonwealth will provide copies of the SPA to Committee Members upon request.
- **CHIP Advisory Committee Presentation** – The Commonwealth presented the plan and general program design at the CHIP Advisory Council meeting. The purpose of the CHIP Advisory Council is to advise the Commonwealth on CHIP outreach activities and to review and evaluate the accessibility and availability of services delivered to children enrolled in CHIP. This meeting is open to the public.

All of Pennsylvania's CHIP outreach and enrollment materials display the eligibility requirements, coverage types and cost sharing requirements. The CHIP contractors include cost sharing requirements in the member handbooks and in letters sent to the applicant that provide notification of eligibility for CHIP. Eligibility letters also clearly indicate the cumulative maximum cost sharing (5% of gross income) expected of the family. Information about cost sharing is also available through the Health and Human Services Help Line at 1-800-986-KIDS. Any changes to costs will be included in correspondence to enrollees a minimum of 30 days in advance of the changes.

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 cost sharing requirement was designed to only include modest premiums and copayments. Only rare circumstances of low income families combined with very high utilization of non-preventive services by multiple family members would result in families potentially exceeding the 5 percent of family income ceiling. The cost-sharing limit will be calculated annually starting with the date of initial enrollment of any children in the family or the annual re-enrollment date. Premium payments will be required monthly, but the need to continue premium payment for the entire 12-month eligibility period will be taken into account in determining if/when the cost-sharing cap has been exceeded.

The initial letter announcing enrollment in a subsidized program includes notification of the requirements for the cost sharing, the family limitation on cost sharing based upon the reported gross income, the requirement for the family to keep track of the cost sharing amounts paid and instructions on what to do when the family's cost sharing limits have been exceeded. Families are instructed to contact the state when the cap is met and then to submit copies of the receipts for calculation. Pennsylvania's claims processing is decentralized to each of the eight insurance contractors. Therefore, there is no simple way for the state to track the copayments made. Additionally, all children are enrolled in our eligibility and enrollment system as separate cases and it would be difficult to provide a linkage to get to family output.

Once the limits have been exceeded, a family can apply to the state for a

rebate of any cost sharing already paid in excess of the limit. Upon verification that the family exceeded the 5% cost sharing limit, the state will issue a letter to each child in the family to present to the provider that explains that cost sharing is exempt until a specified date (redetermination date) that will be included on the letter. The appropriate contractors will also receive the letter and will then know that premiums will not be required from the enrollees until the next eligibility period begins.

- 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)

Pennsylvania ensures that American Indian and Alaska Native children will be excluded from cost sharing by collecting information on the application and at the time of redetermination of eligibility regarding a child's status as an American Indian or Alaska Native. The applicant/enrollee will be asked to indicate their tribal membership by stating this on the application. If they are found to be in the American Indian or Alaska Native category, the family will be notified of the exemption and an identification card will be issued with an appropriate group number that excludes cost sharing. All providers are required to verify eligibility by checking the enrollment card which contains a notation regarding copayments, as does the telephone eligibility verification system used by providers.

- 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))

Failure to pay the premium for the subsidized program may result in termination. Contractors provide for a 30-day grace period for the receipt of premiums. A notice of proposed termination is included on all invoices, providing for the initial termination notice at least 30 days in advance. An additional notice is generated between the first and seventh day of the grace period to inform the parent or guardian of the effective date of termination, the reason for termination (non-payment of premium), what corrective measures may be taken to prevent termination from occurring (pay the premium, appeal the decision to the eligibility review officer or provide proof of a decrease in income since the determination was made), and the contact number for any questions or to resolve the situation. If the premium is not paid, coverage is retro-terminated to the first of the month following the last month for which the premium payment was received.

Upon receipt of the termination notice, the enrollee may provide income information that would lead to a reassessment of their eligibility. During a reassessment, eligibility is redetermined. If income appears to have decreased

enough that the enrollee appears they may be eligible for Medicaid, the enrollee is moved to the Free category of CHIP, the termination is stayed for 30 days and the application and supporting documentation are forwarded to Medicaid for an eligibility determination. If Medicaid denies for income too high, the enrollee will be evaluated for continued coverage in CHIP. For example, if reassessment found the enrollee possibly eligible for Medicaid, they would most likely qualify for free CHIP and would be re-enrolled in the program with no lapse in coverage. Along the same lines, if reassessment results in an income in a lower premium bracket, the individual will be offered the opportunity to pay the lower premium and be re-enrolled in the program.

If the enrollee disagrees with the reassessment results, the enrollee may request an impartial review through the existing Eligibility Review Process (ERP) (please see section 12.1). An enrollee remains enrolled in the current program as long as premiums are paid while the (impartial) ERP officer reviews the case.

Children may be reinstated if all past premium payments are made to ensure no lapse in coverage. If overdue premiums are not paid, the children must serve a six-month period of uninsurance prior to being determined eligible to again participate in the program. This policy encourages families to keep their children enrolled and use the coverage for preventive care, adds continuity to the program, reduces cost and dissuades episodic care (family only pays for coverage when there is an illness).

Copayments will be required at the time of service. Service can be denied if copayments are not paid.

