



**Division of Medical Services**  
**Program Development & Quality Assurance**

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437  
 501-320-6428 · Fax: 501-404-4619  
 TDD/TTY: 501-682-6789



**TO:** Arkansas Medicaid Health Care Providers – ARKids First-B  
**DATE:** August 1, 2015  
**SUBJECT:** Provider Manual Update Transmittal ARKIDS-2-14

| <u>REMOVE</u>  |             | <u>INSERT</u>  |             |
|----------------|-------------|----------------|-------------|
| <b>Section</b> | <b>Date</b> | <b>Section</b> | <b>Date</b> |
| 200.110        | 2-1-10      | 200.110        | 8-1-15      |
| 221.100        | 11-15-11    | 221.100        | 8-1-15      |
| 221.200        | 10-13-03    | 221.200        | 8-1-15      |
| 222.300        | 4-1-09      | 222.300        | 8-1-15      |
| 222.600        | 4-1-09      | 222.600        | 8-1-15      |
| 223.200        | 4-1-09      | 223.200        | 8-1-15      |
| 224.000        | 7-1-11      | 224.000        | 8-1-15      |
| 224.220        | 7-1-11      | 224.220        | 8-1-15      |
| 240.300        | 7-1-10      | 240.300        | 8-1-15      |
| 262.130        | 2-1-10      | 262.130        | 8-1-15      |
| 262.140        | 7-1-07      | 262.140        | —           |
| —              | —           | 262.141        | 8-1-15      |
| —              | —           | 262.142        | 8-1-15      |
| —              | —           | 262.143        | 8-1-15      |
| 262.150        | 4-1-09      | 262.150        | 8-1-15      |
| 262.430        | 3-15-13     | 262.430        | 8-1-15      |

**Explanation of Updates**

Section 200.110 is updated to accurately describe ARKids-First B coverage.  
 Section 221.100 is updated to reflect the most current benefits for ARKids First-B medical care.  
 Section 221.200 is updated to reflect the most current list of services not covered for ARKids First-B beneficiaries.  
 Section 222.300 is updated to include orthodontia services in the dental services benefit.  
 Section 222.600 is updated to include occupational and physical therapy benefits.  
 Section 223.200 is updated to include occupational and physical therapy extended benefits.  
 Section 224.000 is updated to include audiological services in the list of ARKids-First B services that are excluded from cost sharing.  
 Section 224.220 is updated to indicate that the co-insurance charge per inpatient hospital admission includes inpatient psychiatric hospital and psychiatric residential treatment facility services.

Section 240.300 is updated to indicate that prior authorization is required for certain inpatient mental health services.

Section 262.130 is updated to clarify policy for preventive health screening and vaccine injection administration fee procedure codes.

Section 262.140 is updated to be a primary section heading for speech-language pathology, occupational and physical therapy procedure codes.

Sections 262.141, 262.142 and 262.143 are added to include information about speech-language pathology, occupational and physical therapy procedure codes.

Section 262.150 is updated to include policy and procedure codes for orthodontia services.

Section 262.430 is updated to indicate that Arkansas First-B beneficiaries are eligible for vaccines through the Arkansas Department of Health instead of through the Vaccines for Children Program. It is also updated to add procedure codes and billing instructions for SCHIP vaccines.

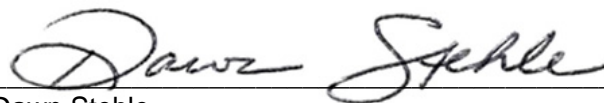
The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: [www.medicaid.state.ar.us](http://www.medicaid.state.ar.us).

Thank you for your participation in the Arkansas Medicaid Program.



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Dawn Stehle  
Director

TOC required

200.110 ARKids First-A and ARKids First-B

8-1-15

Medicaid-eligible children in the SOBRA eligibility category for pregnant women, infants and children (category 61 PW-PL) and newborn children born to Medicaid-eligible mothers (categories 52 and 63), are known as ARKids First-A beneficiaries. Un-insured, non Medicaid-eligible children that meet additional established eligibility requirements will have health coverage under ARKids First-B, a CHIP separate child health program. All ARKids First beneficiaries will receive a program identification card without indication of level of coverage (either ARKids First-A or ARKids First-B).

A Provider Electronic Solutions (PES) eligibility verification transaction response will indicate that the individual is either an ARKids First-A beneficiary or an ARKids First-B beneficiary. The response will also indicate that cost sharing may be required for ARKids First-B beneficiaries.

When a child presents as an ARKids First-A eligible beneficiary, the provider must refer to the regular Medicaid provider policy manuals. When an ARKids First-B eligible beneficiary is identified, the provider must refer to the ARKids First-B Provider Manual for determination of levels of coverage, as well as the associated Medicaid provider policy manuals for the services provided.

221.100 ARKids First-B Medical Care Benefits

8-1-15

Listed below are the covered services for the ARKids First-B program. This chart also includes benefits, whether Prior Authorization or a Primary Care Physician (PCP) referral is required, and specifies the cost-sharing requirements.

| Program Services  | Benefit Coverage and Restrictions            | Prior Authorization/ PCP Referral*                            | Co-payment/ Coinsurance/ Cost Sharing Requirement** |
|---|--|---|---|
| Ambulance (Emergency Only)  | Medical Necessity                            | None  | \$10 per trip                                       |
| Ambulatory Surgical Center  | Medical Necessity                            | PCP Referral  | \$10 per visit                                      |
| Audiological Services (only Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD range ( <a href="#">View ICD codes.</a> )) | Medical Necessity                            | None  | None  |
| Certified Nurse-Midwife   | Medical Necessity                            | PCP Referral  | \$10 per visit                                      |
| Chiropractor  | Medical Necessity                            | PCP Referral  | \$10 per visit                                      |
| Dental Care   | Routine dental care and orthodontia services | None – PA for inter-periodic screens and orthodontia services | \$10 per visit                                      |

| <b>Program Services</b>   | <b>Benefit Coverage and Restrictions</b>  | <b>Prior Authorization/ PCP Referral*</b>                             | <b>Co-payment/ Coinsurance/ Cost Sharing Requirement**</b> |
|---|---|---|--|
| Durable Medical Equipment   | Medical Necessity<br>\$500 per state fiscal year (July 1 through June 30) minus the coinsurance/cost-share. Covered items are listed in Section 262.120 | PCP Referral and Prescription   | 10% of Medicaid allowed amount per DME item cost-share     |
| <b>Emergency Dept. Services</b>   |   |   |  |
| Emergency   | Medical Necessity   | None  | \$10 per visit   |
| Non-Emergency   | Medical Necessity   | PCP Referral  | \$10 per visit   |
| Assessment  | Medical Necessity   | None  | \$10 per visit   |
| Family Planning   | Medical Necessity   | None  | None   |
| Federally Qualified Health Center (FQHC)                                      | Medical Necessity   | PCP Referral  | \$10 per visit   |
| Home Health   | Medical Necessity (10 visits per state fiscal year (July 1 through June 30))  | PCP Referral  | \$10 per visit   |
| Hospital, Inpatient   | Medical Necessity   | PA on stays over 4 days if age 1 or over                              | 10% of first inpatient day                                 |
| Hospital, Outpatient  | Medical Necessity   | PCP referral  | \$10 per visit   |
| Inpatient Psychiatric Hospital and Psychiatric Residential Treatment Facility | Medical Necessity   | PA & Certification of Need is required prior to admittance            | 10% of first inpatient day                                 |
| Immunizations   | All per protocol  | None  | None   |
| Laboratory & X-Ray  | Medical Necessity   | PCP Referral  | \$10 per visit   |
| Medical Supplies  | Medical Necessity<br>Benefit of \$125/mo. Covered supplies listed in Section 262.110  | PCP Prescriptions<br>PA required on supply amounts exceeding \$125/mo | None   |
| Mental and Behavioral Health, Outpatient                                      | Medical Necessity   | PCP Referral<br>PA on treatment services                              | \$10 per visit   |
| Nurse Practitioner  | Medical Necessity   | PCP Referral  | \$10 per visit   |
| Physician   | Medical Necessity   | PCP referral to specialist and inpatient professional services        | \$10 per visit   |
| Podiatry  | Medical Necessity   | PCP Referral  | \$10 per visit   |

| <b>Program Services</b>      | <b>Benefit Coverage and Restrictions</b>  | <b>Prior Authorization/ PCP Referral*</b>   | <b>Co-payment/ Coinsurance/ Cost Sharing Requirement**</b>     |
|------------------------------|---|---|--|
| Prenatal Care                | Medical Necessity   | None  | None   |
| Prescription Drugs           | Medical Necessity   | Prescription  | Up to \$5 per prescription (Must use generic, if available)*** |
| Preventive Health Screenings | All per protocol  | PCP Administration or PCP Referral  | None   |
| Rural Health Clinic          | Medical Necessity   | PCP Referral  | \$10 per visit   |
| Speech Therapy               | Medical Necessity<br>4 evaluation units (1 unit =30 min) per state fiscal year<br>4 therapy units (1 unit=15 min) daily           | PCP Referral<br><br>Authorization required on extended benefit of services        | \$10 per visit   |
| <b>Occupational Therapy</b>  | <b>Medical Necessity</b><br>4 evaluation units (1 unit = 30 min) per state fiscal year<br>4 therapy units (1 unit = 15 min) daily | <b>PCP Referral</b><br><br>Authorization required on extended benefit of services | <b>\$10 per visit</b>  |
| <b>Physical Therapy</b>      | <b>Medical Necessity</b><br>4 evaluation units (1 unit = 30 min) per state fiscal year<br>4 therapy units (1 unit = 15 min) daily | <b>PCP Referral</b><br><br>Authorization required on extended benefit of services | <b>\$10 per visit</b>  |

| Program Services                          | Benefit Coverage and Restrictions                     | Prior Authorization/ PCP Referral*  | Co-payment/ Coinsurance/ Cost Sharing Requirement** |
|---|---|---|---|
| Substance Abuse Treatment Services (SATS) | Medical Necessity                                     | Psychiatrist or Physician Prescription (See Section 221.000 of SATS manual)   | \$10 per visit                                      |
|   |   | Prior Authorization required for all substance abuse treatment services, except codes H0001 & T1007 when billed with no modifier. Codes H0001 & T1007 require prior authorization when billed with a modifier (See Section 231.100 of SATS manual). |   |
|   |   | Prior Authorization required on extended benefit of services (See Section 230.000 of SATS manual)   |   |
| Vision Care                               |   |   |   |
| Eye Exam                                  | One (1) routine eye exam (refraction) every 12 months | None  | \$10 per visit                                      |
| Eyeglasses                                | One (1) pair every 12 months                          | None  | None  |

\*Refer to your Arkansas Medicaid specialty provider manual for prior authorization and PCP referral procedures.

\*\*ARKids First-B beneficiary cost-sharing is capped at 5% of the family’s gross annual income.

\*\*\*ARKids First-B beneficiaries will pay a maximum of \$5.00 per prescription. The beneficiary will pay the provider the amount of co-payment that the provider charges non-Medicaid purchasers up to \$5.00 per prescription.

**Services Not Covered for ARKids First-B Beneficiaries:**

Audiological Services; EXCEPTION, Tympanometry, CPT procedure code **92567**, when the diagnosis is within the ICD range ([View ICD codes.](#))

Child Health Management Services (CHMS)  
 Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT)  
 Developmental Day Treatment Clinic Services (DDTCS)  
 Diapers, underpads and incontinence Supplies  
 Domiciliary Care  
 End Stage Renal Disease Services  
 Hearing aids  
 Hospice  
 Hyperalimentation  
 Non-Emergency transportation  
 Nursing facilities  
 Orthotic Appliances and Prosthetic Devices  
 Personal Care  
 Private Duty Nursing Services  
 Rehabilitation Therapy for Chemical Dependency  
 Rehabilitative Services for Children  
 Rehabilitative Services for Persons with Physical Disabilities (RSPD)  
 School-Based Mental Health Services  
 Targeted Case Management  
 Ventilator Services

### 222.300 Dental Services Benefit

8-1-15

Dental services benefits for ARKids First-B beneficiaries are one periodic dental exam, bite-wing x-rays, and prophylaxis/fluoride treatments every six (6) months plus one (1) day. Scalings are covered once per State Fiscal Year (SFY). Orthodontia services are also covered for ARKids First-B beneficiaries.

The procedure codes listed in Section 262.150 may be billed for the periodic dental exams, interperiodic dental exams and prophylaxis/fluoride, and orthodontia services for ARKids First-B beneficiaries.

Refer to Section II of the Medicaid Dental Provider Manual for a complete listing of covered dental and orthodontia services. Procedures for dental treatment services that are not listed as a payable service in the Medicaid Dental Provider Manual may be requested on individual treatment plans for prior authorization review. These individually requested procedures and dental and orthodontia treatment services are subject to determination of medical necessity, review and approval by the Division of Medical Services dental consultants.

### 222.600 Occupational, Physical and Speech Therapy Benefits

8-1-15

Occupational, physical and speech therapy services are available to beneficiaries in the ARKids First-B program and must be performed by a qualified, Medicaid participating Occupational, Physical or Speech Therapist. A referral for an occupational, physical or speech therapy

evaluation and prescribed treatment must be made by the beneficiary's PCP or attending physician if exempt from the PCP program. All therapy services for ARKids First–B beneficiaries require referrals and prescriptions be made utilizing the "Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21" form DMS-640. [View or print form DMS-640](#)

**Occupational, physical and speech** therapy referrals and covered services are further defined in the Physicians and in the Occupational, Physical and Speech Therapy Provider Manuals. Physicians and therapists must refer to those manuals for additional rules and regulations that apply to **occupational, physical or** speech therapy services for ARKids First–B beneficiaries.

Arkansas Medicaid applies the following daily therapy benefits to **occupational, physical and** speech therapy services in this program:

- A. Medicaid will reimburse up to four (4) **occupational, physical and** speech therapy evaluation units (1 unit = 30 minutes) per state fiscal year (July 1 through June 30) without authorization. Additional evaluation units will require an extended therapy request.
- B. Medicaid will reimburse up to four (4) **occupational, physical and** speech therapy units (1 unit = 15 minutes) daily, without authorization. Additional therapy units will require an extended therapy request.
- C. All requests for extended therapy services must comply with the guidelines located within the Occupational, Physical and Speech Therapy Provider Manual.

**223.200****Occupational, Physical and Speech Therapy Extended Benefits****8-1-15**

If the referring PCP or attending physician, in conjunction with the treating **occupational, physical or** speech therapy provider, determines the beneficiary requires additional daily speech therapy services other than those allowed through regular benefits indicated in Section 222.600, a request for extended therapy services may be made. The therapist must refer to the guidelines in the Occupational, Physical and Speech Therapy Provider Manual to properly apply for extended benefits.

**224.000****Cost Sharing****8-1-15**

Co-payment or coinsurance applies to all ARKids First-B services, with the exception of immunizations, preventive health screenings, family planning, prenatal care, eyeglasses, medical supplies, and audiological services (**only Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD range ([View ICD codes](#).)**). Co-payments or coinsurances range from up to \$5.00 per prescription to 10% of the first day's hospital Medicaid per diem.

ARKids First-B families have an annual cumulative cost sharing maximum of 5% of their annual gross family income. The annual period is July 1 through June 30 SFY (state fiscal year). The ARKids First-B beneficiary's annual cumulative cost sharing maximum will be recalculated and the cumulative cost sharing counter reset to zero on July 1 each year.

The cost sharing provision will require providers to check and be alert to certain details about the ARKids First-B beneficiary's cost sharing obligation for this process to work smoothly. The following is a list of guidelines for providers:

1. On the day service is delivered to the ARKids First-B beneficiary, the provider must access the eligibility verification system to determine if the ARKids First-B beneficiary has current ARKids First-B coverage and whether or not the ARKids First-B beneficiary has met the family's cumulative cost sharing maximum.
2. The provider must check the remittance advice received with the claim submitted on the ARKids First-B beneficiary, which will contain an explanation stating that the ARKids First-B beneficiary has met their cost sharing cap.



3. It is strongly urged that providers submit their claims as quickly as possible to HP Enterprise Services for payment so that the amount of the ARKids First-B beneficiary's co-payment can be posted to their cost share file and the amount added to the accrual.

