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: Georgia
(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))

Lynnette R. Rhodes Executive Director, Medical Assistance Plans, July 17, 2022

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

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

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

Name: Russel Carlson — Position/Title: Commissioner, Georgia
Name: Lynnette Rhodes — Position/Title: Executive Director, Medical Assistance Plans
Name: Stefanie Ashlaw — Position/Title: Director, PeachCare for Kids®

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

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 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, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

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

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new 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 90day 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 the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope

of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

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

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

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

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

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

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

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low-income children in families with incomes of

up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

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))

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

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

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

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

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

Effective date: September 1, 1998

Implementation date: November 1, 1998

State Plan Amendment #1: (Reinstatement policy)
Submitted: January 6, 2000
Approved: April 20, 2000
Effective: October 1, 1999

State Plan Amendment #2: (Clarification of Renewal Process)
Submitted: January 31, 2001
Approved: June 1, 2001
Effective: July 1, 2001

State Plan Amendment #3: (Increase eligibility to 235% FPL)
Submitted: February 6, 2001
Approved: June 1, 2001
Effective: July 1, 2000

Amendment #4: (Change in enrollment process to cover the month of application)
Submitted: June 15, 2001
Approved: August 31, 2001
Effective: April 1, 2001

Amendment #5: (Exempt families spending in excess of 5% of income on private coverage from the crowd-out waiting period

)
Submitted: September 28, 2001

Approved: February 11, 2002
Effective: October 1, 2001

Amendment #6: (Compliance Amendment)
Submitted: July 30, 2002
Approved: January 17, 2003
Effective: August 1, 2002

Amendment #7: (Cost-sharing increase)
Submitted: July 3, 2003
Approved: September 25, 2003
Effective: July 1, 2003

Amendment #8: (Administrative policy changes)
Submitted: July 18, 2003
RESCINDED

Amendment #9: (Change to single late notice)
Submitted: February 13, 2004
Approved: Pending
Effective: January 1, 2004

Amendment #10: (Change to premiums and administrative policy changes)
Submitted: June 21, 2004
Approved: September 17, 2004
Effective: July 1, 2004

Amendment #11: (Change to premium policy, Dental benefit, and Managed Care delivery system)
Submitted: July 7, 2005
Approved: September 30, 2005
Effective: Dental Benefit effective July 1, 2005
Premium Policy effective August 1, 2005
Managed Care delivery system effective January 1, 2006

Amendment #12: (Change Dental Benefit)
Submitted: August 29, 2006
Approved: November 2, 2006
Effective: Dental Benefit effective in accordance with Georgia Families Roll out. Effective June 1, 2006 in Atlanta and Central Region; September 1, 2006, Statewide.

Amendment #13: (Adopt Enrollment Freeze)
Submitted: March 20, 2007
Approved: June 15, 2007
Effective: Close program to new enrollments effective March 11, 2007, and add CMOS Quality assessment fees as a new source of state funds effective March 20, 2007. Updated name change of Georgia Healthy Families to Georgia Families.

Amendment #14: (Implement Full Verification of Income, Citizenship and Identity and Open Enrollment)
Submitted: July 5, 2007
Approved: October 25, 2007
Effective: Require full verification of income, citizenship and identity for all PeachCare applicants and members effective July 1, 2007. Resume enrollment in program effective July 12, 2007, until enrollment reaches 295,000 children.

Amendment #15: (Grace Period, Income, Citizenship and Identity updates)
Submitted: July 13, 2010
Approved: February 10, 2011
Effective: Grace Period Change effective July 31, 2010
Citizenship Changes effective January 1, 2010
Income documentation changes to further align with Medicaid effective June 1, 2010

Amendment 16: (Designate Express Lane Eligibility agency as the Special Nutritional Assistance Program for Women, Infants and Children (WIC)
Submitted: February 7, 2011
Approved: April 13, 2011
Effective: April 1, 2011

Amendment #17: (Implement new co-payments for PeachCare for Kids®)
Submitted: June 27, 2011
Approved: September 28, 2011