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))
- The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
- In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

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

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

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

- 9.1.** Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))
- Increase public awareness of CHIP and other state programs aimed at providing health care assistance.
 - Increase overall access to coverage relative to estimated number of uninsured children in Pennsylvania.
 - Increase access to coverage for racial, ethnic, minority and special needs children eligible for CHIP.
 - Increase access to coverage for children in rural areas, specifically central and northeast Pennsylvania.
 - Increase the percentage of children receiving age appropriate well child care, immunizations and preventive health services.
- 9.2.** Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))
- Increase by 2% per year the combined enrollment in CHIP and Medicaid over the base month in which the Pennsylvania state plan was first approved, May 1998.
 - Continue to implement the Governor's Prescription for Pennsylvania to increase access to coverage (increased use of FQHCs, insurance contractors include Certified Registered Nurse Practitioners and Physician Assistants in provider networks, increase number of practices with after hours appointments, and the like).
 - Increase enrollment in rural counties by at least 5% each of the next three years.
 - Maintain the proportion of CHIP enrollees to reflect the general population of Pennsylvania.
 - Reduce the unnecessary overutilization of Ambulatory Care, Emergency Department visits by 2.2% each of the next three years.
 - Increase frequency of adolescent well-care visits by 3% per year for the next 3 years.
 - Increase the percentage of eligible children receiving all vaccinations in HEDIS combination 2 by 0.7% per year for the next 3 years.
- 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))

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

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. Immunizations
 - 9.3.7.2. Well childcare
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, please list: Lead testing, body mass index, and asthma
- 9.3.8. Performance measures for special targeted populations.

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

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

CHIP requires the submission of annual reports containing information on enrollments, demographics, utilization of services, etc.

CHIP requires monitoring and evaluation of quality and access to health care services. The Department of Health contracts with an external review organization to conduct this evaluation.

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 Commonwealth of Pennsylvania, in December of 1997, conducted public forum hearings across the state to provide a platform for advocacy and community-based groups, private citizens and representatives of the insurance industry, to express concerns and

recommendations on the design and implementation of the state plan.

The Insurance Department in May of 1998, again conducted a public workshop for the purpose of soliciting recommendations on the development of outreach strategies to facilitate maximum enrollment of children in both the CHIP program and Medicaid. As a result of these meetings and workshops, the Insurance Department has developed a business plan to be implemented in phases. The first phase was to “get the word out” about the program expansion. The Departments of Public Welfare and Health helped us to improve the information and referral mechanisms between CHIP and the Medicaid. Additionally, various organizations outside of state government initiated a variety of awareness campaigns which have been endorsed by the Insurance Department, for example, the “Kids First” initiative sponsored by the Hospital Association of Pennsylvania and a grant application submitted to the Robert Wood Johnson Foundation by the Pennsylvania Partnerships for Children entitled “Covering Kids”. Plans for this initial emphasis were begun during the months of July, August, and September of 1998. We then moved on to more long-term enrollment strategies. In addition, tentative plans call for a reconvening of the individuals who participated in the May workshop in early fall for general discussions of community connections, and update and assessment of the impact of our efforts.

Another primary mechanism for public input and involvement is the Children’s Health Advisory Council which was created by state statute. The Children’s Advisory Council is now under jurisdiction of the Insurance Department as a result of amendments to the CHIP law (see **Appendix A**, Act 68, section 2311 (I)). The Children’s Advisory Council is chaired by the Insurance Commissioner and consists of three ex-officio members from the Insurance Department, the Department of Health, and the Department of Public Welfare, respectively and 14 voting members ranging from legislators to a parent with a child enrolled in CHIP.

For the expansion program, the Commonwealth used a multi-step process to solicit input from various stakeholders including providers, CHIP and Medicaid recipients and their families, and advocacy groups. Events that have already occurred or are scheduled include the Governor’s budget address, Secretary level presentations to the state legislature, program summaries to interested parties as part of the budget clarifications, governor’s press announcements at various locations around the state, and Cabinet level presentations to various interest groups. The advocacy community was involved as well as each of the Commonwealth’s insurance contractors.

The legislature hosted Healthcare Excellence and Accountability Response Team (HEART) hearings across the state, focused on the CHIP expansion through the Cover All Kids initiative. Testimony was received from invited guests. Testimony was followed by open discussions in which all attendees are invited to participate. Each of these hearings was open to the general public.

The Commonwealth will continue to accept comments on its implementation of the latest SPA. In addition we are utilizing the following notification processes.

- **Pennsylvania Bulletin Notice** – The *Pennsylvania Bulletin* is the Commonwealth’s official method of communicating information and rulemaking. The Commonwealth will post a notice about the proposed plan and program design prior to the requested effective date of the SPA, and indicate how interested persons can obtain copies of the plan the Commonwealth is submitting to CMS.
- **Medical Assistance Advisory Committee (MAAC) Presentation** – The Commonwealth presented the proposed plan and program design at a MAAC meeting, which is a monthly meeting conducted by DPW for the purpose of presenting and gaining input from stakeholders on issues of policy development and program administration. MAAC is open to the public and is composed of Commonwealth citizens who have experience, knowledge, and interest in the delivery of health care services to low-income citizens and medically vulnerable groups. Members include physicians and other providers, representatives of managed care organizations under contract with the Department, representatives of consumer and provider organizations, current Medicaid recipients and parents of minor child recipients. The Commonwealth will provide copies of the plan it submits to CMS to committee members upon request.
- **Consumer Subcommittee of MAAC** – The Commonwealth presented the proposed plan and program design at a Consumer Subcommittee meeting, which is a monthly subcommittee meeting conducted by DPW for the purpose of reviewing and advising the MAAC on policy development and program administration of publicly funded medical assistance (MA) programs. The Consumer Subcommittee’s mission is to be a resource to the MAAC, enabling the committee to advise the Department of Public Welfare on issues regarding access to service and quality of service. A majority of the members of the Consumer Subcommittee are current MA recipients and may also include representatives of: low-income groups whose membership is primarily medical assistance recipients; advisory groups advocating on health care issues for low-income Pennsylvanians; aging or elderly consumer groups advocating on health care issues for low-income Pennsylvanians; disease or health care condition specific groups;

Hispanic or other ethnic groups advocating on health care issues for low-income Pennsylvanians; former recipients (within past year); parents of minor child recipients; families of recipients; and others knowledgeable and interested in matters that come before the Subcommittee. At least one, but no more than two, members of the Consumer Subcommittee may serve on other subcommittees.