### 224.220 Inpatient Hospital Co-Insurance

8-1-15

The co-insurance charge per inpatient hospital admission (including services in an inpatient psychiatric hospital and a psychiatric residential treatment facility) for ARKids First-B beneficiaries is 10% of the hospital's Medicaid per diem, applied on the first covered day. For example:

An ARKids First-B beneficiary is an inpatient for four (4) days in a hospital with an Arkansas Medicaid per diem of \$500.00. When the hospital files a claim for four (4) days, ARKids First-B will pay \$1950.00; the beneficiary will pay \$50.00.

Four (4 days) times \$500.00 (the hospital per diem) = \$2000.00 (hospital allowed amount).

Ten percent (10% ARKids First-B co-insurance rate) of \$500.00 = \$50.00 co-insurance.

Two thousand dollars (\$2000.00 hospital allowed amount) minus \$50.00 (co-insurance) = \$1950.00 (ARKids First-B payment).

The ARKids First-B beneficiary is responsible for paying a co-insurance amount equal to 10% of the per diem for one (1) day, which is \$50.00 in the above example.

### 240.300 Prior Authorization (PA) for Outpatient and Inpatient Mental Health Services

8-1-15

Certain outpatient and inpatient mental health services require prior authorization. See the appropriate provider manual for a list of procedure codes that require PA. Requests for PA must be sent to the PA contractor. [View or print ValueOptions contact information.](#)

### 262.130 Preventive Health Screening Procedure Codes

8-1-15

There are two (2) types of full medical preventive health screening procedure codes to be used when billing for this service for ARKids First-B beneficiaries; Newborn and Child Preventive Health Screening:

1. ARKids First-B Preventive Health Screening: Newborn

The initial ARKids First-B preventive health screen for newborns is similar to Routine Newborn Care in the Arkansas Medicaid Physician and Child Health Services (EPSDT) Programs.

For routine newborn care following a vaginal delivery or C-section, procedure code 99460, 99461 or 99463, with the required modifier UA and a primary detail diagnosis ([View ICD codes.](#)) must be used one time to cover all newborn care visits by the attending provider. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to code 99460, 99461 or 99463. These codes include the physical exam of the baby and the conference(s) with the newborn's parent(s), and are considered to be the Initial Health Screening.

For newborn illness care, e.g., neonatal jaundice, following a vaginal delivery or C-section, use procedure codes range 99221 through 99223. Do not bill codes 99460, 99461 or 99463 (routine newborn care) in addition to the newborn illness care codes.

2. ARKids First-B Preventive Health Screening: Children

Preventive health screenings in the ARKids First-B Program are similar to EPSDT screens in the Arkansas Medicaid Child Health Services (EPSDT) Program in content and application. Billing, however, differs from Child Health Services (EPSDT). All services, including the preventive health medical screenings, are billed in the CMS-1500 claim format for both electronic and paper claims.

All preventive health screenings after the newborn screen are to be billed using the preventive health screening procedure codes 99381-99385 or 99391-99395.

Providers may bill ARKids First-B for a sick child visit in addition to a preventive health screen procedure code (99381-99385 or 99391-99395) for the same date of service if the screening schedule indicates a periodic screen is due to be performed.

| Procedure Code     | Required Modifier | Description  |
|--------------------|-------------------|--|
| 99460 <sup>1</sup> | UA                | Initial hospital/birthing center care, normal newborn (global).  |
| 99461 <sup>1</sup> | UA                | Initial care normal newborn other than hospital/birthing center (global).                                |
| 99463 <sup>1</sup> | UA                | Initial hospital/birthing center care, normal newborn admitted/discharged same date of service (global). |
| 99221 <sup>1</sup> |                   | Initial Newborn Care For Illness Care (e.g. neonatal jaundice)   |
| 99223 <sup>1</sup> |                   |  |
| 99381-99385        |                   | Comprehensive Preventive Medicine Health Evaluation/Screen (New Patient)                                 |
| 99391-99395        |                   | Comprehensive Preventive Medicine Health Evaluation/Screen (Established Patient)                         |
| 36415 <sup>2</sup> |                   | Collection of venous blood by venipuncture   |
| 83655              |                   | Lead   |

- <sup>1</sup> Exempt from PCP referral requirements
- <sup>2</sup> Covered when specimen is referred to an independent lab
- <sup>3</sup> Arkansas Medicaid description of the service

Immunizations and laboratory tests procedure codes are to be billed separately from comprehensive preventative health screens.

**Billing for ARKids First-B services, including preventive health medical screenings and ARKids First-B SCHIP vaccine injection administration fees, are to be billed in the CMS-1500 claim format ONLY; for both electronic and paper claims.**

**262.140 Speech-Language Pathology, Occupational and Physical Therapy Procedure Codes**

**262.141 Speech-Language Pathology Procedure Codes 8-1-15**

**NOTE: ⚠(...)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

| Procedure Code | Required Modifier | Description |
|----------------|-------------------|-------------|
|----------------|-------------------|-------------|

| Procedure Code | Required Modifier | Description   |
|----------------|-------------------|---|
| 92507          | —                 | Individual Speech Session   |
| 92507          | UB                | Individual Speech Therapy by Speech Language Pathology Assistant  |
| 92508          | —                 | Group Speech Session  |
| 92508          | UB                | Group Speech Therapy by Speech Language Pathology Assistant   |
| 92521          | UA                | ** (Evaluation of speech fluency (e.g., stuttering, cluttering) (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)  |
| 92522          | UA                | ** (Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)  |
| 92523          | UA                | ** (Evaluation of speech production (e.g., articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (e.g., receptive and expressive language) (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30) |
| 92524          | UA                | ** (Behavioral and qualitative analysis of voice and resonance (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)   |

262.142 Occupational Therapy Procedure Codes

8-1-15

| Procedure Code | Required Modifier | Description   |
|----------------|-------------------|---|
| 97003          | —                 | Evaluation for Occupational Therapy                               |
| 97530          | —                 | Individual Occupational Therapy                                   |
| 97530          | UB                | Individual Occupational Therapy by Occupational Therapy Assistant |
| 97150          | U2                | Group Occupational Therapy  |
| 97150          | UB, U1            | Group Occupational Therapy by Occupational Therapy Assistant      |

262.143 Physical Therapy Procedure Codes

8-1-15

| Procedure Code | Required Modifier | Description   |
|----------------|-------------------|---|
| 97001          | —                 | Evaluation for Physical Therapy                           |
| 97110          | —                 | Individual Physical Therapy                               |
| 97110          | UB                | Individual Physical Therapy by Physical Therapy Assistant |
| 97150          | —                 | Group Physical Therapy                                    |

| Procedure Code | Required Modifier | Description  |
|----------------|-------------------|--|
| 97150          | UB                | Group Physical Therapy by Physical Therapy Assistant |

**262.150 Billing Procedure Codes for Periodic Dental Screens and Services and Orthodontia Services 8-1-15**

A. Initial/Periodic Preventive Dental Screens

Periodicity schedule once each six months plus one day – must be billed with procedure code **D0120**.

B. Interperiodic Preventive Dental Screens

ARKids First-B beneficiaries may receive interperiodic preventive dental screening, if required by medical necessity. There are no limits on these services; however, prior authorization must be obtained in order to receive reimbursement. Refer to Section 240.200 of this manual for dental prior authorization information.

Procedure code **D0140** must be billed for an interperiodic preventive dental screen. **This service requires prior authorization (see Section 240.200).**

The procedure codes listed in the table below must be billed for prophylaxis/fluoride.

| Procedure Code | Description   |
|----------------|---|
| D1110          | Prophylaxis – adult (ages 10-18)  |
| D1120          | Prophylaxis – child (ages 0-9)  |
| <b>D1208</b>   | Topical application of fluoride (including prophylaxis) - <b>all ages</b> |
| <b>D1206</b>   | Topical application of <b>fluoride varnish</b> (ages <b>0-20</b> )        |

Refer to Section 222.300 for further details regarding dental services for ARKids First–B beneficiaries.

C. Orthodontia Services

**Comprehensive Orthodontic Treatment – Permanent Dentition**

| Procedure Code | Description                   |
|----------------|-------------------------------|
| <b>D8070</b>   | <b>Class I Malocclusion</b>   |
| <b>D8080</b>   | <b>Class II Malocclusion</b>  |
| <b>D8090</b>   | <b>Class III Malocclusion</b> |

**Other Orthodontic Devices**

| Procedure Code | Description                        |
|----------------|------------------------------------|
| <b>D8210</b>   | <b>Removable appliance therapy</b> |

**Other Orthodontic Devices**

| <b>Procedure Code</b> | <b>Description</b>                           |
|-----------------------|--|
| D8220                 | Fixed appliance therapy                      |
| D8999                 | Unspecified orthodontic procedure, by report |

Refer to Section II of the Medicaid Dental Provider Manual for service definitions, information regarding reimbursement, prior authorization and other information pertaining to orthodontic treatment.

**262.430 Vaccines for ARKids First-B Beneficiaries**

8-1-15

ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. [View or print the Department of Health contact information.](#)

Only a vaccine injection administration fee is reimbursed. When filing claims for administering vaccines for ARKids First-B beneficiaries, providers must use the CPT procedure code for the vaccine administered and the required modifier **SL only** for either electronic or paper claims. Providers must bill claims for ARKids First-B beneficiaries using the CMS-1500 claim format.

The following list contains the SCHIP vaccines available to ARKids-First-B beneficiaries through the Arkansas Department of Health.

| <b>Procedure Code</b> | <b>M1</b> | <b>Age Range</b>                |
|-----------------------|-----------|---------------------------------|
| 90633                 | SL        | 12 months-18 years              |
| 90634                 | SL        | 12 months-18 years              |
| 90636                 | SL        | 18 years only                   |
| 90645                 | SL        | 0-18 years                      |
| 90646                 | SL        | 0-18 years                      |
| 90647                 | SL        | 0-18 years                      |
| 90648                 | SL        | 0-18 years                      |
| 90649                 | SL        | 9-18 years                      |
| 90650                 | SL        | 9-18 years                      |
| 90654                 | SL        | 18 years                        |
| 90655                 | SL        | 6 months-35 months              |
| 90656                 | SL        | 3 years-18 years                |
| 90657                 | SL        | 6 months-35 months              |
| 90658                 | SL        | 3 years-18 years                |
| 90660                 | SL        | 2 years-18 years (not pregnant) |
| 90669                 | SL        | 0-4 years                       |
| 90670                 | SL        | 6 weeks-5 years                 |
| 90672                 | SL        | 2 years-18 years                |

| <b>Procedure Code</b> | <b>M1</b> | <b>Age Range</b>           |
|-----------------------|-----------|----------------------------|
| 90673                 | SL        | 18 years                   |
| 90680                 | SL        | 6 weeks to 32 weeks        |
| 90681                 | SL        | 6 weeks to 32 weeks        |
| 90685                 | SL        | 6 months through 35 months |
| 90686                 | SL        | 3-18 years                 |
| 90688                 | SL        | 3-18 years                 |
| 90696                 | SL        | 4-6 years                  |
| 90698                 | SL        | 0-4 years                  |
| 90700                 | SL        | 0-6 years                  |
| 90702                 | SL        | 0-6 years                  |
| 90707                 | SL        | 0-18 years                 |
| 90710                 | SL        | 0-18 years                 |
| 90713                 | SL        | 0-18 years                 |
| 90714                 | SL        | 7-18 years                 |
| 90715                 | SL        | 7-18 years                 |
| 90716                 | SL        | 0-18 years                 |
| 90720                 | SL        | 0-18 years                 |
| 90721                 | SL        | 0-18 years                 |
| 90723                 | SL        | 0-18 years                 |
| 90732                 | SL        | 2-18 years                 |
| 90734                 | SL        | 0-18 years                 |
| 90743                 | SL        | 0-18 years                 |
| 90744                 | SL        | 0-18 years                 |
| 90747                 | SL        | 0-18 years                 |
| 90748                 | SL        | 0-18 years                 |

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

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

State/Territory: ARKANSAS  
(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))

Dawn Stehle, Director, DMS  
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

|                   |  |
|-------------------|--|
| Name: John Selig  | Position/Title: Director, Department of Human Services (DHS)     |
| Name: Dawn Stehle | Position/Title: Director, DHS Division of Medical Services (DMS) |
| Name:             | Position/Title:  |

**\*Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

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

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

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

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

**Federal Requirements for Submission and Review of a Proposed SPA.** (42 CFR Part 457 Subpart A)

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

When submitting a state plan amendment, states should redline the changes that are being made to the



existing state plan and provide a “clean” copy including changes that are being made to the existing state plan.

The template includes the following sections:

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

and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

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

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

- o **Option to Create a Separate Program-** States may elect to establish a separate child health

program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.

- o **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

#### **Medicaid Expansion- CHIP SPA Requirements**

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

1. (General Description)
2. (General Background)

They will also be required to complete the appropriate program sections, including:

1. (Eligibility Standards and Methodology)
2. (Outreach)
3. (Strategic Objectives and Performance Goals and Plan Administration including the budget)
4. (Annual Reports and Evaluations).

#### **Medicaid Expansion- Medicaid SPA Requirements**

States expanding through Medicaid-only will also be required to submit a Medicaid state plan Amendment to modify their Title XIX state plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

1. (Methods of Delivery and Utilization Controls)
2. (Eligibility Standards and Methodology)
3. (Coverage Requirements for Children's Health Insurance)
4. (Quality and Appropriateness of Care)
5. (Cost Sharing and Payment)
6. (Program Integrity)
7. (Applicant and Enrollee Protections)

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

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

Name of Project Officer  
Centers for Medicare & Medicaid Services  
7500 Security Blvd  
Baltimore, Maryland 21244  
Attn: Children and Adults Health Programs Group  
Center for Medicaid and CHIP Services  
Mail Stop - S2-01-16

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

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

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

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

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

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

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

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

**A. Background**

Arkansas aggressively pursued health care for children by covering optional benefits and categories that benefit children. For example, Arkansas elected to provide the full range of EPSDT services to children without requiring the EPSDT screen. Also Arkansas was one of the first states in the nation to cover the TEFRA-134 children authorized by the Tax Equity and Fiscal Responsibility Act of 1982.

Effective 1-1-03, the State began covering TEFRA children in a TEFRA-like 1115(a) demonstration waiver in which the parents pay a premium based on a sliding scale; some parents are not required to pay a premium. The TEFRA-like demonstration waiver provides for the care of a child in his/her home, if he/she qualifies for Medicaid as a resident in a Title XIX institution, e.g., a nursing facility or an Intermediate Care

Facility for the Mentally Retarded, etc. Parental income and resources are not counted in the child's eligibility determination. Before eligibility determination for the TEFRA-like demonstration waiver, the child must first be determined if he/she would meet Title XIX Medicaid eligibility. Parental income is counted in the premium amount calculation. The eligibility income limit for this demonstration waiver is three times the SSI limit. The TEFRA-like demonstration waiver makes Medicaid available to a large segment of the state's chronically ill children.

In its quest to provide health care for children, the State also opted to cover uninsured children through a Medicaid 1115(a) demonstration waiver, ARKids First. This demonstration is discussed in item B, below.

CHIP Phase I, a Medicaid expansion, was approved August 6, 1998 and implemented October 1, 1998. This was a small CHIP Medicaid expansion in which the last of the eligible children aged-out of the program September 30, 2002. CHIP Phase II is a separate CHIP program that was approved February 16, 2001 but not implemented. Phase III superseded Phase II. Phase III covered some of the children in the State's 1115(a) demonstration waiver, ARKids-B, as an CHIP Medicaid expansion and the Unborn Child program as a separate child health program.

In 2013, on recommendation from CMS, the State made the decision to transition the ARKids-B program from an 1115(a) demonstration waiver CHIP Medicaid expansion program to a separate child health program through the CHIP state plan. The Unborn Child program has been in the CHIP state plan since 1-1-04 as a separate child health program, and the State continues to serve this population.

## **B. ARKids First Background and Development**

In 1997, Arkansas' Governor, the Arkansas State legislature, the President and Congress were all addressing the issue of health care for vast numbers of uninsured children. Governor Mike Huckabee supported enabling state legislation and an appropriations bill in the 1997 legislative session that created and funded ARKids First, an 1115(a) demonstration waiver. The Arkansas Legislature passed both bills and Governor Mike Huckabee signed both bills into law on March 10, 1997. Effective August 4, 2000, the 1115(a) demonstration waiver was renamed ARKids-B.