Effective: November 1, 2011

Amendment 18: (Enrollment of Children of Public Agency Employees)
Submitted: August 30, 2011
Approved: November 18, 2011
Effective: January 1, 2012

Amendment #19: (Implement co-payment changes for PeachCare for Kids®)
Submitted: March 1, 2012
Approved: April 9, 2012
Effective: April 1, 2012

Amendment 20: (Update Premium amounts and delete outdated information)
Submitted: May 2, 2014
Approved: March 31, 2015
Effective: January 1, 2014

Amendment 21: (End Express Lane Eligibility)
Submitted: December 31, 2015
Approved: February 3, 2016
Effective: April 1, 2016

Superseding Pages of MAGI CHIP State Plan Material

State: Georgia

Transmittal Number	SPA Group	PDF#	Description	Superseded Plan Section(s)
GA-13-0016 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low-Income Children	Supersedes the current sections 4.1.1; 4.1.2; 4.1.3
		CS10	Children Who Have Access to Public Employee Coverage	Supersedes the current section 4.4.1 information on dependents of employees of a public agency
		CS10	Maintenance of Agency Contribution (State Health Benefit Plan Employees)	Supersedes current documentation in Appendix
		CS10	Children Who Have Access to Public Employee Coverage	Supersedes the current section 4.4.1 information on dependents of employees of a public agency
		CS10	Hardship Exception (Board of Regents Employees)	Supersedes current documentation in Appendix
		CS13	Deemed Newborns	Adds new subsection in Section 4.3
		CS15	MAGI-Based Income Methodologies	Adds new subsection in Section 4.3 and supersedes information on income counting
GA-13-0025	XXI Medicaid	CS3	Eligibility for Medicaid Expansion	Supersedes the current Medicaid

Effective/Implementation Date: January 1, 2014	Expansion		Program	expansion section 4.0
GA-13-0017 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
GA-13-0018 Effective/Implementation Date: October 1, 2013	Eligibility Process Group	CS24	Eligibility Processing	Supersedes the current section 4.3; 4.4
GA-14-0019 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS20 CS21	Non-Financial Eligibility – Residency Non-Financial – Citizenship Non-Financial – Social Security Number Substitution of Coverage Non-Payment of Premiums	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1-LR; 4.1.1-LR Supersedes the current section 4.1.9.1 Supersedes the current section 4.4.4 Supersedes the current section 8.7

Transmittal Number	Date Submitted	Effective Date	Date Approved	Description	Amended Plan Section(s)
GA-16-0022	07/20/2016	01/01/2016	10/27/2016	FQHC/RHC Methodologies	Section 3.1 was amended to include: Payment Methodologies of FQHC/RHC Unit PPS Rate Method Alternative Payment Method Section 6.2.5 was amended to include: Services provided by RHC/FQHC meet all requirements of EPSDT
GA-17-0023	08/15/2017	07/01/2017	09/14/2017	Applicant and Enrollee Protections: Health Services Matters	Section 12.2 was amended to update the review process for health services matters and the State Fair Hearing process
GA-17-0024	11/06/2017	07/01/2017	01/04/2018	Updated coverages	Section 6.2 was amended to include: Case management services Non-emergency transportation Enabling services Section 6.1.4 was amended to update coverage to include 6.1.4.1 and not 6.1.4.4
GA-18-0025	02/20/2018	07/01/2017	03/22/2018	Lock Out period	CS21 Submitted to remove lock-out period for non-payment of premiums.