- **Income Maintenance Advisory Committee (IMAC)** - The Commonwealth presented the proposed waiver and program design at an IMAC meeting, which is a bi-monthly meeting conducted by the Department for the purpose of advising the Department on the development and implementation of policies and procedures relating to cash assistance, food stamps, the Low-Income Energy Assistance Program (LIHEAP) and eligibility for Medicaid. The IMAC is composed of 17 members: 12 Medicaid recipients, four advocates and an Executive Director of a County Assistance Office. The Committee Members meet every other month with Department staff in Harrisburg, Pennsylvania. The Commonwealth will provide copies of the waiver to Committee Members upon request.
- **CHIP Advisory Committee Presentation** – The Commonwealth presented the proposed plan and general program design at the October CHIP Advisory Council meeting. The purpose of the CHIP Advisory Council is to advise the Commonwealth on CHIP outreach activities and to review and evaluate the accessibility and availability of services delivered to children enrolled in CHIP.

- 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))

Pennsylvania does not have any American Indian Tribes recognized by the Federal or State government. Any Pennsylvania resident, including those who are American Indians or Alaska Natives, may participate, through the process described in Section 9.9, in the design and implementation of the program, including those policies that would ensure the provisions of child health assistance to American Indian and Alaska Native children.

- 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).

Pennsylvania Bulletin Notice – The *Pennsylvania Bulletin* is the Commonwealth's official method of communicating information and rulemaking. The Commonwealth posted a notice about the proposed

plan and program design on December 11, 2010. The notice also indicated how interested persons can obtain copies of the plan the Commonwealth submits to CMS.

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

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

SCHIP Budget	
STATE: Pennsylvania	FFY Budget
Federal Fiscal Year	2011
State's enhanced FMAP rate	68.95%
Benefit Costs	
Insurance payments	
Managed care	419,468,415
<i>per member/per month rate</i>	<i>179.60</i>
Fee for Service	
Total Benefit Costs	419,468,415
(Offsetting beneficiary cost sharing payments)	15,745,205
Net Benefit Costs	403,723,210
Administration Costs	
Personnel	2,225,000
General administration	2,717,000
Information Technology	3,600,000
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	1,500,000
Other	
Total Administration Costs	10,042,000
10% Administrative Cap	44,858,134
Federal Share (see note 1)	285,323,782
State Share	128,441,428
Total Costs of Approved SCHIP Plan	413,765,210
The Source of State Share Funds: State's general fund, a portion of a state tax on cigarettes, and co-premiums paid by enrollees.	

Notes:

1. The federal matching rate for ongoing IT maintenance caused by the CHIP Reauthorization Act of 2009 (\$540,000) is assumed to be at 75%. The federal matching rate for all other expenses is assumed to be 68.95%.

2. Sources of nonfederal funds are the state's general fund, a portion of a state tax on cigarettes, and co-premiums paid by enrollees

Comment: Although not reflected in the above budget numbers, if the possibility again arises to use a federal matching rate of 90% for IT development and 75% federal matching rate for IT maintenance, we will modify the proposed budget to reflect those matching rates..

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.

10.3-D Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website, to the extent this is feasible.

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

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

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

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

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

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

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

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

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

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

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

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

12.1. Eligibility and Enrollment Matters

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

Pennsylvania implemented an Eligibility Review Process on July 1, 2001. An eligibility review may be requested when:

- an applicant is denied coverage
- an enrollee's coverage is to be terminated
- an enrollee's coverage is to change from Free Health Care Insurance to Subsidized Health Care Insurance
- an enrollee's coverage is to move from a lower premium rate to a higher premium rate within the subsidized program or coverage is moved to the at cost program
- an enrollee's coverage is to move from a higher premium rate to a lower premium rate, but the enrollee disagrees with the determination (mistake in calculating income or family size) or states that they should be in the free program or Medicaid
- there is a failure to make a timely determination of eligibility

The parent or guardian of an applicant or an enrollee may request a review within 30 days of the date of the notice of ineligibility, termination or change in coverage. A request for a review is sent to the appropriate insurance contractor.

Notices to the parent or guardian must include information concerning the impartial eligibility review process. Whenever possible, disputes related to eligibility are resolved prior to the conduct of the review by the Department.

When a request for an impartial review is received, the contractor:

- Logs in the request for a review
- Determines the need for expedited review (i.e. the parent or guardian has indicated that the child has an immediate need for medical attention)
- Informs the Department's Review Officer that a request for review has been received
- Continues coverage or reinstates coverage of an enrollee until the review process has been concluded

- Offers coverage for an applicant if a decision is made in favor of the applicant. Coverage begins after the review process is concluded
- When the need for an expedited review is identified, an interview is scheduled consistent with 42 CFR 457.1160(a)
- Conducts a management review of the decision of ineligibility within two working days of the receipt of the appeal request.
 - The purpose of the management review is to assure that the decision made regarding ineligibility was appropriate.
 - A written record of the management review is prepared.
 - The Contractor informs the Department's Review Officer of the results of the management review.
- If the management review results in a determination that the eligibility decision was not appropriate, the Contractor:
 - Informs the parent or guardian and review officer in writing that an error occurred and the child is eligible
 - Enrolls the applicant child retroactively to the date that the child should have been enrolled
 - Re-enrolls an enrollee who has been terminated retroactively to the date the child was terminated
- If the management review results in a determination that the decision was appropriate, the Department's Review Officer conducts an interview with the appellant and the Contractor's representative.
 - The review is an informal process and is not an administrative hearing.
 - The Review Officer:
 - Informs the parent or guardian in writing of the:
 - Date, time and location of the interview
 - Right to review records maintained by the contractor regarding the eligibility determination
 - Right to receive a copy of the relevant portions of the CHIP Procedures Manual and State or Federal law upon which the decision of ineligibility was based
 - Right to have a representative during the interview
 - Right to have appropriate interpretative service available during the interview if needed
 - Opportunity for continuation of coverage for an enrolled child (with the payment of premium, if required)
 - Provides the parent or guardian with a copy of the application and verification received from the Contractor
 - Informs the Contractor that the interview has been scheduled
 - Reviews the application document and verification and the letter of request prior to the conference call in order to become familiar with the case circumstances. Additional documents that may have an impact on the outcome may be submitted by the parent or guardian or their representative.