Ray Hanley, then Director, Division of Medical Services (DMS), formed and chaired an ARKids First work group, composed of individuals from the Governor's Office (the Department of Human Services liaison), Arkansas Children's Hospital, Arkansas Department of Health, Catholic Social Services, Arkansas Advocates for Children and Families, Easter Seals, Communities in School of Arkansas, Arkansas Chapter for American Academy of Pediatrics, Electronic Data Systems (Arkansas Medicaid's then fiscal agent), and various individuals in the Department of Human Services (DHS),

including Tom Dalton, then Department Director. The first meeting was held February 7, 1997, one day after President Clinton announced his FFY '98 budget package that included a proposal to expand health insurance access for poor children in families that earn too much for Medicaid but not enough to afford private health insurance. Additional ARKids First meetings were held as needed. Most of the discussion and concerns involved eligibility factors and the benefit package.

The Arkansas legislation, though not as detailed, mirrors the CHIP legislation in its purpose, i.e., to provide health insurance coverage for uninsured children under age 19 whose family income is at or below 200% of the poverty level. The ARKids First program was designed as a CHIP program, but used the 1115(a) demonstration waiver process for implementation, since the CHIP legislation had not been passed at the time Arkansas' program was under development. The ARKids First 1115(a) demonstration waiver was approved by CMS on August 19, 1997 and implemented on September 1, 1997; only days after the CHIP legislation was signed by the President.

Arkansas developed the ARKids First Program with the thought that it would be able to roll the ARKids First 1115 demonstration waiver into a CHIP program. However, the State recognized that as the ARKids First demonstration waiver and the CHIP legislation were developing, they didn't make completely parallel steps. Therefore, ARKids First enrollees, who did not meet the definition of a CHIP targeted low-income child, would continue to receive their health care services through Title XIX federal funding. Children in ARKids First who met the definition of a CHIP targeted low-income child would be able to receive their services through either Title XIX or Title XXI federal funding, at the discretion of the State. All of the ARKids First children would remain in the 1115(a) demonstration waiver regardless of the funding source. The children who did not meet the definition of a CHIP targeted low-income child were the children of state employees and the children who met the eligibility requirements for regular Title XIX Medicaid. In 2002, CMS instructed the State that parents or guardians of children who met eligibility for Title XIX Medicaid did not have the choice to have their children receive services through either Title XIX Medicaid or the Title XXI CHIP ARKids First 1115(a) demonstration waiver. Children found eligible for Title XIX Medicaid must receive services through the Title XIX Medicaid program. Effective August 4, 2000, the ARKids First program was separated into ARKids-A (regular children's Title XIX Medicaid program) and ARKids-B (1115(a) demonstration waiver Title XXI CHIP program), and ARKids First became an umbrella for these two programs.

The application form and the promotional materials for ARKids-A and ARKids-B identify the two programs as ARKids First. Applications may be made at the local DHS County Office, by mail, or through the internet, and a toll free number is available to clients. Applications in English or Spanish may be printed from the ARKids First website at [www.arkidsfirst.com](http://www.arkidsfirst.com). Applications in other languages are available upon request.

### **C. ARKids-B Title XXI CHIP Separate Child Health Program**

In November 2013, CMS recommended the State transition the ARKids-B 1115(a) demonstration waiver Title XXI CHIP Medicaid expansion program to a Title XXI CHIP separate child health program through the CHIP state plan and advised that if this was done, orthodontia services would have to be added to the ARKids-B program's benefit package of services. As the current ARKids-B 1115(a) demonstration waiver's renewal was due to end December 31, 2013, the State requested and CMS approved an extension of the ARKids-B demonstration waiver to allow the State time to prepare, submit, and have approved an amendment to the CHIP state plan.

Effective 1/1/14 ARKids-B beneficiaries ages 6 through 18 in families with incomes from 100% FPL up to 142% FPL were moved to Title XIX Medicaid ARKids-A (MAGI CHIP SPA Group 2/CS2 PDF page) but continue to be funded through title XXI CHIP.

Children ages 0 through age 18 in families with a household income above 142% FPL up to and including 211% FPL are eligible for ARKids-B. There is no asset test. The State maintains qualifying criteria for ARKids-B that includes income criteria based on modified adjusted gross income methodologies as defined at 42 CFR §435.603. As allowed under 42 CFR §457.805, all ARKids-B enrollees must not have had employer-sponsored or group health insurance within 90 days prior to program enrollment. The State maintains, at minimum, the required exemptions to the period of uninsurance as specified at 42 CFR §457.805. There is no presumptive eligibility. Retroactive eligibility may be determined up to three months prior to the date of application. ARKids-B offers a less comprehensive benefit package than the State's traditional Title XIX Medicaid program (ARKids-A) and requires co-payments.

The State elected a copayment as the only cost sharing requirement, because it is the most equitable form of cost sharing. The State did not want to assess an enrollment fee nor monthly premiums because it wanted the family's cost sharing responsibility to be related solely to usage. Cost sharing is required for services that are not categorized as well-health. The State will keep the current copayment structure in place for ARKids-B enrollees.

The benefit package includes inpatient and outpatient hospital services, physician surgical and medical services, laboratory and x-ray services, well-baby care, including age-appropriate immunizations. Enrollees in the ARKids-B are not eligible for the full range of Medicaid State Plan services. The ARKids-B schedule of benefits is outlined in the table in section 6.2. ARKids-B Program).

ARKids-B utilizes the same provider system as ARKids-A (regular children's Title XIX Medicaid) and operates under a primary care case management model. ARKids-B beneficiaries select or align with a primary care physician responsible for furnishing



primary and preventive services and making medically necessary referrals. Enrollees are entitled to change their primary care physician selection at any time, without limitation. As part of the enrollment materials, enrollees are provided with information concerning their disenrollment rights.

The Division of Medical Services (DMS) and the Division of County Operations (DCO) are divisions of the Department of Human Services. DMS is responsible for the administration of the Medicaid and CHIP programs except for eligibility, which is the responsibility of DCO.

#### **D. Overview of Unborn Child Title XXI CHIP Separate Child Health Program**

The Arkansas Department of Human Services administers the CHIP Unborn Child program.

The essential elements of the program are:

- Medical verification of the pregnancy is required.
- Applicant must have no other insurance that covers the pregnancy.
- Statewide income standard is from zero up to 209% FPL
- There is no resource test for the Unborn Child program.
- The benefits (with the exception of sterilization or any other family planning services) will be the same as the SIXTH OMNIBUS BUDGET RECONCILIATION ACT (SOBRA) pregnant women category under Title XIX Medicaid and include only obstetrical services and treatment for conditions that may complicate or endanger the pregnancy. Benefits include:
  - Prenatal services
  - Delivery
  - Postpartum services (Postpartum coverage is through the end of the month in which the 60<sup>th</sup> day from the date of delivery falls. When one or more physicians in a group see the Unborn Child program beneficiary and at least two months of antepartum care were provided culminating in delivery or the beneficiary was continuously CHIP eligible for two or more months before delivery and on the delivery date, the global method of billing CHIP for postpartum services provided is used. When less than two months of antepartum care was provided to the Unborn Child program beneficiary or the beneficiary was not CHIP eligible for at least the last two months of the pregnancy, the antepartum/obstetrical care without delivery

and the delivery and postpartum care can be billed to CHIP using the itemized billing method.)

- Services that are determined by the physician as medically necessary as, if not provided, could complicate or endanger the eligible Unborn Child program's beneficiary's pregnancy.

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

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

The State assures 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.

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

The state assures that it 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.

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its state plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the state plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

**1.4.** Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

**Original Plan**

Effective Date: Medicaid Expansion (ARKids First Program) – Phase I: 10-1-98

Implementation Date: Medicaid Expansion (ARKids First Program) – Phase I: 10-1-98

**SPA # 1, Purpose of SPA:** Separate State CHIP – Phase II

Effective Date: Not Implemented

Implementation Date: Not Implemented

**SPA # 2, Purpose of SPA:** Medicaid Expansion (ARKids-B Program) – Phase III

Effective Date: 1-1-01

Implementation Date: Implemented retroactively to 1-1-01

**SPA # 3, Purpose of SPA:** Separate State CHIP (Unborn Child Program) – Phase III

Effective Date: 7-1-04

Implementation Date: 7-1-04

**SPA # 4, Purpose of SPA:** To make technical changes to align Arkansas' CHIP state plan with current practice in the State---To delete the references to the ARKids-B opt-out provision & to clarify that Primary Care Case Management (PCCM) is now included in the HIFA ARHealthNetworks 1115(a) demonstration waiver.

Effective Date: 5-5-11

Implementation Date: 5-1-11

**SPA # 5, Purpose of SPA:** Add Poison Control & Drug Information Center Health Services Initiative

Effective Date: 7-1-11

Implementation Date: 7-1-11

**SPA # 6, Purpose of SPA:** Separate State CHIP (ARKids-B Program)

Effective Date: 8-1-15

Implementation Date: 8-1-15

**1.4- TC**

**Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this state plan amendment, when it occurred and who was involved.

Not applicable, as there are no Indian Health Programs or Urban Indian Organizations in the State of Arkansas

TN No: Approval Date Effective Date \_\_\_\_\_

**Section 2.**

**General Background and Description of Approach to Children's Health Insurance Coverage and Coordination**

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

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

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

**2.1.**

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

**A. Children Covered by Department of Human Services (DHS) Programs**

As of the January - March, 2014 quarter, there were 307,568 children enrolled in regular Title XIX

Medicaid (ARKids-A). The racial break out is as follows: 165,507 (53.81%) White; 76,006 (24.71%) Black or African American; 38,727 (12.59%) Hispanic or Latino (No Race Information Available); 6,253 (2.03%) Hispanic or Latino and One or More Races; 1,000 (.33%) American Indian or Alaska Native; 2,127 (.69%) Asian; 2,061 (.67%) Native Hawaiian or Other Pacific Islander; 5,215 (1.70%) More than One Race (Hispanic or Latino Not Indicated) 10,657 (3.46%) Unknown; and 15 (.00487) No Entry.

There were 71,506 children enrolled in the Title XXI CHIP ARKids-B category as of the January – March, 2014 quarter. The racial breakout is as follows: 44,559 (62.31%) White; 13,428 (18.77%) Black or African American; 7,947 (11.11%) Hispanic or Latino (No Race Information Available); 1,041 (1.45%) Hispanic or Latino and One or More Races; 196 (.27%) American Indian or Alaska Native; 715 (.99%) Asian; 358 (.50%) Native Hawaiian or Other Pacific Islander; 928 (1.29%) More than One Race (Hispanic or Latino Not Indicated); 2,333 (3.26%) Unknown and 1(.00135%) No Entry.

## **B. CHIP**

Phase I, was implemented 10-1-98. Phase I was a Medicaid expansion, which added children under age 19 born after 9-30-82 and before 10-1-83. The last child aged out of the Medicaid expansion on 9-30-02.

Phase II, a separate CHIP, was approved 2-16-01, but was not implemented. The separate state CHIP would have covered a portion of the ARKids-B children.

Phase III, was a combination program: The Medicaid expansion was a subset of the Title XXI CHIP ARKids-B 1115(a) demonstration waiver (implemented retroactively to 1-1-01). The separate child health program covered the Unborn Child program (implemented 7-1-04). Phase III supersedes Phase II.

In November 2013, CMS recommended the State transition the Title XXI CHIP ARKids-B 1115(a) demonstration waiver Medicaid expansion program to a separate child health program through the CHIP state plan. As the current ARKids-B 1115(a) demonstration waiver's renewal period was due to end December 31, 2013, the State requested and CMS approved a 6-month extension (January 1 – June 30, 2014), a one-month (July 1 -31, 2014) extension, a 5-month (August 1 – December 31, 2014) extension, and a 5-month (January 1 – May 31, 2015) extension of the ARKids-B 1115(a) demonstration waiver to allow the State time to prepare and submit an amendment to the CHIP state plan, make necessary systems changes, put into place an inter-agency agreement with the Arkansas Department of Health (ADH) for the ADH to continue to provide vaccines to providers of ARKids-B beneficiaries, since these beneficiaries would no longer be eligible for the VFC program once ARKids-B is transitioned to the CHIP state plan as a separate child health program, and to accomplish other needed actions to accomplish this transition. Because the State's currently approved CHIP state plan had been entered on an older template version, before the CHIP SPA #6 was completed, the State's currently approved CHIP state plan was transitioned to the latest version of the CHIP state plan template, and the CHIP SPA #6 was prepared on the latest template version.

### **C. Continued Need for CHIP Coverage Within the State of Arkansas**

In a report release March 13, 2014, it is indicated Arkansas children are more likely to receive vaccinations, dental care, mental health and other health services than they were just a few years ago, although the State continues to lag behind most of the nation in many areas of children's well-being, and State's youth still need better access to medical care and consistent health education. These findings were published in the fourth edition of "Natural Wonders: The State of Children's Health in Arkansas" that was published by Natural Wonders Partnership Council, a group that includes the Arkansas Department of Human Services, the Arkansas Department of Health, the Arkansas Department of Education, Arkansas Children's Hospital, Arkansas Advocates for Children & Families, Arkansas State Dental Health Association, Arkansas Chapter of the American Academy of Pediatrics, the University of Arkansas for Medical Sciences College of Medicine Department of Pediatrics, the University of Arkansas for Medical Sciences Fay W. Boozman College of Public Health, the University of Arkansas at Little Rock, University of Arkansas at Little Rock Institute of Economic Advancement, the University of Arkansas Clinton School of Public Service, Arkansas Blue Cross and Blue Shield, Arkansas Center for Health Improvement, Arkansas Kids Count, the Arkansas Association of Educational Administrators, Arkansas Children's Trust Fund, Arkansas Hunger Relief Alliance, Arkansas Minority Health Commission, and other state agencies and organizations.

The report provides an update on efforts to address the biggest risks faced by the State's children and offers strategies for improving children's health based on data collection and analysis drawing on reports by other organizations, as well as focus groups conducted by Children's Hospital and a survey of 1,000 households in 2012, the report lists 10 priorities for improving children's health. The report identified nine areas of emphasis for addressing the health needs of Arkansas children: 1.) Prenatal Care, Infant Mortality and Teen Pregnancy; 2.) Immunizations; 3.) Oral Health; 4.) Injury Prevention; 5.) Tobacco Use Prevention; 6.) Obesity Prevention; 7.) Mental Health Services; 8.) Health Services Needs and Expansions; 9.) Capacity Building.

The Arkansas System of Care is now reaching more families than ever. Family support partners help families set wrap-around goals for at-risk children, local care coordinating councils strengthen community-based servicers, and local youth-and family-focused activities help support families struggling with behavioral health problems. The federal Patient Protection and Affordable Care Act of 2010 and the "Private Options" 1115 demonstration waiver, the State's program to use federal Medicaid money to subsidize private insurance for people earning up to 138% of the FPL are expected to extend insurance coverage to 500,000 previously uninsured Arkansans. As their parents secure coverage, as many as 40% of the State's remaining uninsured children are expected to receive coverage as well. A 2013 law ensures that new home-visiting programs are evidence-based and establishes an evaluation plan to track and measure outcomes for child and family well-being and school readiness. Arkansas has already received more than \$7 million annually to expand evidence-based home-visiting program and to improve training of home visitors across the State. An additional 1,000 families are being served today as a result of this effort.

The 2014 update provides a new dataset, allowing analysis to compare progress made in these areas since the first report was issued. Conducted in late 2012, the survey questioned 1,000 households about needs, challenges and assets related to children's health. The Natural Wonders update also drew on the results of eight focus groups in Batesville, Forrest City, Gurdon, Lavaca, Little Rock, Jonesboro, and Springdale. Additional data was drawn from existing sources ranging from the U. S. Census Bureau to the Annie E. Casey Foundation Kids Count to neighborhood focused research by local organizations. The report emphasizes opportunities for improvement in several areas where children still face risks to their health and well-being.