GA-18-0026	06/19/2018	10/02/2017	06/28/2018	Mental Health Parity	Section 6 and Section 8.4 amended to comply with Mental Health Parity requirements
GA-18-0027	07/16/2018	07/01/2018	09/13/2018	Applicant and Enrollee Protections:	CHIP/Medicaid Eligibility and enrollment and appeals process
GA-18-0028	11/06/2018	07/01/2018	01/17/2019	Managed Care	Section 3 amended to comply with Methods of Delivery and Utilization Controls and Managed Care Assurances
GA-20-0029	04/10/2020	03/01/2020	05/07/2020	Disaster Relief	Section 4.3 was amended to allow: Temporary suspension of timely processing of applications. Temporary suspension of timely processing of renewals Temporary suspension of acting on certain changes in circumstance Section 8.2.1 Premiums: was amended to allow premiums to be waived for CHIP applicants and/or beneficiaries as specified during a disaster. Section 8.2.3 Copays: was amended to allow that cost sharing may be waived for CHIP applicants and/or beneficiaries as specified during a disaster. Section 8.7 was amended to provide an exception to disenrollment for Failure to Pay Premiums.

					9.10 Budget impact from Disaster relief
GA-20-0030	06/26/2020	10/24/2019	10/13/2020	Support Act	Section 6.3 and 6.4 amended to include Behavioral Health Coverage, Mental Health, and Substance Abuse Treatment
GA-22-0031	02/25/2022	03/11/2021	03/10/2022	American Rescue Plan Act	Section 1.4 will be amended to include ARPA 6.2.27 COVID-19 Health Care Services 8.2.3 Coinsurance or Copayments
GA-22-0032	05/20/2022	10/01/2022	08/25/2022	Express Lane Eligibility	ELE Sections of Section 4 amended to include ELE for SNAP and TANF Section 5 amended to include ELE Outreach Section 12 amended to include Applicant and Enrollee Protections for ELE
GA-22-0033	09/08/2022	11/01/2022	10/26/2022	CS27	Sections 4.1.2, 4.1.9.2, 6.2.9, 8.2.1 and 9.10 were updated to include 12 Months Continuous Post-Partum Coverage and Lactation Consultants.
GA-23-0034	11/03/2023	01/01/2024	11/21/2023	CS18	Update CS18 to include CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States.
GA-23-0035	11/03/2023	01/01/2024	11/21/2023	Lawfully Residing Option	Sections 4.1-LR and 4.1.1-LR to include the Lawfully Residing Option for eligible children up to age 19, lawfully residing in the United States.

GA-24-0036	01/16/2024	07/01/2023	03/13/2024	Objectives and Performance Goals	Update Section 9, Strategic objectives and Performance goals
GA-24-0037	02/02/2024	07/01/2023	02/28/2024	Health Services Matters	Update Section 12.2, Health Services Matters, to align with Section 3.9 Grievances and Appeals of the State Plan and to demonstrate compliance with 42 CFR 457.1120
GA-24-0038	02/02/2024	10/01/2023	02/28/2024	Providing Vaccines with no cost sharing	Update Section 6.5 to assure the state is providing age-appropriate vaccines with no cost sharing.
GA-24-0039	02/07/2024	01/01/2024	07/22/24	Continuous Eligibility and Non-Payment of Premiums	Update CS27 to include continuous coverage to CHIP eligible children and pregnant teens for at least 12 months regardless of change in circumstances. Update CS21: Non-Payment of Premiums to include that enrollees will no longer be terminated due to non-payment of premiums.
GA-24-0040	04/02/2024	03/01/2024	06/27/2024	ELE Expansion	Update Section 4.3.3EL to Expand ELE to include Refugee Cash Assistance(RCA), Childcare (CC), Women, Infants and Children(WIC)
GA-24-0041	05/02/2024	10/01/2024	07/22/24	Update of Section 8.7 Companion SPA to GA-24-0039	Update Section 8.7 to provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

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.

There are no federally recognized tribes in Georgia. Recognizing that a member of a tribe may re-locate to the State, CHIP will exempt children who are members of federally recognized tribes from the cost-sharing requirements as stipulated in Section 2103(e)(1)(A).

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))

In 1997, Congress created Title XXI of the Social Security Act to provide health care for the growing number of uninsured children in the United States. This legislation enabled states to create State Children's Health Insurance (S-CHIP) programs to increase access to affordable health insurance. In Georgia, this program is known as "PeachCare for Kids®." PeachCare for Kids® began covering children in 1998 and provides comprehensive coverage to uninsured children. S-CHIP was reauthorized in January 2018 for an additional 10 years.