- Conducts the review interview
 - The primary objectives of the review are, where possible, to facilitate resolution of the matter at issue and to enroll the child, when appropriate.
 - The Review Officer may ask either or both parties for additional documentation, as needed.
- Issues a written decision within a reasonable time consistent with 42 CFR 457. 1180. A written decision in the form of letter is prepared and sent to the parent or guardian, the representative (if appropriate) and to the Contractor. The Contractor implements the decision of the review officer upon receipt of the letter.
- If anytime during the process, the appellant sends confirmation that a request for a review has been withdrawn, a written confirmation of the request and the resulting action(s) is explained. (Withdrawal of a request may occur if the contractor, applicant or enrollee informs the Department that the request for review has been withdrawn for any reason. Example: contractor has resolved the matter at issue prior to the date of the scheduled review interview.)

A parent or guardian or representative may request reconsideration of the decision of the review officer if they are dissatisfied with the outcome of the review. A parent or guardian must file a written request for reconsideration with the Insurance Commissioner within 15 calendar days from the date of the Review Officer's decision. The request for reconsideration must describe the reason(s) upon which the request is made. Requests for reconsideration will stay the action proposed in the decision of the Review Officer (e.g. that coverage should be terminated).

The Commissioner may affirm, amend, or reverse the decision of the review officer. After a review of the factors considered by the review officer and the request for reconsideration, the Insurance Commissioner issues a written reconsideration decision. A copy of the reconsideration decision will be sent to the parent or guardian, the representative (if appropriate) and to the Contractor.

A parent or guardian or representative may appeal the decision of the Pennsylvania Insurance Department to Commonwealth Court within 30 days from the date that the Insurance Commissioner responds to the request for reconsideration.

12.2. Health Services Matters

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

The review process for health services matters comports with Section 2161 of Act 1998-68 (relating to Grievances) and associated regulations promulgated by the Department of Health. Pennsylvania assures that the health services matters subject to review as described are consistent with the intent of 42 CFR 457.1130(b).

See **Appendix A**.

12.3. Premium Assistance Programs

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

Appendix C

Number of Children Enrolled – September 2010
Categorized by Age

	Under 1	1-5	6-12	13-19	Total
Free CHIP	740	26,331	71,989	66,025	165,085
Sub 1 CHIP	446	4,166	6,952	7,300	18,864
Sub 2 CHIP	118	968	1,585	1,654	4,325
Sub 3 CHIP	60	564	825	867	2,316
At Cost CHIP	114	576	626	851	2,167
Medicaid	80,421	341,038	359,146	335,011	1,115,616
Private Insurance	76,256	381,277	690,799	668,835	1,817,167
Total	158,155	754,920	1,131,922	1,080,543	3,125,540

Categorized by Gender, Race, and Ethnicity

	Free CHIP	Sub 1 CHIP	Sub 2 CHIP	Sub 3 CHIP	At Cost CHIP	Medicaid	Private Insurance
Female	81,932	9,387	2,147	1,170	1,032	544,127	875,327
Male	83,153	9,477	2,178	1,146	1,135	571,489	941,840
Unspecified	0	0	0	0	0	0	0
Total	165,085	18,864	4,325	2,316	2,167	1,115,616	1,817,167
AI/AN	121	9	3	1	3	1,430	1,680
Asian	5,608	483	134	53	56	24,359	19,924
African American	23,851	1,719	342	179	103	304,907	47,530
Native Hawaiian or other Pacific Islander	86	11	7	1	0	461	N/A
White	103,649	12,716	2,961	1,602	1,585	630,042	1,495,022
More than one race	2,065	322	79	35	28	3,694	N/A
Unspecified Race	29,705	3,604	799	445	392	150,723	12,963
Total	165,085	18,864	4,325	2,316	2,167	1,115,616	1,817,167
Hispanic or Latino	11,072	662	127	73	44	154,006	54,731
Non-Hispanic	114,065	11,898	2,654	1,392	1,329	961,610	1,762,436
Unspecified Ethnicity	39,948	6,304	1,544	851	794	0	N/A
Total	165,085	18,864	4,325	2,316	2,167	1,115,616	1,817,167

Categorized by Gender, Race, and Ethnicity

	Free CHIP	Sub 1 CHIP	Sub 2 CHIP	Sub 3 CHIP	At Cost CHIP	Medicaid	Private Insurance
Female	81,932	9,387	2,147	1,170	1,032	544,127	875,327
Male	83,153	9,477	2,178	1,146	1,135	571,489	941,840
Unspecified	0	0	0	0	0	0	0
Total	165,085	18,864	4,325	2,316	2,167	1,115,616	1,817,167
AI/AN	121	9	3	1	3	1,430	1,680
Asian	5,608	483	134	53	56	24,359	19,924
African American	23,851	1,719	342	179	103	304,907	47,530
Native Hawaiian or other Pacific Islander	86	11	7	1	0	461	N/A
White	103,649	12,716	2,961	1,602	1,585	630,042	1,495,022
More than one race	2,065	322	79	35	28	3,694	N/A
Unspecified Race	29,705	3,604	799	445	392	150,723	12,963
Total	165,085	18,864	4,325	2,316	2,167	1,115,616	1,817,167
Hispanic or Latino	11,072	662	127	73	44	154,006	54,731
Non-Hispanic	114,065	11,898	2,654	1,392	1,329	961,610	1,762,436
Unspecified Ethnicity	39,948	6,304	1,544	851	794	0	N/A
Total	165,085	18,864	4,325	2,316	2,167	1,115,616	1,817,167