Addressing access to health-care services, the report noted that more than 3000 children are enrolled in the ARKids First programs (Title XIX Medicaid ARKids-A and Title XXI CHIP ARKids-B), but Arkansas children on Medicaid/CHIP are less likely than those in other states to receive recommended medical checkups.

According to the report, vaccination compliance among Arkansas children increased from 57% in 2007 to 72% in 2011. However, the report also noted that more than 4,300 Arkansas children didn't receive vaccinations in 2012 – 2013, blamed in part because parents can claim a "philosophical" objection to having their children vaccinated.

Twenty seven percent of Arkansas children ages 6 – 9 years of age now have dental sealants compared to 15% in 2009, and three new mobile dental clinics managed and staff by Arkansas Children's Hospital have resulted in more than 2,000 previously underserved Arkansas children receiving dental care annually.

Arkansas' childhood obesity rates are still high, with about 38% of children registering overweight or obesity weight levels. That percentage is about 6 points higher than the national average of 32%. Arkansas ranks 44<sup>th</sup> in the nation for obese children.

The State's youth smoking rate dropped from 36% in 2000 to 24% in 2010. In 2013, two state laws passed that will help reduce children's access and exposure to e-cigarettes.

The Arkansas Trauma System was formalized in 2009 so injured patients could be routed more efficiently to the best facility for care.

With support from Arkansas Children's Hospital and the Blue & You Foundation, hundreds of classrooms in the State now have free access to online health education curriculum through Health Teacher and GoNoodle. Arkansas is the only state in the nation with this kind of initiative.

And while teenage births reported in 2011 for Arkansas dropped slightly by about 2.9% since 2009, falling from 15.5% of all births in 2002 to 12.6 % of all births in 2011, The State is the fourth highest nationwide in babies born to 15 – 19 year old mothers. In addition, the State's infant mortality rate is high and deaths attributed to Sudden Infant Death Syndrome are almost twice the national average. The report suggests renewed emphasis on strategies to reduce these statistics and relieve other risks

children in Arkansas face.

The report noted that a study by Feeding America, a national network of food banks, found that 28% of Arkansas children in 2011 lived in households that are considered food insecure, meaning household members reported that a lack of money limited what they ate. Arkansas ranks first nationwide in food insecurity, despite Arkansas food banks providing more than 34 million pounds of food to families in 2013. The report notes that Arkansas' child food insecurity rate is 27.8%. Children's Hospital's financial counselors, who normally help parents find assistance to pay medical bills, began helping eligible families apply for food stamps. The hospital also began participating in the U. S. Agriculture Department's summer food service program, offering children free lunches from the cafeteria. The hospital gave out 1,728 meals under the program and plans to expand the program within the next few months to provide meals year-round.

A law was passed in 2009 that prohibits 16 and 17 year olds from driving between 11:00 p.m. and 4:00 a.m. or with more than one unrelated passenger younger than 21 unless the driver who is 21 years of age or older is also in the car. Also drivers younger than 18 years of age are prohibited from using a cellphone while driving. A 2012 study by the Arkansas Center for Health Improvement found that traffic deaths in crashes in Arkansas involving teen drivers dropped 59% from 25 deaths per 10,000 drivers in 2008 to 10 deaths per 10,000 drivers in 2010. However, the State's motor vehicle accidents are still the leading cause of death in unintentional injuries for residents between the ages of 1 – 44 years of age.

#### **D. Public-Private Partnerships**

The State does not have a public-private partnership. The State does not have a BC/BS Caring Program for Children.

**Guidance:** Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

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

Arkansas uses the health services initiative (HSI) option allowed at 42 CFR 457.10 to support the Arkansas Poison and Drug Information Center (APDIC). The University of Arkansas for Medical Sciences (UAMS) College of Pharmacy operates the APDIC as a service to individuals and healthcare professionals of the State. The APDIC mission is to provide timely, useful clinical advice in potential poison exposures while enhancing a statewide system of population-based surveillance, vital records and statistics, with an ongoing plan to monitor, test and implement processes to reach unprecedented levels of performance. The APDIC provides emergency telephone treatment advice, referral assistance, and information to manage exposure to poisonous and hazardous substances and provides emergent



drug information to healthcare providers statewide. APDIC operates 24 hours a day, seven days a week at no charge to the public with full information and treatment capabilities. Presently all the Specialists in Poison Information (SPIs) are Certified Specialists in Poison Information (CSPIs), and the center employs three toxicologists (2 pharmacists and 1 physician) to manage cases. The services are provided via a toll-free telephone number to all communities throughout Arkansas, including underserved, low income, and indigent populations. Services are available by use of an interpreter in over 150 languages and telecommunication devices are used for the deaf and hearing impaired.

APDIC public education programs on poisoning response and prevention direct attention and resources to at-risk children, adolescents and adults living in poverty, including minority and immigrant communities. The public education specifically targets the federally designated delta region of Arkansas. The APDIC works closely with schools, healthcare organizations, parenting groups, and childcare providers throughout Arkansas to promote poison awareness. The toxicologists in the center have worked closely with the Arkansas Department of Health on emerging drugs of abuse and were instrumental in helping move the synthetic marijuana substances, "Bath Salts", and phenazepam to scheduled status in Arkansas. The APDIC public education program provided education programs to over 30,000 children, parents and caregivers throughout Arkansas. Additionally, over 150,000 educational brochures, telephone stickers and magnets are distributed throughout Arkansas each year. Materials have been developed in English and Spanish.

Approximately 23,000 exposure cases from Arkansas are received annually by APDIC. From SFY12 children represented 63.4% of all poisoning exposure cases received by APDIC. An estimated 34.8% of total cases relate to poisoning exposures of children in families whose annual household incomes are no more than 200% FPL. APDIC calculated the number of children below 200% by tracking the total number of calls; the ages of the persons involved and then estimated the number of children below 200% based on The Kids Count Data Center 2010 statistics that estimates 55% of Arkansas' children are living in households with incomes no greater than 200% FPL. In addition to calls regarding exposures, the APDIC receives over 11,500 calls each year from Arkansans requesting poison or drug information. These calls are considered preventive.

APDIC intervention resulted in over 88% of the exposure calls originating at home (in children less than six years of age) being handled in the home, so the children did not have to use an emergency department or need a 911 call and response. Each call to the APDIC significantly reduces costs in other medical spending. A recent study in the **Journal of Medical Toxicology** showed a median of 36 dollars in unnecessary healthcare charges were prevented for each dollar spent supporting a poison center.

The APDIC public toll-free number is listed in the emergency section of all Arkansas telephone directories. The number is also included in numerous community directories throughout Arkansas. The APDIC serves every county of the State on at least a monthly basis.

Without the CHIP funding, the Arkansas Poison and Drug Information Center would not have the operating funds to continue to provide 24 hour services to the citizens of Arkansas. The funds provided for the APDIC from the Health Services Initiative will only provide funding for costs that are directly related to the provision of services by the APDIC.

The APDIC will provide actual expenditures on children for each quarter of the SFY for reimbursement. Exposures in children have ranged from 62-68% of total case annually during 2004-2011.

The only provider that currently qualifies under the APDIC methodology is the University of Arkansas for Medical Sciences (UAMS), a State Operated public provider. UAMS receives and retains the entire Medicaid payments under APDIC. However, a specific agreed upon quarterly IGT dollar amount is received from UAMS and by signed agreement (one single quarterly agreement) is associated with the total of all Medicaid amounts paid to UAMS. The agreement specifies that the IGT \$ amount cannot exceed the quarterly total Medicaid amount paid to UAMS after the IGT is received multiplied by the quarterly State Match % rate.

The State assures that the APDIC will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

**2.3-TC Tribal Consultation Requirements** - (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

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

Not applicable, as there are no Indian Health Programs or Urban Indian Organizations in the State of Arkansas.

### **Section 3. Methods of Delivery and Utilization Controls**

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

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity

health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

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

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

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

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding. If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

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

The delivery standards will be the same as under Title XIX Medicaid.

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

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package.

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

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

The utilization controls will be the same as under Title XIX.

#### **Section 4. Eligibility Standards and Methodology**

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

**4.0. [X] Medicaid Expansion**

**4.0.1.** Ages of each eligibility group and the income standard for that group:

See page CS3.

**4.1. [ ] Separate Program** Check all standards that will apply to the state plan. (42CFR 457.305(a) and 457.320(a))

See page CS14 for children who lose Medicaid/CHIP due to the elimination of income disregards.

**4.1.0**  Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

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

See page CS9.

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

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

See page CS9.

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

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

See page CS9.

**4.1.4**  Resources of each separate eligibility group (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):

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

Not applicable.

4.1.7  Access to or coverage under other health coverage:

CHIP enrollees cannot be eligible for Title XIX Medicaid. CHIP enrollees cannot have access to a state health benefits program. Enrollees in the Title XXI CHIP Unborn Child separate child health program may not have health insurance that covers pregnancy related services. If a parent or guardian voluntarily terminates within 90-days preceding application for a child for the Title XXI CHIP ARKids-B separate child program an insurance in which the child is covered for a reason other than those allowed conditions or exemptions specifically stated in eligibility criteria, the child will be ineligible for the ARKids-B separate child health program. See also page CS20 – Substitution of Coverage.

4.1.8  Duration of eligibility, not to exceed 12 months:

Continuous eligibility does not apply to the Unborn Child CHIP separate child program.

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

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

4.1.9.1  States should specify whether Social Security Numbers (SSN) are required.

See page CS19

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

4.1.9.2  Continuous eligibility

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

remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of “lawfully residing” children and/or pregnant women. States may elect to cover (1) “lawfully residing” children described at section 2107(e)(1)(J) of the Act; (2) “lawfully residing” pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

**4.1- LR**

**Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

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

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

pending application for adjustment of status;

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

Elected for pregnant women.

Elected for children under age \_\_\_\_.

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

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

**4.2.** **Assurances** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and



42 CFR 457.320(b))

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

4.2.2.  Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the state plan as well as targeted low-income children.

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

#### 4.2-DS

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

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

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

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

#### 4.3.

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

See page CS15 for Modified Adjusted Gross Income (MAGI)-based income methodologies.

See page CS24 for eligibility processing.

**Retroactive coverage for the Title XXI CHIP separate child health programs ARKids-B and Unborn Child:** The effective first day of coverage for the ARKids-B and Unborn Child programs is the first day of the month of application unless retroactive coverage is approved. The State is required to provide retroactive eligibility for up to three full months prior to the date of application to applicants who:

1. Received medical services in the retroactive period, and
2. Were eligible in the month the medical services were received.

Retroactive eligibility will be provided to applicants who were otherwise eligible in the month services were received regardless of whether they were ineligible at other times during retroactive period. Retroactive eligibility is separate and apart from current eligibility, i.e., applicants not

eligible for the current period may be eligible for the retroactive period. Retroactive eligibility is the same for the Title XXI CHIP ARKids-B and Unborn Child programs. Coverage for ARKids-B will end on the last day of the month that eligibility ceases, unless continued eligibility is determined at the time of reevaluation. Women in the Unborn Child program will receive coverage during pregnancy and the 60 day postpartum period. Postpartum coverage is through the end of the month in which the 60<sup>th</sup> day from the date of delivery falls. When one or more physicians in a group see the Unborn Child program beneficiary and at least two months of antepartum care were provided culminating in delivery or the beneficiary was continuously CHIP eligible for two or more months before delivery and on the delivery date, the global method of billing CHIP for postpartum services provided is used. When less than two months of antepartum care was provided to the Unborn Child program beneficiary or the beneficiary was not CHIP eligible for at least the last two months of the pregnancy, the antepartum/obstetrical care without delivery and the delivery and postpartum care can be billed to CHIP using the itemized billing method.

The methods of establishing eligibility and continuing enrollment are the same as under Title XIX.

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

**4.3.1. Limitation on Enrollment** Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

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

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

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

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

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

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

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

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

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

**4.3.3.3-EL** List the component/components of CHIP eligibility that are determined under the Express Lane.

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

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

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

#### **4.4. Eligibility screening and coordination with other health coverage programs**

See page CS24 for eligibility processing.

States must describe how they will assure that:

- 4.4.1.**  only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women applicants

At eligibility determination and redetermination, an applicant for/beneficiary of the Title XXI CHIP ARKids-B separate child health program is reviewed to determine that the applicant/beneficiary is not Title XIX Medicaid eligible and that the parent or guardian did not voluntarily terminate an insurance policy in which the child was covered within 90-days preceding application for the child for ARKids-B, for a reason other than those allowed conditions or exemptions specifically stated in eligibility criteria,. At eligibility determination and redetermination, an applicant for/beneficiary of the Title XXI CHIP Unborn Child separate child health program is reviewed to determine that the applicant/beneficiary is not Title XIX Medicaid eligible and is not under an insurance policy that covers pregnancy related services prior to enrollment in the State's Unborn Child program. The Unborn Child separate child health program does not assess a waiting period for applicants. See also page CS10 – Children Who Have Access to Public Employee Coverage.

- 4.4.2.**  children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))

Screening procedures identify any applicant or enrollee of the Title XXI CHIP ARKids-B or Unborn Child separate child health programs who would be potentially eligible for Title XIX Medicaid services. An application can be completed and submitted electronically. An application can also be completed in writing on an approved DHS application form and submitted to the Agency via mail, fax, e-mail, telephone or in person to a designated DHS Agency. An application can be submitted by the individual, the individual's spouse, or Authorized Representative, emancipated minor, or if the applicant is a minor who is not living with a parent, a caretaker acting responsibly for the minor. Although an application will be accepted and processed with only the minimal information listed below, the applicant is to complete as much information as possible in order to avoid delays in determining eligibility and processing the application. An application must include at a minimum the following information:

1. Applicant's name,

2. Applicant's address (or other means of contacting the applicant if homeless), and
3. Applicant's signature (written, telephonic, or electronic).

An application submitted to DHS for processing must be monitored and tracked to ensure that the application is disposed of in a timely manner. The system is designed to monitor and track the application process from beginning to end. Therefore, each application received by the Agency must be entered into the system upon receipt to begin the process and to assign an application ID. This is referred to as registering the application. Applications submitted online will automatically be registered by the system. Applications submitted to DHS via mail, phone, fax, e-mail or in person must be entered into the system and registered by the Agency staff. Medicaid/CHIP applications must be disposed of within 45 days from the date of application unless a disability determination is required. Applications requiring a disability determination must be disposed of within 90 days from the date of application. Eligibility for all Medicaid/CHIP categories is determined in accordance with general eligibility requirements and financial eligibility. Non-financial criteria are determined depending on the category of coverage. Eligibility factors are verified in accordance with Medical Services eligibility policy requirements. Generally speaking, the system determines Medicaid/CHIP eligibility according to a rules based engine utilizing the data entered into the system by the individual, agency staff, or a combination of both. Specific eligibility determination process steps are as follows:

1. Once enough information has been entered, the system will screen the applicant's eligibility for Medicaid/CHIP and if the individual appears eligible, will verify the applicant's data through various data matches.
2. If the applicant's data and data sources are "reasonably compatible" and eligibility exists, the system will approve the application, update all information regarding the case, and send a notification of approval to the individual.
3. If eligibility does not exist based on the information entered on the application, the system will deny the application and send a notice to the individual.
4. If additional information is required to process the application due to reasonable compatibility issues or missing data, the system will send a notification to the individual requesting the needed information.
5. An interview with the applicant is not required. The applicant will be contacted only if necessary to obtain necessary information.
6. When all requested information is supplied by the applicant, the caseworker will enter the information into the system which will then determine eligibility.
7. If the application is denied, the system will send a notification of denial.

Applications must be disposed of by one of the following actions:

Approval: \_\_\_\_\_ When all eligibility requirements are determined to be met, the application will be approved, and the individual enrolled in the appropriate Medicaid/CHIP coverage group. An approval notice is sent to the

applicant advising that he or she has been approved for coverage with the effective date of coverage.

Denial: An application will be denied in the following situations:

1. The applicant is determined to be ineligible due to an eligibility requirement not being met;
2. Eligibility cannot be established due to failure of the applicant to provide information necessary to determine eligibility; or
3. The applicant withdraws the application.

When an application is denied, a denial notice is sent advising the applicant of the denial, reason for denial, and the applicant's right to appeal the denial.