PeachCare for Kids® is a comprehensive health care program for uninsured children

living in Georgia. The health benefits include primary, preventive, specialist, dental care and vision care. PeachCare for Kids® also covers hospitalization, emergency room services, prescription medications and mental health care. Each child in the program is served through one of four Georgia Families Care Management Organizations (CMOs) which are responsible for coordinating the child's care.

In Georgia, children under the age of 19 who do not have insurance may be eligible for PeachCare for Kids®. These children are in families with incomes less than or equal to 247 percent of the federal poverty limit. Eligibility is determined based on the modified adjusted gross income (MAGI). MAGI-based budgeting is used to calculate a person's household size and income, using federal income tax rules and a tax filer's family size to determine eligibility for Medical Assistance. The MAGI Medicaid program started January 1, 2014.

Premiums are required for children ages 6 and older. The cost per month for PeachCare for Kids® coverage is $11 to $36 for one child and a maximum of $72 for two or more children living in the same household. Once a child is determined eligible, enrollment begins once the first premium payment is received. Premiums are due the first day of the month prior to the month of coverage. For example, premiums for coverage in February are due on January 1. Children that are under age 6, in Foster Care, Alaskan Natives, or American Indians are exempt from premium payments.

PeachCare for Kids® customers are required to pay co-payments for their children. These co-payments are paid to medical care providers on the date medical services are received. However, children under the age of 6, Foster children, Alaskan Natives, or American Indians are exempt from these co-payments and will not have to pay any fees for services received.

PeachCare for Kids® is available for children age 18 and under (eligible until 19th birthday) in families who meet the following criteria:

- Children must be a U.S. Citizen or fall within an eligible legal immigrant category. Original documents may be required to verify the status of the child. Parents are not required to verify their own citizenship or immigration status.
- PeachCare for Kids® requires verification of income at application and annual renewal and must fall within 247 percent of the FPL. Eligibility is dependent on the successful completion of this documentation.
- To be eligible for PeachCare for Kids® the child must not have current creditable coverage.
- Children that are eligible for Medicaid are not eligible for PeachCare for Kids®. However, applying for PeachCare for Kids® is part of the overall integrated Medical

Assistance application process. The application process, which uses household composition, income, and other circumstances, determines the most beneficial coverage for each child or children. Children who fall within the Medicaid income limits will be added to the appropriate type of Medicaid. Children who fall within the PeachCare for Kids® income limits will be added to Peachcare for Kids®. No separate application is needed.

Insurance Status of Children in Georgia

Number of Enrollees in PeachCare for Kids ® 2018 144,751

CPS Data Collected in Year: 2018
Persons - All

(Numbers in Thousands)

State: GA			Totals	Health Insurance Coverage in 2017		Health Insurance: Medicaid in 2017		Health Insurance: Employment-Based Ins in 2017	
				Insured	Uninsured	Covered	Not Covered	Covered	Not Covered
Age									
00 to 19	Totals	Totals	2,818	2,603	215	1,079	1,739	1,439	1,379
		Race							
		White alone	1,529	1,403	126	468	1,061	841	688
		Black or African American alone	993	930	63	505	489	438	555
		American Indian and Alaska Native alone	12	12	.	6	6	6	6
		Asian alone	173	163	10	61	112	94	79
		Native Hawaiian and Other Pacific Islander alone	13	13	.	13	.	6	7
		Two or more races	98	81	17	26	71	55	43
	Sex								
	Male	Totals	1,406	1,324	82	548	858	710	697
		Race							
		White alone	776	731	45	251	525	428	348
		Black or African American alone	490	468	22	254	236	212	278
		American Indian and Alaska Native alone	3	3	.	3	.	.	3
		Asian alone	76	71	6	21	56	41	36
		Native Hawaiian and Other Pacific Islander alone	7	7	.	7	.	.	7
		Two or more races	54	44	10	13	41	29	25
	Female	Totals	1,412	1,279	132	531	881	730	682
		Race							
		White alone	753	672	80	217	536	413	340
		Black or African American alone	504	463	41	251	253	226	277
		American Indian and Alaska Native alone	10	10	.	4	6	6	4
		Asian alone	96	92	4	40	56	53	43
		Native Hawaiian and Other Pacific Islander alone	6	6	.	6	.	6	.
		Two or more races	44	37	7	14	30	26	18