Note: From Health Insurance Survey

Appendix H

Revised PA CHIP Dental Benefit Package – Effective 1/1/2011

The PA CHIP Dental Program is limited to an annual maximum dental benefit expenditure of \$1,500 per member with the exception of comprehensive orthodontic services which are limited to a lifetime maximum of \$5,200 per member. Please refer to the Orthodontic Services section for more information on limits related to comprehensive orthodontic services.

Contractors are expected to develop internal guidelines including, but not limited to prior authorization policies, that will be used to facilitate the administration of the PA CHIP dental benefit package and to assist in determining medical necessity for certain services. In addition to non-emergent oral and maxillofacial surgical services, prior authorization policies should apply, at a minimum, to any services that are categorized as being endodontic, prosthodontic, or orthodontic in nature using the most recently published version of the American Dental Association's Current Dental Terminology classification system. Members who are denied services will have the right to appeal the denial using the appeals and grievances process as defined by Act 68.

When applicable, the dental benefit package outlined in the following pages has been designed to be consistent with the periodicity schedule utilized by Pennsylvania's Department of Public Welfare (DPW) in the administration of their Medical Assistance Program. DPW's periodicity schedule is adapted from the recommendations made by the American Pediatric Association, the American Dental Association, and the American Academy of Pediatric Dentistry and is routinely reviewed in order to assure that its standards are consistent with the current recommendations of accredited organizations involved in children's healthcare.

The following is a list of services and their corresponding limits that are payable under the PA CHIP Dental Plan. The list includes those services most commonly provided to covered individuals, but other services may be covered for an individual member if it is determined that the requested service is medically necessary and one of the services identified below is insufficient to meet their dental needs.

Diagnostic Services		
Code	Service	Limits
D0120	Periodic oral evaluation	Limited to twice per benefit period. Applies to all oral evaluations including consultations.
D0150	Comprehensive oral evaluation	Limited to twice per benefit period. Applies to all oral evaluations including consultations. Limited to one comprehensive exam per patient per dentist or dental group per lifetime.
D0210	Intraoral – complete series (including bitewings)	1 every 5 years. Limited to one D0210 or D0330 related service every five years..
D0220	Intraoral - periapical first film	
D0230	Intraoral - periapical - each additional film	
D0240	Intraoral - occlusal film	
D0270	Bitewing - single film	1 set per benefit period
D0272	Bitewings - two films	1 set per benefit period.
D0274	Bitewings - four films	1 set per benefit period.
D0277	Vertical bitewings – 7 to 8 films	1 set every 3 years.
D0330	Panoramic film	Limited to one D0210 or D0330 related service every five years.

Preventive Services		
Code	Service	Limits
D1110	Prophylaxis – Adult	Limited to one D1110 or D1120 related service twice per benefit period.
D1120	Prophylaxis – Child	Limited to one D1110 or D1120 related service twice per benefit period.
D1203	Topical application of fluoride (excluding prophylaxis)	Limited to twice per benefit period; “High Risk”* members are eligible for three applications per benefit period.
D1204	Topical application of fluoride (excluding prophylaxis) – Age 15 to 18	Limited to twice per benefit period; “High Risk”* members are eligible for three applications per benefit period.
D1206	Topical fluoride varnish - Less than age 19	Limited to twice per benefit period; “High Risk”* members are eligible for four applications per benefit period. Service should be considered a covered service when billed by either a dental provider or a primary care provider.
D1351	Sealant - per tooth	Member must be less than 18 years of age. Limited to permanent molars free from caries and or restoration. Limited to one treatment per tooth every 3 years except when visible evidence of clinical failure is apparent.
D1510	Space maintainer – fixed – unilateral	Once per lifetime per quadrant.
D1515	Space maintainer – fixed – bilateral -	Once per lifetime per quadrant.
D1550	Recementation of space maintainer	
D1555	Removal of fixed space maintainer	Not allowed by dentist of the dental group that placed the space maintainer. Limited to once per lifetime per device.

* “High Risk” members are pregnant members and those members that are determined to be “high risk” using the American Dental Association’s Caries Risk Assessment tool, or other similar Contractor approved tool.

Restorative Services		
Code	Service	Limits
D2140	Amalgam - one surface, primary or permanent	
D2150	Amalgam - two surfaces, primary or permanent	
D2160	Amalgam - three surfaces, primary or permanent	
D2161	Amalgam - four or more surfaces, primary or permanent	
D2330	Resin-based composite - one surface, anterior	Limited to permanent anterior teeth.
D2331	Resin-based composite - two surfaces, anterior	Limited to permanent anterior teeth.
D2332	Resin-based composite - three surfaces, anterior	Limited to permanent anterior teeth.
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	Limited to permanent anterior teeth.
D2390	Resin based composite crown - anterior	Not reimbursable with construction of a permanent crown for teeth 6-11, 22-27. Limited to permanent teeth and primary teeth with no permanent successors. Limited to once per tooth every 5 years when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser restoration procedure is not possible.
D2391	Resin based composite – one surface posterior	Limited to permanent teeth. Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser restoration procedure is not possible. Not covered for cosmetic purposes.
D2392	Resin based composite – two surfaces - posterior	Limited to permanent teeth. Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser restoration procedure is not possible. Not covered for cosmetic purposes.