Each individual approved for Medicaid/CHIP by DHS will be enrolled in the appropriate eligibility coverage group. The system will make this determination based on the information entered to the system. Upon enrollment, a Medicaid or ARKids ID card is issued to the eligible individual if the person does not already have an existing care.

- 4.4.3.**  children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) 42CFR 431.636(b)(4))

Any applicant or enrollee who is found ineligible for Medicaid services is automatically reviewed for CHIP separate child health program eligibility.

- 4.4.4.**  the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)

See page CS20 for substitution of coverage

- 4.4.4.1.**  (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

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

American Indian and Alaska Native children are eligible for Arkansas' CHIP separate child health program on the same basis as any other children in the State, regardless of

whether they may be eligible for or served by Indian Health Services-funded care.

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

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

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

## **Section 5. Outreach and Coordination**

**5.1.** (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

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

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

## **Medicaid/CHIP**

The State has been extremely active in its effort to identify and enroll uncovered children who are eligible to participate in the Arkansas Medicaid/CHIP Program.

The State has cooperative agreements with 35 hospitals, clinics, and organizations throughout the state to place out-stationed DHS Medicaid/CHIP eligibility workers in their facilities. This has simplified the application process and has encouraged individuals and families to apply for Medicaid/CHIP when otherwise they might not have done so.

DHS also has an agreement with the Federally Qualified Health Centers for 19 staff who cover their 36 sites. These FQHC staff members assist in the application process. Medicaid/CHIP outreach is also furthered by a contract between the Arkansas Department of Human Services and the Arkansas Department of Health (ADH) for ConnectCare, the Arkansas Primary Care Case Management program. ConnectCare provides outreach through statewide television and radio advertisements to inform both current eligibles and potential eligibles about the merits of primary medical coverage through Arkansas Medicaid/CHIP.

## **State-only Child Health Insurance**

The State does not have any State-only child health insurance programs.

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

- 5.1.2.** (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

The State does not have a public-private partnership. The State does not have a BC/BS Caring Program for Children.

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

- 5.2.** (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant



child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

Children formerly covered in the 1115 demonstration ARKids B will be covered for health coverage funded through Title XXI CHIP as a separate child health program.

#### **Targeted to Uninsured Children**

The ARKids-B program is designed to provide health insurance coverage for uninsured children under age 19. Uninsured is defined as not having group or employer sponsored primary comprehensive health insurance within the previous 90 days prior to program enrollment unless such insurance was lost through no-fault. An example of no-fault would be if the child had had health insurance through a parent's employment, and the parent is no longer employed. Also children who have inaccessible health insurance are considered to be uninsured. For example, a child has inaccessible health insurance if the child has an out of state, non-custodial parent with HMO insurance for his/her child, but the HMO network does not contain medical providers where the child resides.

#### **Coordination With Medicaid**

The ARKids First name is used as an umbrella for ARKids-A (Title XIX Medicaid) and ARKids-B (Title XXI CHIP).. Based on the family's countable income and household size, eligibility will be determined in the appropriate ARKids First category; ARKids-A or ARKids-B.

The application form contains a chart, which shows the services and cost sharing requirements in each program.

Title XXI CHIP ARKids-B uses the same provider network and the same fiscal agent to process claims that Title XIX Medicaid ARKids-A uses.

NOTE: ARKids-B will be funded by Title XXI.

#### **Coordination with Children's Medical Services**

The Department of Human Services operates a Children's Medical Services Program which provides care coordination and/or specialized medical care and rehabilitation for children with special health care needs whose families are partially or wholly unable to provide for such services, and who meet the agency's criteria. Children's Medical Services are funded by federal (Title V) and state funds. The Children's Medical Services staff coordinates closely with Medicaid/CHIP, especially with regard to the TEFRA-like Medicaid 1115 demonstration waiver, to ensure that the children they serve receive the widest range of services to which they are entitled. Please reference Section 1.1.3. (Sub-Section A) for more information and history regarding the TEFRA-like demonstration.

### **Coordination with Maternal and Child Health**

The Title V Maternal and Child Health (MCH) programs are administered by the Arkansas Department of Health. Preventive health services are available to women, children, adolescents and families in 100 service sites in the state's 75 counties. Preventive services provided include well-child screens, immunizations, prenatal care, family planning, hearing and vision screening, newborn screening, blood lead screening, and follow-up. Over 250,000 Arkansans receive some level of Title V MCH services each year. Services to children with Special Health Care Needs are coordinated with DHS.

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

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

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

- 5.3.** **Strategies** Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

Arkansas developed a comprehensive outreach strategy for ARKids-B. The strategy applies equally to the Title XXI CHIP ARKids-B and the Unborn Child separate child health programs. Outreach for the ARKids-B and Unborn Child programs is through the ConnectCare contract with ADH and through the ADH pregnant women's program. Outreach and education for ARKids First (Title XIX Medicaid ARKids-A and Title XXI CHIP ARKids-B) is also through a contract.

### **Media Campaign**

In addition to the regular Title XIX Medicaid ARKids-A outreach, Arkansas developed outreach geared specifically to the Title XXI CHIP ARKids-B Program. Governor Mike Huckabee held a gala press conference on September 11, 1997, to launch the ARKids-B Program. This has been followed by an extensive media campaign, including television, radio, print, and distribution of brochures in such places as McDonald's® food sacks. A key factor in the success of this campaign was the active role Governor Huckabee took by appearing in television and radio public service announcements, as well as in the printed materials and on the ARKids-B website: [www.ARKidsfirst.com](http://www.ARKidsfirst.com).

The media campaign has been modified to incorporate the changes in the use of the ARKids First name; ARKids First is now composed of ARKids-A (Title XIX Medicaid) and ARKids-B, (Title XXI CHIP)..

### **Coordination With Public and Private Entities**

The outreach effort has been further advanced by working in cooperation with a broad range of public and private entities. These include Arkansas Children's Hospital (they co-sponsor an ARKids First (ARKids-A (Title XIX Medicaid) and ARKids-B (Title XXI CHIP) newspaper insert with DHS), Arkansas Advocates for Children and Families, and several public schools, day care centers, hospitals, clinics, churches, and community centers. Arkansas Department of Human Services (DHS) county offices widely distribute ARKids First application forms to these organizations. Arkansas Advocates for Children and Families has been particularly instrumental in providing outreach by targeting outreach efforts in key parts of the state.

A supply of applications for ARKids First (ARKids-A (Title XIX Medicaid), ARKids-B (Title XXI CHIP) and the Unborn Child (Title XXI CHIP) separate child health programs) are provided to the Arkansas Department of Health (ADH) for distribution in their WIC clinics. ADH is a primary intake point for the separate child health insurance programs.

### **Contracts**

#### **A. Contract Funded through the Arkansas Department of Human Services to Provide Education and Outreach**

Arkansas Department of Human Services spends approximately \$125,000 each state fiscal year on outreach and education for ARKids First (Title XIX Medicaid ARKids-A and Title XXI CHIP ARKids-B). The primary goal of the outreach and education is to prompt families already participating in the ARKids program to utilize prevention services, such as well child checkups. There is a print media campaign that promotes using ARKids for well-child, dental and eye check-ups. Materials are purchased (such as refrigerator magnets with a list of every needed well-child checkup for the first four years of a child's life) that are distributed during at least a dozen large scale family consignment sales across the state. In addition, Radio Disney Summer Safety Roadshow events are held at each of five summer feeding sites across the state and radio advertising is conducted.

#### **B. Contract with the Arkansas Department of Health**

The State has a contract with the Arkansas Department of Health (ADH) to provide information to

recipients/applicants through a media campaign and a 24 hour toll-free telephone Help Line Service. The Help Line Service responds to questions received from ARKids First (ARKids–A (Title XIX Medicaid) and ARKids–B (Title XXI CHIP)) applicants/recipients and providers by telephone concerning eligibility, access, enrollment, rights and responsibilities and other issues. The ADH media campaign publicizes the telephone Help Line, promotes appropriate usage of the medical care system, and uses the most cost-effective strategies, as determined by ADH with DHS approval. The campaign may include television and radio advertising, direct mail, print media, telemarketing and other viable methods that target children.

### **Website**

The ARKids First website address is <http://www.arkidsfirst.com>. The site has six subject links: 1) eligibility, 2) questions, 3) apply, (this includes an application in English or Spanish which can be printed from the website), 4) benefits, 5) more information, and 6) other services.

The Arkansas Medicaid website is located at <https://www.medicaid.state.ar.us>. This site contains a link to the ARKids First site.

## **Section 6. Coverage Requirements for Children’s Health Insurance – ARKids-B Program**

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

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

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

**6.1.1.[X]** Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

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

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

Guidance: Check box below if the benchmark benefit package to be offered by the State is State

employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

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

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

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

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3)

and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

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

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

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

- 6.1.3.**  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440). This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

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

- 6.1.4.[X]** Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450) .) See ATTACHMENT A for a copy of Arkansas State

and Public School Employees benchmark benefits description.

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

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

- 6.1.4.4.**  Coverage that includes benchmark coverage plus additional coverage.) Vision services (eye exam – one routine eye exam [refraction] every 12 months and eyeglasses – one pair every 12 months) and dental services (routine dental care & orthodontia) make up the additional benefit coverage to the Arkansas State and Public School Employees benchmark benefits. (See ATTACHMENT A for a copy of Arkansas State and Public School Employees benchmark benefits description).
- 6.1.4.5.**  Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

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

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

Guidance: Check below if the State elects to provide a source of coverage that is not described

above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

**6.1.4.7.[ ] Other (Describe)**

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

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

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

**ARKids-B Program**

The Title XXI CHIP ARKids-B program's benefit package includes inpatient and outpatient hospital services, physician, surgical and medical services, laboratory and x-ray services, well baby care, including age-appropriate immunizations. Enrollees in ARKids-B are not eligible for the full range of Medicaid State Plan services. The chart below provides a description of the coverage and the amount, duration, and scope of services covered in certain services included in the ARKids-B benefit package, as well as any exclusions or limitations. The services checked below in the pre-print are included in the ARKids-B benefit package.

|   |
|---|
| Ambulance (Emergency Only)  |
| Ambulatory Surgical Center  |
| Audiological Services (only Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD-9-CM range of 381.0 through 382.9) |
| Certified Nurse Midwife   |
| Chiropractor  |
| Dental Care (routine dental care & orthodontia)   |
| Durable Medical Equipment (DME) (Limited to \$500 per State Fiscal Year (SFY) July 1 – June 30)   |
| Emergency Dept. Services (Emergent, non-emergent, assessment)   |
| Family Planning   |
| Federally Qualified Health Center (FQHC)  |
| Home Health (10 visits per SFY (July 1 – June 30))  |
| Hospital, Inpatient   |
| Hospital, Outpatient  |



|  |
|--|
| Inpatient Psychiatric Hospital & Psychiatric Residential Treatment Facility  |
| Immunizations (All per protocol)   |
| Laboratory & X-Ray   |
| Medical Supplies (Limited to \$125/month unless benefit extension is approved)   |
| Mental & Behavioral Health, Outpatient   |
| Nurse Practitioner   |
| Physician  |
| Podiatry   |
| Prenatal Care  |
| Prescription Drugs   |
| Preventive Health Screenings (All per protocol)  |
| Rural Health Clinic  |
| Speech Therapy<br>Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved<br>Therapy – Four 15 minute units/day unless benefit extension is approved       |
| Physical Therapy<br>Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved<br>Therapy – Four 15 minute units/day unless benefit extension is approved     |
| Occupational Therapy<br>Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved<br>Therapy – Four 15 minute units/day unless benefit extension is approved |
| Substance Abuse Treatment Services (SATS), outpatient  |
| Vision<br>(Eye exam – One routine eye exam (refraction) every 12 months<br>Eyeglasses) – One pair every 12 months  |

- 6.2.1.[X]** Inpatient services (Section 2110(a)(1))
- 6.2.2.[X]** Outpatient services (Section 2110(a)(2))
- 6.2.3.[X]** Physician services (Section 2110(a)(3))
- 6.2.4.[X]** Surgical services (Section 2110(a)(4))
- 6.2.5.[X]** Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6.[X]** Prescription drugs (Section 2110(a)(6))
- 6.2.7.[X]** Over-the-counter medications (Section 2110(a)(7))

- 6.2.8.[X] Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9.[X] Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10.[X] Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11.[X] Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12.[X] Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13.[X] Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

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

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

- 6.2.15.[X] Nursing care services (Section 2110(a)(15))
- 6.2.16.  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17.[X] Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
- 6.2.18.  Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19.[X] Outpatient substance abuse treatment services (Section 2110(a)(19))

- 6.2.20.[X] Case management services (Section 2110(a)(20))
- 6.2.21.  Care coordination services (Section 2110(a)(21))
- 6.2.22.[X] Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23.  Hospice care (Section 2110(a)(23))

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

- 6.2.24.[X] Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

The Title XXI CHIP ARKids-B benefit package includes vision services that include one eye exam (refraction) and one pair of eyeglasses every 12 months

- 6.2.25.  Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26.[X] Medical transportation (Section 2110(a)(26))

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

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

**6.2.1-DC** State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT<sup>1</sup>) codes are included in the dental benefits:

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

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

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

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

**6.2.2.1-DC**  FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT<sup>2</sup> codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

**6.2.2.3-DC**  HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach

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a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

- 6.2-DS**  Supplemental Dental Coverage- The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

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

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

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

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

**6.3.2.**  The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

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

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

**6.4.1.**  **Cost Effective Coverage-** Payment may be made to a State in excess of the 10

percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

- 6.4.1.1.** Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))
- 6.4.1.2.** The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

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

1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

Guidance: Check 6.4.2 if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

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

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

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

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

**6.4.3-PA:** **Additional State Options for Providing Premium Assistance** (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No

subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

- Yes  
 No

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

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

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

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

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

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

**6.4.3.2.3-PA** If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer



will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

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

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

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

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

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

**6.4.3.5-PA**

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

provide this option?

Yes

No

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

**6.6.3.5.2-PA** Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

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

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

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

**Section 6. Coverage Requirements for Children's Health Insurance – Title XXI CHIP Unborn Child Program**

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

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

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

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

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

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

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

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

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

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

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,

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

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

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

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

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If “existing comprehensive state-based coverage” is

modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for “existing comprehensive state-based coverage” must be described in the space provided for all states. (Section 2103(a)(3))

- 6.1.3.**  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440). This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

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

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

**6.1.4.1.**  Coverage the same as Medicaid state plan

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

**6.1.4.3.**  Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

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

**6.1.4.4.**  Coverage that includes benchmark coverage plus additional coverage

**6.1.4.5.**  Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

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

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

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

- 6.1.4.7.[X] Other (Describe)

**Conception through birth:** For the Title XXI CHIP **Unborn Child program**, the State covers the same services that it covers in the Medicaid state plan for SIXTH OMNIBUS BUDGET RECONCILIATION ACT (SOBRA) pregnant women with the exception of sterilization or other family planning services. Services include prenatal services, delivery, 60 day postpartum services and services for conditions that are determined by a physician as needed, as if not provided, could complicate and/or endanger the pregnancy. Postpartum coverage is through the end of the month in which the 60<sup>th</sup> day from the date of delivery falls. When one or more physicians in a group see the Unborn Child program beneficiary and at least two months of antepartum care were provided culminating in delivery or the beneficiary was continuously CHIP eligible for two or more months before delivery and on the delivery date, the global method of billing CHIP for postpartum services provided is used. When less than two months of antepartum care was provided to the Unborn Child program beneficiary or the beneficiary was not CHIP eligible for at least the last two months of the pregnancy, the antepartum/obstetrical care without delivery and the delivery and postpartum care can be billed to CHIP using the itemized billing method.

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

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

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

**Title XXI CHIP Unborn Child Program**

For the Unborn Child program, the State covers pregnancy related services and services that are determined as medically needed by a physician as, if not provided, could complicate or endanger the pregnancy. In the Unborn Child program the State covers the same services that it covers for the SIXTH OMNIBUS BUDGET RECONCILIATION ACT (SOBRA) pregnant women category in the Title XIX Medicaid state plan with the exception of sterilization or any other family planning services. The services checked below are covered as a result of the eligible Unborn Child program's beneficiary's pregnancy. Other services not checked below could potentially be covered for the CHIP Unborn Child group, depending on the need of the recipient and is determined by a physician as medically needed, as if not provided, could complicate and/or endanger the pregnancy. Arkansas CHIP program rules apply; examples include benefit limits, extension of benefit limit procedures, prior authorization requirements, age limits, etc.