Inferences should be made with extreme caution when the cell sizes are small. To examine cell sizes, select "Display Unweighted Record Counts" under the Statistics Option.
Some CPS questions, such as income, ask about the previous year. Others, such as age, refer to the time of the survey. The column labels indicate any subject with a reference year
Current Population Survey, Annual Social and Economic Supplement, 2018
Source: U.S. Census Bureau

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

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

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

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

There are no federally recognized tribes in Georgia. Recognizing that a member of a tribe may re-locate to the State, CHIP will exempt children who are members of federally recognized tribes from the cost-sharing requirements as stipulated in Section 2103(e)(1)(A). Children who identify themselves as American Indian or Native Alaskan on the CHIP application will be notified that, upon receipt of documentation of tribal membership they will no longer be required to submit monthly premiums. Any premiums paid after October 1, 1999, will be reimbursed within 45 days of receipt of documentation of tribal membership.

The materials sent to all new enrollees will include information on the cost-

sharing exemption for members of federally recognized American Indian or Native Alaskan tribes to ensure that those not indicating race on the application will be notified of this exemption.

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 to Section 4 (Eligibility Standards and Methodology).

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

☐ No, the State does not use a managed care delivery system for any CHIP populations.

☒ Yes, the State uses a managed care delivery system for all CHIP populations.

☐ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States

will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

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

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- 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 utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State's responses to the following questions will only apply to those populations.

Payment Methodologies of FQHC/RHC Unit

Our providers are paid the Prospective Payment Method (PPS) or Alternative Payment plan method. When a Federal Qualified Health Center (FQHC) and/or Rural Health Clinic (RHC) application is received from DCH Enrollment unit, they are paid utilizing the PPS

method. Only the Critical Access Hospital RHC's (CAH RHC) are given the option of choosing the PPS method or the Alternative method of payment.

PPS Rate Method

The basis of the PPS reimbursement is providing for "core" services and other ambulatory services per encounter visit cost during FY 1999 and FY 2000. This baseline rate, effective January 2001, is utilized as the basis for rates in succeeding years. Annually, each FQHC/RHC's per visit rate is calculated by adjusting the prior year's rate by the Medical Economic Index (MEI). The MEI is announced in Recurring Update Notifications (RUNs) issued by Centers for Medicare and Medicaid Services (CMS) each year.

For newly qualified FQHCs and RHCs that participate in PPS payments after FY 2000 have their rates established by a statewide average for similar centers. Similar meaning, all FQHCs, hospital based RHCs, and free standing RHCs; each have an average state rate. After the initial year, payment will be set using the MEI and change of scope methods used for other clinics.

Change of Scope

A change in scope of services for a FQHC and RHC is defined as a change in the type, intensity, duration and/or amount of services. It is the clinics responsibility to recognize any changes in their scope of services and to notify the Department of those changes and to provide documentation and projections of the cost and volume impact of the change. Once all documents are received, a review of clinic activity is completed. This may happen once a year.

Alternative Payment Method

This method is only available to critical access hospital RHCs; they have the choice of the PPS method of payment listed above or the Alternative Payment Method (APM). The APM is a cost-based reimbursement method. The Department will calculate the settlement based on the hospital cost report. If the hospital cost is lower than the equivalent PPS rate, the Department will make the additional payment up to the equivalent of PPS rate. This information is derived from the latest cost report and the critical access hospital reports (HS&R reports) for the same period. The Department reviews CAH-RHC activity annually to determine if payment is due to the hospital from the Department or if the hospital owes the Department for over payment.