D2393	Resin based composite – three surfaces - posterior	Limited to permanent teeth. Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser restoration procedure is not possible. Not covered for cosmetic purposes.
D2394	Resin based composite – four or more surfaces - posterior	Limited to permanent teeth. Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser restoration procedure is not possible. Not covered for cosmetic purposes.

Restorative Services (continued)

D2710	Crown – resin based composite (indirect)	Limited to one D2710, D2721, D2740, D2751, or D2791 service per tooth every five years. Only one crown of any type (excluding D2970 emergency related services) per tooth per calendar year. Limited to permanent teeth or primary teeth with no permanent successors. Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such direct minor restoration is not possible.
D2721	Crown – resin based with predominately base metal	Limited to one D2710, D2721, D2740, D2751, or D2791 service per tooth every five years. Only one crown of any type (excluding D2970 emergency related services) per tooth per calendar year. Limited to permanent teeth or primary teeth with no permanent successors. Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such direct minor restoration is not possible.
D2740	Crown – porcelain/ceramic substrate	Anterior teeth only. Limited to one D2710, D2721, D2740, D2751, or D2791 service per tooth every five years. Only one crown of any type (excluding D2970 emergency related services) per tooth per calendar year. Limited to permanent teeth or primary teeth with no permanent successors. Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such direct minor restoration is not possible.
D2751	Crown - porcelain fused to predominately base metal	Anterior teeth only. Limited to one D2710, D2721, D2740, D2751, or D2791 service per tooth every five years. Only one crown of any type (excluding D2970 emergency related services) per tooth per calendar year. Limited to permanent teeth or primary

		teeth with no permanent successors. Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such direct minor restoration is not possible.
D2791	Crown - full cast predominately base metal	Limited to one D2710, D2721, D2740, D2751, or D2791 service per tooth every five years. Only one crown of any type (excluding D2970 emergency related services) per tooth per calendar year. Limited to permanent teeth or primary teeth with no permanent successors. Only covered when the tooth structure is insufficient to support restoration by another material such as amalgam and a lesser method such direct minor restoration is not possible.
D2930	Prefabricated stainless steel crown - primary tooth	No reimbursement for primary teeth with early loss. Limited to once per tooth per lifetime. Only one crown of any type (excluding D2970 emergency related services) per tooth per calendar year. Only covered if the tooth cannot be restored by another method or material.
Restorative Services (continued)		
D2931	Prefabricated stainless steel crown - permanent tooth	No reimbursement for primary teeth with early loss. Limited to once per tooth per lifetime. Only one crown of any type (excluding D2970 emergency related services) per tooth per calendar year. Only covered if the tooth cannot be restored by another method or material.
D2933	Prefabricated stainless steel crown with resin window	Anterior teeth only. No reimbursement for primary teeth with early loss. Limited to once per tooth per lifetime. Only one crown of any type (excluding D2970 emergency related services) per tooth per calendar year. Only covered if the tooth cannot be restored by another method or material.
D2954	Prefabricated post and core, in addition to crown	Limited to once per tooth per lifetime.

Endodontic Services		
Code	Service	Limits
D3220	Therapeutic pulpotomy (excluding final restoration)	If a root canal is within 45 days of the pulpotomy, total benefit for the root canal will include the allowance given for the pulpotomy.
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime. Not eligible for payment if root canal was started in the same day.
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration) - Incomplete endodontic treatment when you discontinue treatment.	Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime. Not eligible for payment if root canal was started in the same day.
D3310	Anterior root canal (excluding final restoration)	Performed on permanent teeth only. Limited to once per tooth per lifetime.
D3320	Bicuspid root canal (excluding final restoration)	Performed on permanent teeth only. Limited to once per tooth per lifetime.
D3330	Molar root canal (excluding final restoration)	Performed on permanent teeth only. Limited to once per tooth per lifetime.

Periodontic Services		
Code	Service	Limits
D4210	Gingivectomy or gingivoplasty – four or more teeth	Limited to 1 service per quadrant every 3 years. No more than one D4210 or D4341 service per quadrant every two years.
D4341	Periodontal scaling and root planning-four or more teeth per quadrant	Limited to 1 service per quadrant every 2 years. No more than 2 quadrants on the same date of service. No more than one D4210 or D4341 service per quadrant every two years.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Limited to 1 per lifetime after 3 years have elapsed since last dental cleaning.
D4910	Periodontal maintenance	Limited to members that have one or more of the following conditions: diabetes, immunodeficiency, or a systemic disease that impacts the periodontic health, use tobacco products, or members that have completed active periodontal therapy within the past two years. Limited to two services per benefit period.

Prosthodontic Services		
Code	Service	Limits
D5110	Complete denture - maxillary	Limited to 1 every 5 years.
D5120	Complete denture - mandibular	Limited to 1 every 5 years.
D5130	Immediate denture - maxillary	Limited to 1 every 5 years.
D5140	Immediate denture - mandibular	Limited to 1 every 5 years.
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years.
D5213	Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years.
D5214	Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	Limited to 1 every 5 years.
D5410	Adjust complete denture – maxillary	Limited to two adjustments per denture per benefit period after 6 months have elapsed since initial placement.
D5411	Adjust complete denture – mandibular	Limited to two adjustments per denture per benefit period after 6 months have elapsed since initial placement.
D5421	Adjust partial denture – maxillary	Limited to two adjustments per denture per benefit period after 6 months have elapsed since initial placement.
D5422	Adjust partial denture – mandibular	Limited to two adjustments per denture per benefit period after 6 months have elapsed since initial placement.
D5510	Repair broken complete denture base	Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect. Limited to a maximum of two services per benefit

		period.
D5520	Replace missing or broken teeth - complete denture (each tooth)	Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect. Limited to a maximum of three teeth per benefit period.
D5610	Repair resin denture base	Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect. Limited to a maximum of two services per benefit period.
D5620	Repair cast framework	Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect. Limited to a maximum of two services per benefit period.
D5630	Repair or replace broken clasp	Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect. Limited to a maximum of two services per benefit period.