- 6.2.1.[X]** Inpatient services (Section 2110(a)(1))
- 6.2.2.[X]** Outpatient services (Section 2110(a)(2))
- 6.2.3.[X]** Physician services (Section 2110(a)(3))
- 6.2.4.[X]** Surgical services (Section 2110(a)(4))
- 6.2.5.[X]** Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6.[X]** Prescription drugs (Section 2110(a)(6))
- 6.2.7.**  Over-the-counter medications (Section 2110(a)(7))
- 6.2.8.[X]** Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9.[X]** Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10.**  Inpatient mental health services, other than services described in 6.2.18.,

but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

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

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

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

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

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

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.15.  Nursing care services (Section 2110(a)(15))

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

6.2.17.  Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

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

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

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

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



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

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

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

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

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

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

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

6.2.27.  Enabling services (such as transportation, translation, and outreach services) (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-DC

Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)): Not applicable for Title XXI CHIP Unborn Child program, as there is no dental coverage included in this program.

6.2.1-DC  State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology

(CDT<sup>3</sup>) codes are included in the dental benefits:

10. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
11. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
12. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
13. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
14. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
15. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
16. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
17. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
18. Emergency Dental Services

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

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

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

**6.2.2.1-DC**  FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT<sup>4</sup> codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

**6.2.2.3-DC**  HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach

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a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

- 6.2-DS**  Supplemental Dental Coverage- The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

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

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

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

- 6.3.1.**  The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
- 6.3.2.**  The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

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

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

- 6.4.1.**  **Cost Effective Coverage-** Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child

health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

- 6.4.1.1.** Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))
- 6.4.1.2.** The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

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

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

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

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary’s satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

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

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

the aggregate.

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

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

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

- Yes  
 No

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

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

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

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

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

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

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

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

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

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

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

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

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

- Yes
- No

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

**6.6.3.5.2-PA** Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State’s CHIP plan.

**6.6.3.5.3-PA** Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation



of such a pool except to the extent such payment would otherwise be permitted under this title.

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

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

## **Section 7. Quality and Appropriateness of Care**

Guidance: **Methods for Evaluating and Monitoring Quality-** Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health

plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

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

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

**Tools for Evaluating and Monitoring Quality-** Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

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

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

- 7.1.** Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

**7.1.1.**  Quality standards

**7.1.2.** Performance measurement

**7.1.2 (a)** CHIPRA Quality Core Set

### 7.1.2 (b)[X] Other

7.1.3.[X] Information strategies

7.1.4.[X] Quality improvement strategies

**Access to Services** – Arkansas Foundation for Medical Care (AFMC), DHS DMS contract agent for provider relations, encourages provider participation and compliance in the primary care case management program and other programs through site visits and regular correspondence to primary care physicians, select specialty physicians, and hospitals. Additionally, AFMC provider relations provides submissions to professional journals, participates in professional and specialty organizations, and sponsors conferences. Each quarter more than 750 primary care physicians are visited and pertinent information is shared related to program performance, policy, and updates on planned activities and initiatives.

AFMC regularly distributes articles of interest directly to the provider community via newsletter, blast faxes, conference calls and virtual meetings as well as publications in established journals. Furthermore, provider representatives are actively engaged in trade associations, such as the Arkansas Medical Society, the Arkansas Academy of Family Practice, and the Arkansas Hospital Association. These relationships afford additional opportunities for strengthening the provider network via collaboration, presentations, and exhibits at conferences and other healthcare related events throughout the state annually to offer a more dedicated venue for detailed discussion, collaboration and relationship advancement with the provider community and related stakeholders.

**Information to Beneficiaries Regarding Covered Services, Preventive Health, and Facilitate Access to Primary Care Physicians and Specialists** – Arkansas Foundation for Medical Care (AFMC), DHS DMS contract agent for beneficiary relations improves the quality and effectiveness of medical care by establishing and maintaining positive relationships with beneficiaries in Medicaid and CHIP related matters. This is accomplished through direct contact with beneficiaries and the creation, printing, and distribution of promotional, interventional, and informational materials. AFMC also operates a toll free complaint line that is available to the Medicaid or CHIP beneficiaries Monday – Friday.

There are a minimum of four beneficiary communications per year. Materials are available in Spanish and English and other languages upon request, e.g., beneficiaries are mailed a postcard with the number of the Beneficiary Grievance Line.

AFMC beneficiary relations also maintains a website that contains tools for beneficiaries as well as professionals. Educational materials can be downloaded and printed or ordered at the website by either beneficiaries or health care professionals. Currently the website has approximately 10 pages of educational brochures available, e.g. Acute MI Indicators, Adolescent Immunization (Spanish and English), Adolescent Immunization Poster (Spanish and English), All Terrain Vehicle Safety (Spanish and English), Antibiotic Resistance Activity Sheet. Informational blogs are also available at the AFMC website. New B/P Guideline and Eat Like a Diabetic are the newest blogs

posted. Other current informational blogs are: Adult Immunization, Adverse Drug Events, Breast Cancer Prevention, Cardiac Disparities, Colorectal Cancer.

Additionally, DHS DMS partners with the Arkansas Department of Health (ADH) to provide beneficiary outreach in the form of a newsletter with pertinent Medicaid or CHIP related messages. ADH provides a call center to facilitate the selection of a primary care physician and assistance in locating a dental provider.

**Quality Improvement Strategies** – DHS DMS contracts with a Quality Improvement Organization (QIO) to serve as a quality improvement contract agent. The QIO identifies potential projects through research of current challenges, national initiatives and HEDIS measures that will improve the quality of care for Arkansas beneficiaries. Data analysis is performed to determine the target population, clinical measures, and strategies for success. Project topics and research are presented to DHS DMS for approval.

Upon approval by DHS DMS, development of the project is begun including more intensive research utilizing evidence-based guidelines and criteria, journal research, and data analysis.

Strategies for success, resources, educational tools, and materials are developed for academic detailing. Materials are reviewed by the QIO contract agent's communication department to ensure that the literacy level is appropriate for the target audience. The project plan including all resources, educational tools and materials, and strategies for success is submitted to DHS for approval prior to dissemination of the project to the provider community. Academic detailing is provided to the relevant provider population to increase the quality of service provided to Medicaid and CHIP beneficiaries.

**Performance Metrics** – Arkansas Foundation for Medical Care (AFMC) beneficiary relations also assesses beneficiaries' needs and satisfaction through standardized surveys or focus groups. AFMC develops and conducts surveys and provides data analysis and reports. AFMC statisticians and analysts conduct consumer satisfaction surveys for beneficiaries participating in Primary Care Case Management (PCCM), Children's Health Insurance Program, Tax Equity and Fiscal Responsibility Act (TEFRA). These populations are surveyed using Consumer Assessment of Healthcare Providers and Systems (CAHPS®) modified CAHPS®, Experience of Care and Health Outcomes (ECHO®), Pregnancy Risk Assessment Monitoring System (PRAMS)-Like, SF-36. And custom designed surveys.

AFMC manages all aspects of sample design, population sampling, survey design, data collection, and analysis. AFMC also sends survey results to the National CAHPS® Benchmarking Database (NCBD). This process provided a means for comparison to other participating states' health care programs and set appropriate benchmarks CAHPS® surveys are designed to assess consumer satisfaction with various aspects of the healthcare delivery system including, but not limited to, the plan structure, providers, customer service, and overall healthcare and wellness.

In addition to CAHPS®, DHS DMS monitors performance of both the Medicaid and CHIP state

plans through use of the HEDIS data set. Each year, DHS DMS data analytics contract agents publish a HEDIS report with many of the available metrics. Additionally, AFMC data analytics contract agent assists DHS DMS in compiling the data required for the submission through CARTS and CHIPRA core metrics such as annual well-child visits, annual dental visits, and immunization data.

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

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

**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))

Enrollees participating in the Title XXI CHIP ARKids-B separate child health program must enroll with a ConnectCare primary care physician (PCP) or Patient Centered Medical Home (PCMH) who is responsible for managing the health care of the enrollees. This would include the provision of primary care services and health education to the enrollees; making referrals for medically necessary specialty physicians' services and for hospital care and other medically necessary services; monitoring and coordinating the immunization status of childhood and adolescent immunizations of enrollees under the age of 21 in his/her PCP caseload; coordinating and monitoring enrollees' prescribed medical and rehabilitative services with the providers of those services, hospital care, and other services; as well as assisting in locating medical services for the enrollees; and the monitoring and maintenance of the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening periodicity of any enrollees under the age of 21, regardless of who screens those enrollees. This would also include the coordination and monitoring of any subsequent referrals, treatment, or testing for the enrollees. This monitoring and assurance in accessing care are consistent with those methods used for Title XIX enrollees.

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

The role of the Provider Representative includes the ongoing visitation with health care providers, facilities, and emergency rooms to ensure these providers continued acceptance of Title XIX and Title XXI eligible beneficiaries and their adherence to policies of covered health care services. Statistical analysis is used as a means of identifying,

among other things, problem(s) associated with access to covered services. When any access problems are identified, the Provider Representative conducts follow-up with providers to identify solutions and correction of the identified problem(s).

Enrollees participating in the Title XXI CHIP ARKids-B and Unborn Child separate child health programs must enroll with a ConnectCare primary care physician (PCP) or Patient Centered Medical Home (PCMH). ConnectCare and Patient Centered Medical Home enrollees must have the same access as private pay and insured persons to emergency and non-emergency medical services.

ConnectCare PCPs must have hours of operation that are reasonable and adequate to serve all of his/her patients; make available 24/7 telephone access to a live voice (an employee of the primary care physician or an answering service) or to an answering machine that will immediately page an on-call professional who will provide information and instructions for treating emergency and non-emergency conditions, make appropriate referrals for non-emergency services, and provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed; respond to after-hours calls regarding non-emergencies within 30-minutes; make after-hours telephone numbers as widely available as possible to his/her patients; and regularly check answering machines to ensure the machine functions correctly and instructions are up-to-date when answering machines with recorded instructions are employed for after-hours callers.

Patient Centered Medical Homes (PCMH) must make available 24/7 access to care; provide telephone access to a live voice (e.g., an employee of the primary care physician or an answering service) or to an answering machine that immediately pages an on-call medical profession 24/7 who will provide information and instructions for treating emergency and non-emergency conditions, make appropriate referrals for non-emergency services, and provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed; respond to after-hours calls regarding non-emergencies within 30-minutes (calls must be treated as an emergency if made under circumstances where a prudent layperson with an average knowledge of health care would reasonably believe that treatment is immediately necessary to prevent death or serious health impairment); make after-hours telephone number known, at a minimum, by providing the 24-hour emergency number to all beneficiaries, posting the 24-hour emergency number on all public entries to each site, and including the 24-hour emergency phone number on answering machine greetings; and regularly check answering machines to ensure the machine functions correctly and instructions are up-to-date when answering machines with recorded instructions are employed for after-hours callers. Documentation by written report of the completion of these activities must be provided by the Patient Centered Medical Home (PCMH) via provider portal.

- 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))

Enrollees participating in the Title XXI CHIP ARKids-B and Unborn Child separate child health programs must enroll with a ConnectCare primary care physician (PCP) or Patient Centered Medical Home (PCMH) who is responsible for managing the health care of the enrollees. This would include the provision of primary care services and health education to the enrollees; making referrals for medically necessary specialty physicians' services and for hospital care and other medically necessary services; monitoring and coordinating the immunization status of childhood and adolescent immunizations of enrollees under the age of 21 in his/her PCP caseload; coordinating and monitoring enrollees' prescribed medical and rehabilitative services with the providers of those services, hospital care, and other services; as well as assisting in locating medical services for the enrollees in-network and out-of-network when in-network providers are not adequate for the enrollees' medical condition; and the monitoring and maintenance of the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening periodicity of any enrollees under the age of 21, regardless of who screens those enrollees. This would also include the coordination and monitoring of any subsequent referrals, treatment, or testing for the enrollees. ConnectCare and Patient Centered Medical Home enrollees must have the same access as private pay and insured persons to emergency and non-emergency medical services. This monitoring and assurance in accessing care are consistent with those methods used for Title XIX enrollees.

ConnectCare PCPs must have hours of operation that are reasonable and adequate to serve all of his/her patients; make available 24/7 telephone access to a live voice (an employee of the primary care physician or an answering service) or to an answering machine that will immediately page an on-call professional who will provide information and instructions for treating emergency and non-emergency conditions, make appropriate referrals for non-emergency services, and provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed; respond to after-hours calls regarding non-emergencies within 30-minutes; make after-hours telephone numbers as widely available as possible to his/her patients; and regularly check answering machines to ensure the machine functions correctly and instructions are up-to-date when answering machines with recorded instructions are employed for after-hours callers.

Patient Centered Medical Homes (PCMH) must identify the top 10% of high-priority beneficiaries using DMS patient panel data that ranks beneficiaries by risk or the practice's patient-centered assessment to determine which beneficiaries on this list are high-priority; identify and reduce medical neighborhood barriers to coordinated care at the practice level; make available 24/7 access to care; provide telephone access to a live voice (e.g., an employee of the primary care physician or an answering service) or to an answering machine that immediately pages an on-call medical profession 24/7 who will provide

information and instructions for treating emergency and non-emergency conditions, make appropriate referrals for non-emergency services, and provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed; respond to after-hours calls regarding non-emergencies within 30-minutes (calls must be treated as an emergency if made under circumstances where a prudent layperson with an average knowledge of health care would reasonably believe that treatment is immediately necessary to prevent death or serious health impairment); make after-hours telephone number known, at a minimum, by providing the 24-hour emergency number to all beneficiaries, posting the 24-hour emergency number on all public entries to each site, and including the 24-hour emergency phone number on answering machine greetings; regularly check answering machines to ensure the machine functions correctly and instructions are up-to-date when answering machines with recorded instructions are employed for after-hours callers; establish processes that result in contact with beneficiaries who have not received preventive care; complete a short survey related to beneficiaries' ability to receive timely care, appointments, and information from specialists, including Behavioral Health (BH) specialists.

The role of the Provider Representative includes the ongoing visitation with health care providers, facilities, and emergency rooms to ensure these providers continued acceptance of Title XIX and Title XXI eligible beneficiaries and their adherence to policies of covered health care services. Statistical analysis is used as a means of identifying, among other things, problem(s) associated with access to covered services. When any access problems are identified, the Provider Representative conducts follow-up with providers to identify solutions and correction of the identified problem(s).

- 7.2.4.** Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

The Arkansas DHS Division of Medical Services employs and contracts with quality improvement organizations who exercise a stringent review of prior authorizations (PAs) completed for covered health care services for Title XIX and Title XXI enrollees to ensure PAs have been completed in accordance with State law, in accordance with the medical needs of the patient, and within the specified number of days after the receipt of a request for services.

## **Section 8. Cost-Sharing and Payment**

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



**8.1.** Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

**8.1.1.**  Yes for the Title XXI CHIP ARKids-B separate child health program

NOTE: There is no cost-sharing imposed on beneficiaries of the Title XXI CHIP Unborn Child separate child health program

**8.1.2.**  No, skip to question 8.8.

**8.1.1-PW**  Yes

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

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

### **CHIP Title XXI CHIP ARKids-B Program**

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

**8.2.1.**  Premiums:

**8.2.2.**  Deductibles:

**8.2.3.**  Coinsurance or copayments:

Co-payments and co-insurance apply for all services with the exception of immunizations, preventive health screenings, family planning, and prenatal care. The Title XXI CHIP ARKids-B schedule of co-payments and co-insurance is outlined in the following table. The annual cumulative cost-sharing maximum cannot exceed 5% of the ARKids-B beneficiary's family's income.

| <b>Benefits/Limits</b>   | <b>Co-Pay/Co-Insurance</b>                            |
|--|---|
| Ambulance (Emergency Only)   | \$10 per trip   |
| Ambulatory Surgical Center   | \$10 per visit  |
| Audiological Services (only Tympanometry, CPT procedure code 92567, when the diagnosis is within the ICD-9-CM range of 381.0 through 382.9)  | None  |
| Certified Nurse Midwife  | \$10 per visit  |
| Chiropractor   | \$10 per visit  |
| Dental Care (routine dental care & orthodontia)  | \$10 per visit  |
| Durable Medical Equipment (DME) (Limited to \$500 per State Fiscal Year (SFY) July 1 – June 30)  | 10% of Medicaid allowed per DME item                  |
| Emergency Dept. Services (Emergent, non-emergent, assessment)  | \$10 per visit  |
| Family Planning  | None  |
| Federally Qualified Health Center (FQHC)   | \$10 per visit  |
| Home Health (10 visits per SFY (July 1 – June 30))   | \$10 per visit  |
| Hospital, Inpatient  | 10% of first inpatient day                            |
| Hospital, Outpatient   | \$10 per visit  |
| Inpatient Psychiatric Hospital & Psychiatric Residential Treatment Facility  | 10% of first inpatient day                            |
| Immunizations (All per protocol)   | None  |
| Laboratory & X-Ray   | \$10 per visit  |
| Medical Supplies (Limited to \$125/month unless benefit extension is approved)   | None  |
| Mental & Behavioral Health, Outpatient   | \$10 per visit  |
| Nurse Practitioner   | \$10 per visit  |
| Physician  | \$10 per visit  |
| Podiatry   | \$10 per visit  |
| Prenatal Care  | None  |
| Prescription Drugs   | \$5 per prescription (Must use generic, if available) |
| Preventive Health Screenings (All per protocol)  | None  |
| Rural Health Clinic  | \$10 per visit  |
| Speech Therapy<br>Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved<br>Therapy – Four 15 minute units/day unless benefit extension is approved   | \$10 per visit  |
| Physical Therapy<br>Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved<br>Therapy – Four 15 minute units/day unless benefit extension is approved | \$10 per visit  |
| Occupational Therapy<br>Evaluation – Four 30 minute units/SFY (July 1 – June 30) unless benefit extension is approved<br>Therapy – Four 15 minute units/day unless benefit                   |   |

|   |  |
|---|--|
| extension is approved                                 | \$10 per visit                             |
| Substance Abuse Treatment Services (SATS), outpatient | \$10 per visit                             |
| Vision (Eye exam, Eyeglasses)                         | \$10 per visit<br>No co-pay for eyeglasses |

8.2.4.  Other:

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

8.2.1-DS  Premiums:

8.2.2-DS  Deductibles:

8.2.3-DS  Coinsurance or copayments:

8.2.4-DS  Other:

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

The State has developed and distributed to Division of County Operations (DCO) County Offices, physicians' offices, hospitals, and other public businesses throughout the state ARKids First (includes ARKids-A (Title XIX Medicaid program) and ARKids-B (Title XXI CHIP state plan separate child health program)) pamphlets that include information pertaining to cost sharing, the cumulative 5% cap based on the ARKids-B beneficiary's families' income, and families of eligible ARKids-B beneficiaries are not responsible for tracking their out-of-pocket expenses for the purpose of the 5% cap. There is also an ARKids First website that includes this same information. The Arkansas Department of Human Services spends approximately \$125,000 per state fiscal year via contract on outreach and education for ARKids First which includes information pertaining to cost sharing, the cumulative 5% cap based on the ARKids-B beneficiary's families' income, and families of eligible ARKids-B beneficiaries are not responsible for tracking their out-of-pocket expenses for the purpose of the 5% cap are not responsible for tracking their out-of-pocket expenses for the purpose of the 5% cap.

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

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

- 8.4.1. [X]** 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. [X]** 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. [X]** 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))

To protect families against excessive medical expenses and comply with the statutory limit of no more than 5% of family income being expended on cost sharing expenses, the state keeps the co-pays the families are required to pay minimal. Because of the low co-payment, very few families are likely to exceed the limit and would not approach the 5% limit.

The annual 5% cap is calculated when the ARKids-B beneficiary is approved. The MMIS generates a notice to the ARKids-B beneficiary's family notifying the family of their specific cumulative cap for cost sharing based on the family's income. If a family's income decreases during the year, the 5% cap is recalculated, and a new notice is sent to the family. The 5% cap is not recalculated if the family's income increases. All beneficiaries' specific 5% limits are recalculated each year in June, and the recalculated limit is effective July 1.

Arkansas' Medicaid MMIS system tracks the ARKids-B beneficiaries' families' progress toward the 5% cap. Families are not responsible for tracking their out-of-pocket expenses for the purpose of the 5% cap. Providers (who are responsible for the collection of co-pays from Medicaid and CHIP beneficiaries) indicate the services rendered to the ARKids-B beneficiary on the claim form submitted. The MMIS automatically calculates the co-pay that would apply for the services rendered and checks the accrual amount against the ARKids-B beneficiary's family's income (via ARKids Family Income/File). When cost sharing reaches, in the aggregate, 5% of the ARKids-B beneficiary's family's total income, co-payments are no longer assessed against the ARKids-B beneficiary's family until the next SFY.

Families are notified when their cost sharing maximum is met. There will be a statement on the

notice (received by both the ARKids-B beneficiary's family and the provider) that the cost-sharing maximum has been met and that Medicaid is paying the full Medicaid allowed rate for the service.

Sometimes an ARKids-B beneficiary's family will exceed the 5% cap due to a lag in processing previous claims. Providers are required to refund to the ARKids-B beneficiary's family the cost sharing amount that exceeded the 5% cap that the provider collected from the family if, at the time a claim is submitted and processed, the system determines that the family's cumulative cost-sharing maximum has been met. This may happen even though the family was required to provide cost-sharing on the date of service if the provider waited a period of time to submit the claim for payment. For example, a family had not yet met its cost-sharing maximum on the date of service, and therefore the provider collected the required cost share amount. The provider submitted the claim two months later, and in the interim, the family met its cost sharing maximum through receiving and paying for other services. In this case, even though the family was required to pay a co-payment on the date of service, that amount is not in the system until the claim is processed. On the date the claim was adjudicated, the family had met its obligation for cost sharing, and the provider must refund to the family the amount the family paid that exceeds the 5% cap that the provider collected from the family for cost sharing.

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

The MMIS checks the race of enrollees. Any enrollee who is of the American Indian race (based on the definition in the Indian Health Care Improvement Act of 1976) or are children of the Alaska Native race are excluded from cost sharing.

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

Collecting co-payments from beneficiaries is providers' responsibility. Providers may not deny services to CHIP eligible beneficiaries because of the beneficiaries' inability to pay cost-sharing. However, beneficiaries' inability to pay cost-sharing does not eliminate beneficiaries' liability for the cost-sharing charge.

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

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

Guidance: Provide a description below of the State's premium grace period

process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

The State does not charge premiums to Title XXI CHIP ARKids-B enrollees.

- 8.7.1.1.  State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

The State does not dis-enroll Title XXI CHIP ARKids-B beneficiaries due to non-payment of a co-payment.

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

- 8.7.1.3.  In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

- 8.7.1.4  The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

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

- 8.8.1.  No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2.  No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3.  No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4.  Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

- 8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)
- 8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

**Section 9. Strategic Objectives and Performance Goals and Plan Administration**

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

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

- I. Increase the number of children in Arkansas who are enrolled in CHIP.
- II. Increase access to care for children enrolled in CHIP.
- III. Improve the healthcare of children enrolled in CHIP through the use of preventative care.

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

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

**Performance Goal for Objective I:**

The total number of children enrolled in CHIP will increase each year by one half percent or be adjusted up or down based on historical data.

**Performance Goal for Objective II:**

The total number of children receiving preventive dental services, including orthodontia, will increase each year by one half percent or be adjusted up or down based on historical data.

**Performance Goal for Objective III:**

The total number of children under 15 months of life; children ages 3 through 6 years; and adolescents ages 12 through 18 years receiving well-child visits will increase each year by one half percent or be adjusted up or down based on historical data.

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

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

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

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

**Measurement of Performance Goal for Objective I:**

The baseline for measuring this goal will be based on the beneficiary enrollment data for ARKids-B for FFY 2014. Thereafter, beneficiary enrollment data for ARKids-B for the current FFY will be used.

**Measurement of Performance Goal for Objective II:**

The baseline for measuring this goal will be based on preventive dental services claims data for FFY 2014. Thereafter, preventive dental services claims data for the current FFY will be used.

**Measurement of Performance Goal for Objective III:**

The baseline for measuring this goal will be based on well-child visits HEDIS measures claims data



for FFY 2014. Thereafter, well-child visits HEDIS measures claims data for the current FFY will be used.

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

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

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

- 9.3.7.1.  Immunizations
- 9.3.7.2.  Well childcare
- 9.3.7.3.  Adolescent well visits
- 9.3.7.4.  Satisfaction with care
- 9.3.7.5.  Mental health
- 9.3.7.6.  Dental care
- 9.3.7.7.  Other, list:

9.3.8.  Performance measures for special targeted populations.

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

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

to assessment and evaluation of the program.

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

The State uses a Primary Care Case Management (PCCM) and Patient Centered Medical Home (PCMH) systems. The State is responsible for assessment and evaluation under the PCCM and PCMH systems and intends to use the same contract for the Title XXI CHIP ARKids-B and Unborn Child separate state child health programs. The contractor evaluates data including number of office visits, continuity of care, and hospitalizations, etc.

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

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

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

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

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

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

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

The ARKids-B work group and the Arkansas Advocates for Children and Families agency agree that Arkansas should continue funding eligible children through the Title XXI ARKids-B CHIP separate state child health program and to cover unborn children in the Unborn Child CHIP separate child health program. This is supported by the Arkansas Advocates for Children and Families, the Arkansas Department of Health, and the Arkansas Center for Health Improvement.

Changes in the Title XXI CHIP ARKids-B and Unborn Child CHIP separate child health programs will be promulgated as required by the State's Administrative Procedures Act (APA). The APA also requires that the agency publish a notice, regarding proposed rules, in a newspaper with statewide circulation. As a part of the APA process, DMS also notifies "interested persons" and appropriate Medicaid/CHIP providers of proposed rules to solicit comments and input. A public hearing will be conducted during the required APA 30-day comment period to obtain public comment. The APA process requires the review of new and revised rules by the Administrative Public Health and Rules and Regulations Subcommittees of the Arkansas Legislative Council.

- 9.9.1.** Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

Not applicable, as there are no American Indian Nations, Tribes, reservations or organizations in the State of Arkansas.

- 9.9.2.** For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

Amendments relating to eligibility or benefits, including cost sharing and enrollment procedures will be promulgated according to the State's Administrative Procedures Act. The Act requires a public notice in a statewide newspaper with a 30-day comment period.

A public hearing will be conducted during the required APA 30-day comment period to obtain public comment/input.

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

Not applicable, as there are no American Indian Nations, Tribes, reservations or organizations in the State of in the State of Arkansas.

- 9.10.** Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

Please See ATTACHMENT B for State's projected one-year CHIP budget

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
  
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

Please See ATTACHMENT B for State's projected one-year CHIP budget

**CHIP Budget**

| <b>STATE:</b>                    | <b>FFY Budget</b> |
|----------------------------------|-------------------|
| <b>Federal Fiscal Year</b>       |                   |
| State's enhanced FMAP rate       |                   |
|                                  |                   |
| <b>Benefit Costs</b>             |                   |
| Insurance payments               |                   |
| Managed care                     |                   |
| <u>per member/per month rate</u> |                   |

|  |  |
|--|--|
| Fee for Service                                |  |
| <b>Total Benefit Costs</b>                     |  |
| (Offsetting beneficiary cost sharing payments) |  |
| <b>Net Benefit Costs</b>                       |  |
| <b>Cost of Proposed SPA Changes – Benefit</b>  |  |
|  |  |
| <b>Administration Costs</b>                    |  |
| Personnel                                      |  |
| General administration                         |  |
| Contractors/Brokers                            |  |
| Claims Processing                              |  |
| Outreach/marketing costs                       |  |
| Health Services Initiatives                    |  |
| Other  |  |
| <b>Total Administration Costs</b>              |  |
| 10% Administrative Cap                         |  |
|  |  |
| <b>Cost of Proposed SPA Changes</b>            |  |
|  |  |
| Federal Share                                  |  |
| State Share                                    |  |
| <b>Total Costs of Approved CHIP Plan</b>       |  |

**NOTE: Include the costs associated with the current SPA.**

**The Source of State Share Funds:**

**Section 10. Annual Reports and Evaluations**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The review process for CHIP eligibility and enrollment matters is the same as the Medicaid Fair Hearing process.

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

**12.2. Health Services Matters-** Describe the review process for health services matters that comply with 42 CFR 457.1120.

The review process for CHIP health service matters is the same as the Medicaid Fair Hearing process.

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

N/A

### **Key for Newly Incorporated Templates**

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

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



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| Region 10-<br>Seattle       | Idaho<br>Washington                           | Alaska<br>Oregon   | Carol Peverly<br><a href="mailto:carol.peverly@cms.hhs.gov">carol.peverly@cms.hhs.gov</a>          | 2001 Sixth Avenue<br>MS RX-43<br>Seattle, WA 98121   |

## **GLOSSARY**

Adapted directly from Sec. 2110. DEFINITIONS.

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

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

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

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

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

60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

**ADDITIONAL DEFINITIONS - For purposes of this title:**

1. **CHILD** - The term ‘child’ means an individual under 19 years of age.
2. **CREDITABLE HEALTH COVERAGE** - The term ‘creditable health coverage’ has the meaning given the term ‘creditable coverage’ under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. **GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC** - The terms ‘group health plan’, ‘group health insurance coverage’, and ‘health insurance coverage’ have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. **LOW-INCOME CHILD** - The term ‘low-income child’ means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. **POVERTY LINE DEFINED** - The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. **PREEXISTING CONDITION EXCLUSION** - The term ‘preexisting condition exclusion’ has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. **STATE CHILD HEALTH PLAN; PLAN** - Unless the context otherwise requires, the terms ‘State child health plan’ and ‘plan’ mean a State child health plan approved under Section 2106.
8. **UNINSURED CHILD** - The term ‘uninsured child’ means a child that does not have creditable health coverage.



# CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

## Eligibility for Medicaid Expansion Program

CS3

42 CFR 457.320(a)(2) and (3)

Income eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards:

There should be no overlaps or gaps for the ages entered.

### Age and Household Income Ranges

|          | From Age             | To Age               | Above (% FPL) | Up to & including (% FPL) |          |
|----------|----------------------|----------------------|---------------|---------------------------|----------|
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |

### PRA Disclosure Statement

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



# CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: AR - 14 - 0015

Expiration date: 10/31/2014

**Separate Child Health Insurance Program Eligibility - Targeted Low-Income Children** **CS7**

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.310, 315 and 320

**Targeted Low-Income Children** - Uninsured children under age 19 whose household income is within standards established by the state.

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

**Age**

Must be under age 19.

**Income Standards**

Income standards are applied statewide.

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard?

**Statewide Income Standards**

Begin with lowest age range first.

Please note that the lower bound for CHIP eligibility should be the highest standard used for Medicaid poverty-level children for the same age group or groups entered here.

|          | From Age             | To Age               | Above (% FPL) | Up to & including (% FPL) |          |
|----------|----------------------|----------------------|---------------|---------------------------|----------|
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |
| <b>+</b> | <input type="text"/> | <input type="text"/> |               |                           | <b>X</b> |

Age ranges may overlap. If there is an overlap, provide an explanation. Include the age ranges for each income standard that has overlapping ages and the reason for having different income standards.



# CHIP Eligibility

Special Program for Children with Disabilities

Does the state have a special program for children with disabilities?

## PRA Disclosure Statement

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

V.20140415



# CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

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

CS9

42 CFR 457.10

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

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

### Age Standard

From conception through birth.

Does the state have an additional age definition or other age-related conditions?

### Income Standards

Income standards are applied statewide.

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard?

### Statewide Income Standard

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

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

Exempted from requirement of verifying citizenship status.

### PRA Disclosure Statement

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





# CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: AR - 14 - 0015

Expiration date: 10/31/2014

**Separate Child Health Insurance Program** **CS10**  
**Eligibility - Children Who Have Access to Public Employee Coverage**

Sec. 2110(b)(2)(B) and (b)(6) of the SSA

**Children Who Have Access to Public Employee Coverage** - Otherwise eligible targeted low-income children who have access to public employee coverage on the basis of a family member's employment.