Prosthodontic Services (continued)

D5640	Replace broken teeth - per tooth	Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect. Limited to a maximum of three teeth per benefit period.
D5650	Add tooth to existing partial denture	Limited to a maximum of two services per benefit period.
D5660	Add clasp to existing partial denture	Limited to a maximum of two services per benefit period.
D5730	Reline complete maxillary denture (chairside)	Limited to 1 in 3 years 6 months after the initial installation.
D5731	Reline complete mandibular denture (chairside)	Limited to 1 in 3 years 6 months after the initial installation.
D5740	Reline maxillary partial denture (chairside)	Limited to 1 in 3 years 6 months after the initial installation.
D5741	Reline mandibular partial denture (chairside)	Limited to 1 in 3 years 6 months after the initial installation.
D5750	Reline complete maxillary denture (laboratory)	Limited to 1 in 3 years 6 months after the initial installation.
D5751	Reline complete mandibular denture (laboratory)	Limited to 1 in 3 years 6 months after the initial installation.
D5760	Reline maxillary partial denture (laboratory)	Limited to 1 in 3 years 6 months after the initial installation.
D5761	Reline mandibular partial denture (laboratory)	Limited to 1 in 3 years 6 months after the initial installation.
D6211	Pontic – predominantly base metal	Limited to 1 every 5 years. Only covered in cases where the service is medically necessary as a result of an accident or injury.
D6241	Pontic - porcelain fused to predominately base metal	Limited to 1 every 5 years. Only covered in cases where the service is medically necessary as a result of an accident or injury.
D6751	Crown - porcelain fused to predominately base metal	Limited to 1 every 5 years. Only covered if the tooth cannot be restored by another material such as amalgam or a less intensive restorative procedure. Only covered in cases where the service is medically necessary as a result of an accident or injury.
D6791	Crown - full cast predominately base metal	Limited to 1 every 5 years. Only covered if the tooth cannot be restored

		by another material such as amalgam or a less intensive restorative procedure. Only covered in cases where the service is medically necessary as a result of an accident or injury.
D6930	Recement fixed partial denture	Limited to once in five years.
D6980	Fixed partial denture repair, by report	Service is not covered when the damage to the appliance is a result of abuse, misuse or neglect. Limited to a maximum of two services per benefit period.

Oral and Maxillofacial Surgery Services*

**Some oral surgery services may be fully or partially covered under a member's medical benefits. Services paid out under a member's medical benefit should not be counted against the \$1,500 annual dental benefit maximum.*

Code	Service	Limits
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
D7220	Removal of impacted tooth - soft tissue	Removal of asymptomatic teeth not covered.
D7230	Removal of impacted tooth – partially bony	Removal of asymptomatic teeth not covered.
D7240	Removal of impacted tooth - completely bony	Removal of asymptomatic teeth not covered.
D7250	Surgical removal of residual tooth roots (cutting procedure)	Removal of asymptomatic teeth not covered.
D7260	Oroantral fistula closure	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	Removal of asymptomatic teeth not covered.
D7280	Surgical access of an unerupted tooth	Only covered if the member has been approved for medically necessary orthodontic intervention of the condition.
D7283	Placement of device to facilitate eruption of impacted tooth	
D7288	Brush biopsy – transepithelial sample collection.	
D7310	Alveoloplasty in conjunction with extractions - per quadrant	Limited to once per lifetime. Minimum of three extractions in the affected quadrant.
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	Limited to once per lifetime. No extractions performed in the edentulous area.
D7450	Removal of benign odontogenic cyst or tumor up to 1.25cm	
D7451	Removal of benign non-odontogenic cyst or tumor 1.25cm or greater	
D7460	Removal of benign non-	

	odontogenic cyst or tumor up to 1.25cm	
D7461	Removal of benign odontogenic cyst or tumor 1.25cm or greater	
D7471	Removal of exostosis	Limited to once per lifetime.
D7472	Removal of torus paltines	
D7473	Removal of torus mandubularis	
D7485	Surgical reduction of osseious tuberosity	
D7510	Incision and drainage of abscess - intraoral soft tissue	
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated	
D7520	Incision and drainage of abscess - extraoral soft tissue	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated	
D7960	Frenulectomy	Limited to once per lifetime.

Orthodontic Services

The PA CHIP Dental Program is limited to an annual maximum dental benefit expenditure of \$1,500 per member with the exception of comprehensive orthodontic services which are limited to a lifetime maximum of \$5,200 per member.

With the exception of services related to the comprehensive orthodontic treatment bundle, orthodontic related treatments count toward the annual dental program limit of \$1,500 per member. Payments made using D8690 and D8080 are never applied toward the \$1,500 annual dental program limit.

Once a member has been approved for comprehensive orthodontic treatment, payment will be paid to the authorized dental provider as a lump sum at the beginning of the member's course of treatment. The Contractor will not be reimbursed for any portion of this by the member or the provider if the member leaves the MCO.

Payments associated with comprehensive orthodontic services are subject to a lifetime limit of \$5,200 per member regardless of whether the claims are paid out using D8080 or D8690 codes.