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

Select one of the following conditions as described in Section 2110(b)(6) of the Social Security Act:

- Maintenance of agency contribution as provided in 2110(b)(6)(B) of the SSA.
- Hardship criteria as provided in section 2110(b)(6)(C) of the Social Security Act.

Coverage under this option is extended to children whose household income is:

Select one of the options for the income standard when compared to Targeted Low Income Children

- The same as the standards for Targeted Low-Income Children
- Lower than the income standards for Targeted Low-Income Children

Income standards are applied statewide.

Indicate whether coverage under this option is extended to all children who have access to public employee coverage, or only certain children:

- All children who have access to public employee coverage
- Certain children who have access to public employee coverage:
  - Employees of certain public agencies.
  - Certain types of public employees.

Attach methodology the state has used to calculate maintenance of agency contribution.

**An attachment is submitted.**

The state provides assurance that the state will, on an annual basis, recalculate expenditures for each participating public agency to determine if the maintenance effort condition continues to be met.

Children who are eligible for public employee health benefits coverage who are not described above are excluded from eligibility under the plan.

Children considered to have access to public employee coverage, and therefore not excluded from CHIP through this option, otherwise meet the definition of targeted low-income child provided at 42 CFR 457.310.



# CHIP Eligibility

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V.20140415

**Methodology Calculations Used to Calculate Financial Hardship State's Health Benefits Plan Causes State Employees for Health Coverage for Their Children**

The 2014 Poverty Guidelines for the 48  
Contiguous States and the District of  
Columbia

**Evaluation of ESI and SCHIP**

| <b>Persons in family</b> | <b>211% FPL</b> | <b>Annual ESI Premium and out-of-pocket medical expense</b> | <b>5% of 211 FPL</b> | <b>Test equals</b> | <b>ESI or SCHIP</b> |
|--------------------------|-----------------|---|----------------------|--------------------|---------------------|
| 2                        | \$ 33,190       | \$ 2,698  | \$ 1,660             | =                  | SCHIP               |
| 3                        | \$ 41,757       | \$ 4,317  | \$ 2,088             | =                  | SCHIP               |
| 4                        | \$ 50,324       | \$ 4,317  | \$ 2,516             | =                  | SCHIP               |
| 5                        | \$ 58,890       | \$ 4,317  | \$ 2,945             | =                  | SCHIP               |

| <b>Annual Premiums</b> |          |
|------------------------|----------|
| Employee & Child       | \$ 1,713 |
| Employee and Family    | \$ 2,446 |

| <b>Annual Out of Pocket Expenses</b> |          |
|--------------------------------------|----------|
| Employee & Child                     | \$ 985   |
| Employee and Family                  | \$ 1,871 |

## **Methodology Used to Calculate Financial Hardship State's Health Benefits Plan Causes State Employees for Health Coverage for Their Children**

The State has researched the State employee costs for the State-funded health benefits program and determined that the annual costs do exceed 5% of a State employee's gross family income. The State looked at the annual costs for the "Employee and Children" and "Employee and Family" categories of coverage. The average associated out-of-pocket expenses, including deductibles and co-pays, within each of these categories were also included in the calculation.

*Example:* A family of four with an annual household income at 211% of the FPL, \$50,324, will pay approximately \$4,317 in premiums for an employee and family policy and out-of-pocket expenditures per year which, in fact, exceeds 5% of their annual income. This example is based upon annual premiums for an Employee and Family which are \$2,446 and annual out-of-pocket expenses which are estimated to be \$1,871.

Other scenarios with various family sizes, etc. yielded the same result in which the annual expenditures for the State-funded health benefits exceed 5% of their household income. (Please see attached.)



# CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: AR - 14 - 0015

Expiration date: 10/31/2014

## Separate Child Health Insurance Program Eligibility - Deemed Newborns

CS13

Section 2112(e) of the SSA and 42 CFR 457.360

**Deemed Newborns** - Children born to targeted low-income pregnant women are deemed to have applied for and be eligible for CHIP or Medicaid until the child turns one.

The state operates this covered group in accordance with the following provisions:

The child was born to an eligible targeted low-income pregnant woman under section 2112 of the SSA.

The child is deemed to have applied for and been found eligible for CHIP or Medicaid, as appropriate, as of the date of the child's birth, and remains eligible without regard to changes in circumstances until the child's first birthday.

The state elects the following option(s):

The state elects to cover as a deemed newborn a child born to a mother who is covered as a targeted low-income child under the state's separate CHIP on the date of the newborn's birth.

The state elects to recognize a child's deemed newborn status from another state and provides benefits in accordance with the requirements of section 2112(e) of the SSA.

The state elects to cover as a deemed newborn a child born to a mother who is covered under Medicaid or CHIP through the authority of the state's section 1115 demonstration on the date of the newborn's birth.

### PRA Disclosure Statement

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V.20140415



# CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

|   |             |
|---|-------------|
| <b>Child Health Insurance Program</b>   | <b>CS14</b> |
| <b>Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards</b> |             |

Section 2101(f) of the ACA and 42 CFR 457.310(d)

Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

- The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

- The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

- The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.
- The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.
- The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

% FPL

- The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.

- Other.

Describe the benefits provided to this population:

- This population will be provided the same benefits as are provided to children in the state's Medicaid program.
- This population will be provided the same benefits as are provided to children in the state's separate CHIP.
- Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

- Cost sharing is the same as for children in the Medicaid program.



# CHIP Eligibility

- Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

## PRA Disclosure Statement

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V.20130917



# CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

## Separate Child Health Insurance Program MAGI-Based Income Methodologies

CS15

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.315

- The CHIP Agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups, as described below, and consistent with 42 CFR 457.315 and 435.603(b) through (i).

In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility, whichever is later.

If the state covers pregnant women, in determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted just as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size.
- Projected annual household income for the remaining months of the current calendar year and family size.

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of the reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 457.315 and 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.

- The CHIP Agency certifies that it has submitted and received approval for the conversion for all separate CHIP covered group income standards to MAGI-equivalent standards.

**An attachment is submitted.**

PRA Disclosure Statement





# CHIP Eligibility

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V.20130917



# CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

## Separate Child Health Insurance Program Non-Financial Eligibility - Residency

CS17

42 CFR 457.320

### Residency

- The CHIP Agency provides CHIP to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

A child is considered to be a resident of the state under the following conditions:

- A non-institutionalized child, if capable of indicating intent and who is emancipated or married, if the child is living in the state and:
  1. Intends to reside in the state, including without a fixed address, or
  2. Has entered the state with a job commitment or seeking employment, whether or not currently employed.
- A non-institutionalized child not described above and a child who is not a ward of the state:
  1. Residing in the state, with or without a fixed address, or
  2. The state of residency of the parent or caretaker, in accordance with 42 CFR.435.403(h)(1), with whom the individual resides.
- An institutionalized child, who is not a ward of the state, if the state is the state of residence of the child's custodial parent or caretaker at the time of placement, or
- A child who is a ward of the state regardless of where the child lives, or
- A child physically located in the state when there is a dispute with one or more states as to the child's actual state of residence.

If the state covers pregnant women, a pregnant woman is considered to be a resident under the following conditions:

- A non-institutionalized pregnant woman who is living in the state and:
  1. Intends to reside in the state, including without a fixed address, or if incapable of indicating intent, is living in the state, or
  2. Entered with a job commitment or seeking employment, whether or not currently employed.
- An institutionalized pregnant woman placed in an out-of-state-institution, as defined in 42 CFR 435.1010, including foster care homes, by an agency of the state, or
- An institutionalized pregnant woman residing in an in-state-institution, as defined in 42 CFR 435.1010, whether or not the individual established residency in the state prior to entering the institution, or
- A pregnant woman physically located in the state when there is a dispute with one or more states as to the pregnant woman's actual state of residence.

The state has in place related to the residency of children and pregnant women (if covered by the state):



# CHIP Eligibility

One or more interstate agreement(s).

A policy related to individuals in the state only for educational purposes.

Provide a description of the policy:

An individual age 18-22 and a full-time student in an Arkansas school is not a resident of Arkansas if: a) Neither parent lives in Arkansas, b) The student is claimed as a tax dependent by someone in a state other than Arkansas, and c) The student is applying on his or her own behalf.

## PRA Disclosure Statement

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V.20130917



# CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: AR - 14 - 0016

Expiration date: 10/31/2014

## Separate Child Health Insurance Program Non-Financial Eligibility - Citizenship

CS18

Sections 2105(c)(9) and 2107(e)(1)(J) of the SSA and 42 CFR 457.320(b)(6), (c) and (d)

### Citizenship

The CHIP Agency provides CHIP eligibility to otherwise eligible citizens and nationals of the United States and certain non-citizens, including the time period during which they are provided with reasonable opportunity to submit verification of their citizenship, national status or satisfactory immigration status.

The CHIP Agency provides eligibility under the Plan to otherwise eligible individuals:

Who are citizens or nationals of the United States; or

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), and 1902(ee) of the Act, and 42 CFR 435.406, 407, 956 and 457.380.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

The date benefits are furnished is:

- The date of application containing the declaration of citizenship or immigration status.
- The date the reasonable opportunity notice is sent.
- Other date, as described:

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3).



# CHIP Eligibility

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible pregnant women, lawfully residing in the United States, as provided in Section 214 of CHIPRA 2009, P.L. 111-3. The state may not select this option unless the state also elects to cover lawfully residing children. A state may not select this option unless the state also covers Targeted Low-Income Pregnant Women.

## PRA Disclosure Statement

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V.20140415



# CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: AR - 14 - 0016

Expiration date: 10/31/2014

## Separate Child Health Insurance Program Non-Financial Eligibility - Social Security Number

CS19

42 CFR 457.340(b)

### Social Security Number

As a condition of eligibility, the CHIP Agency must require individuals who have a social security number or are eligible for one as determined by the Social Security Administration, to furnish their social security number, or numbers if they have more than one number.

- The CHIP Agency requires individuals, as a condition of eligibility, to furnish their social security number(s), with the following exceptions:

Individuals refusing to obtain a social security number (SSN) because of well established religious objections, or

Individuals who are not eligible for an SSN, or

Individuals who are issued an SSN only for a valid non-work purpose.

- The CHIP Agency assists individuals, who are required to provide their SSN, to apply for or obtain an SSN from the Social Security Administration if the individual does not have or forgot their SSN.

- The CHIP Agency informs individuals required to provide their SSN:

By what statutory authority the number is solicited; and

How the state will use the SSN.

- The CHIP Agency provides assurance that it will verify each SSN furnished by an applicant or beneficiary with the Social Security Administration, not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by the Social Security Administration and that the state's utilization of the SSNs is consistent with sections 205 and 1137 of the Social Security Act and the Privacy Act of 1974.

The state may request non-applicant household members to voluntarily provide their SSN, if the state meets the requirements below.

The state requests non-applicant household members to voluntarily provide their SSN.

- When requesting an SSN for non-applicant household members, the state assures that:

- At the time such SSN is requested, the state informs the non-applicant that this information is voluntary and provides information regarding how the SSN will be used; and

- The state only uses the SSN for determination of eligibility for CHIP or other insurance affordability programs, or for a purpose directly connected with the administration of the state plan.



# CHIP Eligibility

## PRA Disclosure Statement

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V.20140415



# CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: AR - 14 - 0016

Expiration date: 10/31/2014

## Separate Child Health Insurance Program Non-Financial Eligibility - Substitution of Coverage

CS20

Section 2102(b)(3)(C) of the SSA and 42 CFR 457.340(d)(3), 457.350(i), and 457.805

### Substitution of Coverage

The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

Substitution of coverage prevention strategy:

|          | Name of policy | Description |          |
|----------|----------------|-------------|----------|
| <b>+</b> |                |             | <b>X</b> |
| <b>+</b> |                |             | <b>X</b> |
| <b>+</b> |                |             | <b>X</b> |
| <b>+</b> |                |             | <b>X</b> |
| <b>+</b> |                |             | <b>X</b> |
| <b>+</b> |                |             | <b>X</b> |

A waiting period during which an individual is ineligible due to having dropped group health coverage.

How long is the waiting period?

- One month
- Two months
- 90 days
- Other

The state allows exemptions from the waiting period for the following reasons:

- The premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income.
- The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Marketplace because the ESI in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v).
- The cost of family coverage that includes the child exceeded 9.5 percent of the household income.
- The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan.





# CHIP Eligibility

- A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA).
- The child has special health care needs.
- The child lost coverage due to the death or divorce of a parent.

Does the state allow other exemptions in addition to those listed above?

|          | Describe   |          |
|----------|--|----------|
| <b>+</b> | Health insurance coverage is available to a child through a person other than the child's custodial adult and is determined to be inaccessible (e.g., the absent parent lives out-of-state and covers the child on his or her HMO which the child cannot access due to distance. | <b>X</b> |

- Describe the processes the state employs to facilitate enrollment of CHIP-eligible children who have satisfied the waiting period.

CHIP-eligible children who have satisfied the 90-day waiting period are enrolled using the application and the submission of information already provided by the family immediately preceding the waiting period

- Describe the processes the state employs to coordinate coverage of children subject to a waiting period with other insurance affordability programs, including safeguards to prevent gaps in coverage for children transitioning from another insurance affordability program to CHIP after satisfying the waiting period.

CHIP-eligible children who have satisfied the 90-day waiting period are enrolled using the application and the submission of information already provided by the family immediately preceding the waiting period, and State coordinates with the insurance program the child is transitioning from to ensure there are no gaps in coverage.

The state provides assurance that:

- It does not require a new application or the submission of information already provided by the family immediately preceding the waiting period for the purpose of enrolling CHIP-eligible children who have satisfied a waiting period.

- For children subject to the waiting period, it will promptly transfer each individual's electronic account to the applicable insurance affordability program and notify such program of the date on which the waiting period ends for each individual.

- If the state covers pregnant women, the waiting period does not apply to pregnant women.

If the state elects to offer dental only supplemental coverage, the following assurances apply:

- The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(5) of the SSA.

- The waiting period does not apply to children eligible for dental only supplemental coverage.



# CHIP Eligibility

## PRA Disclosure Statement

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V.20140415

**USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION**

Paper Application       Online Application

**TRANSMITTAL NUMBER:**

AR-13-0039

**STATE:**

Arkansas

Through June 30, 2014, the state is using an interim online alternative single streamlined application. After June 30, 2014, the state will use a revised online alternative single streamlined application, which will address the issues outlined in the CMS letter concerning the state's application. The revised application will be incorporated by reference into the state plan.



# CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

## Separate Child Health Insurance Program General Eligibility - Eligibility Processing

CS24

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

- The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

### Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.
- An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

**An attachment is submitted.**

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

**An attachment is submitted.**

- The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

- Other electronic means:

### Screen and Enroll Process

- The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:

- Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and
- Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and



# CHIP Eligibility

- Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA.

## Redetermination Processing

- Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:
- Once every 12 months.
  - Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.

- If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

## Screening by Other Insurance Affordability Programs

- The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.

- The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

Check all types of agencies that apply:

- The Exchange
- Medicaid
- Other agency administering insurance affordability programs

- The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

## PRA Disclosure Statement

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

V.20130917



# CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: AR - 14 - 0016

Expiration date: 10/31/2014

## Separate Child Health Insurance Program General Eligibility - Continuous Eligibility

CS27

2105(a)(4)(A) of the SSA and 42 CFR 457.342 and 435.926

The CHIP Agency may provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, during a continuous eligibility period up to 12 months, or until the time the child reaches an age specified by the state (not to exceed age 19), whichever is earlier.

The CHIP Agency elects to provide continuous eligibility to children under this provision.

For children up to age 19

For children up to age

The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends:

At the end of the  months continuous eligibility period.

Exceptions to the continuous eligibility period:

The child attains the age specified by the state Agency or age 19.

The child or child's representative requests voluntary disenrollment.

The child is no longer a resident of the state.

The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to child or child's representative.

The child dies.

There is a failure to pay required premiums or enrollment fees on behalf of a child, as provided for in the state plan.

Other

### PRA Disclosure Statement

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