- Members must have a fully erupted set of permanent teeth to be eligible for comprehensive orthodontic services.
- **All orthodontic services require prior approval**, a written plan of care, and must be rendered by a participating provider.
- Orthodontic treatment must be considered medically necessary and be the only method considered capable of:
 - Preventing irreversible damage to the member's teeth or their supporting structures.
 - Restoring the member's oral structure to health and function.
- A medically necessary orthodontic service is an orthodontic procedure that occurs as a part of an approved orthodontic treatment plan that is intended to treat a severe dentofacial abnormality or serious handicapping malocclusion. Orthodontic services for cosmetic purposes are not covered.
- Orthodontia procedures will only be approved for dentofacial abnormalities that severely compromise the member's physical health or for serious handicapping malocclusions. Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite, and crossbite.
 - Dentofacial abnormalities that severely compromise the member's physical health may be manifested by:
 - Markedly protruding upper jaw and teeth, protruding lower jaw and teeth, or the protrusion of upper and lower teeth so that the lips cannot be brought together.

- Under-developed lower jaw and receding chin.
 - Marked asymmetry of the lower face.
- A “handicapping” malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the recipient by causing:
 - Obvious difficulty in eating because of the malocclusion, so as to require a liquid or semisoft diet, cause pain in jaw joints during eating, or extreme grimacing or excessive motions of the orofacial muscles during eating because of necessary compensation for anatomic deviations.
 - Obvious severe breathing difficulties related to the malocclusion, such as unusually long lower face with downward rotation of the mandible in which lips cannot be brought together, or chronic mouth breathing and postural abnormalities relating to breathing difficulties.
 - Lipping or other speech articulation errors that are directly related to orofacial abnormalities and cannot be corrected by means other than orthodontic intervention.
- Members who score 25 or higher on the Salzmann Evaluation Index upon examination and evaluation by an orthodontist are considered to meet the criteria required to substantiate the medical necessity for orthodontic treatment of a serious handicapping malocclusion.

Orthodontic Benefits**Other Orthodontic Services**

D8660	Pre-orthodontic treatment visit	Only covered as a separate service if member is determined to be ineligible for other orthodontic services. Limited to once per benefit period. <i>When covered as a separate service, payments associated with this code are applied to the \$1,500 annual dental program benefit limit <u>instead</u> of the \$5,200 comprehensive orthodontic treatment lifetime benefit limit.</i>
D8680	Orthodontic retention	Limited to once per lifetime. Can only be billed for separately if not associated with comprehensive orthodontic treatment services. <i>When covered as a separate service, payments associated with this code are applied to the \$1,500 annual dental program benefit limit <u>instead</u> of the \$5,200 comprehensive orthodontic treatment lifetime benefit limit.</i>
D8690	Orthodontic treatment (alternative billing to a contract fee)	Used when a patient under active treatment, transfers from one provider to another. The new provider bills under this code and receives a prorated amount determined by the DCO. It is up to the DCO to collect the overpayment made to the previous provider if necessary. <i>Payments associated with this code should <u>only</u> be applied toward the \$5,200 comprehensive orthodontic treatment lifetime benefit limit. Payments associated with this code are NOT applied toward the \$1,500 annual dental program benefit limit.</i>

Comprehensive Orthodontic Treatment

D8080	Comprehensive treatment of adolescent dentition.	Comprehensive treatment of adolescent dentition. Limited to once per lifetime. All inclusive payment for comprehensive treatment also includes the following services: D0140 (limited oral evaluation, problem focused), D8660 (Pre-orthodontic treatment visit),
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		<p>and D8680 (Orthodontic retention). Limited to once per lifetime. <i>Payments associated with this code should <u>only</u> be applied toward the \$5,200 comprehensive orthodontic treatment lifetime benefit limit. Payments associated with this code are NOT applied toward the \$1,500 annual dental program benefit limit.</i></p>
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Emergency Services*

**If a member exhausts their \$1500 annual dental program limit, they will still be entitled to receive the below services if they are determined to be medically necessary and emergent in nature.*

Code	Service	Limits
D2970	Temporary crown (fractured tooth)	Benefit is subject to review as an emergency dental service.
D3410	Apicoectomy/periradicular surgery - anterior	Once per lifetime, does not include placement of retrograde filling material. Only covered in an emergency situation in the presence of swelling or infection. Not allowed for molars. Benefit is subject to review as an emergency dental service.
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	Once per lifetime, does not include placement of retrograde filling material. Only covered in an emergency situation in the presence of swelling or infection. Not allowed for molars. Benefit is subject to review as an emergency dental service.
D3425	Apicoectomy/periradicular surgery - molar (first root)	Once per lifetime, does not include placement of retrograde filling material. Only covered in an emergency situation in the presence of swelling or infection. Not allowed for molars. Benefit is subject to review as an emergency dental service.
D3426	Apicoectomy/periradicular surgery (each additional root)	Once per lifetime, does not include placement of retrograde filling material. Only covered in an emergency situation in the presence of swelling or infection. Not allowed for molars. Benefit is subject to review as an emergency dental service.
D9110	Palliative treatment of dental pain – minor procedure	Benefit is subject to review as an emergency dental service.

Adjunctive Services*

**Certain services identified below may be covered by the member's medical insurance, or may be subject to limits relating to facility type, provider type, or member age. Certain services may only be approved to be used with certain procedure, may only be billed separately under certain circumstances, and/or may require prior authorization. Services paid out under a member's medical benefit should not be counted against the \$1,500 annual dental benefit maximum.*

Code	Service	Limits
D9220	Deep sedation/general anesthesia – first 30 minutes	<i>*See above for potential limitations affecting this benefit.</i>
D9221	Deep sedation/general anesthesia – each additional 15 minutes	<i>*See above for potential limitations affecting this benefit.</i>
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	<i>*See above for potential limitations affecting this benefit.</i>
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	<i>*See above for potential limitations affecting this benefit.</i>