Settlement Calculation

Annually the department obtains the latest available cost report as well as the hospital statistical and reimbursement report (HS&R reports) from each CAH-RHC. The new percentage is derived from the information from the cost report annually. The comparison of cost to expenses is obtained from the HS&R reports. The amount the Department paid to the CAH-RHC as well as the number of visits are obtained from the HS&R reports. The visits are multiplied by the PPS rate (normally the state average) to determine what the PPS total amount would have been if chosen by the clinic. The reimbursement amount is compared to the PPS amount to determine if the clinic was paid at least the PPS. If not, the department will reimburse the hospital.

CMO's (Care Management Organization)

When an FQHC or RHC provides services pursuant to a contract between the clinic and a Care Management Organization, the State shall perform a reconciliation at least annually, and as needed to ensure that CMO payment equivalent to the amount calculated under the PPS rate. The State is responsible based on the contract between the department and CMO equal to the amount by which the PPS rate exceeds the amount of the payments provided by the CMO on an aggregate annual base. Any such supplemental payments shall be made pursuant to a payment schedule agreed to by the State and the clinic.

3.1.1.2 Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

☒ No
☐ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☒ Managed care organization (MCO) (42 CFR 457.10)
- ☒ Capitation payment
  Describe population served: All CHIP Populations

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
- ☐ Capitation payment
- ☐ Other (please explain)
  Describe population served:

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

☐ Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
- ☐ Capitation payment
- ☐ Other (please explain)
  Describe population served:

☐ Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Other (please explain)

☐ Primary care case management entity (PCCM Entity) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
- ☐ Other (please explain)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as described in 42 CFR 457.10), in addition to PCCM services:

☐ Provision of intensive telephonic case management
☐ Provision of face-to-face case management
☐ Operation of a nurse triage advice line
☐ Development of enrollee care plans
☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program

- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State
- ☐ Provision of enrollee outreach and education activities
- ☐ Operation of a customer service call center
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers
- ☐ Coordination with behavioral health systems/providers
- ☐ Other (please describe)

3.1.2.2 ☒ The State assures that if its contract with an MCO, PAHP, or PIHP allows the entity to use a physician incentive plan, the contract stipulates that the entity must comply with the requirements set forth in 42 CFR 422.208 and 422.210. (42 CFR 457.1201(h), cross-referencing to 42 CFR 438.3(i))

3.1.3 Nonemergency Medical Transportation PAHPs

Guidance: Only complete Section 3.1.3 if the State uses a PAHP to exclusively provide non-emergency medical transportation (a NEMT PAHP). If a NEMT PAHP is the only managed care entity for CHIP in the State, please continue to Section 4 after checking the assurance below. If the State uses a PAHP that does not exclusively provide NEMT and/or uses other managed care entities beyond a NEMT PAHP, the State will need to complete the remaining sections within Section 3.

☒ The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
- The provisions on enrollee rights and protections in 42 CFR 457.1220,

457.1222, 457.1224, and 457.1226.

- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

3.2.1 ☒ The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

3.2.2 ☒ The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

3.2.3 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

3.2.4 ☒ The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

☒ Based on public or private payment rates for comparable services for comparable populations; and

☒ Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

Guidance: States that checked both boxes under 3.3.1 above do not need to make the next assurance. If the state is unable to check both boxes under 3.1.1 above, the state must check the next assurance.

☐ If the State is unable to meet the requirements under 42 CFR 457.1203(a), the State attests that it must establish higher rates because such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. (42 CFR 457.1203(b))

3.3.2 ☒ The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))

3.3.3 ☒ The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))

3.3.4 ☒ The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))

3.3.5 Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))

☒ No, the State does not require any MCO, PIHP, or PAHP to pay remittances.
☐ Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.
☐ Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

If the State requests some, but not all, MCOs, PIHPs, and PAHPs to pay remittances through the contract for not meeting the minimum MLR required by the State, please describe which types of managed care entities are and are not required to pay remittances. For example, if a state requires a medical MCO to pay remittances but not a dental PAHP, please include this information.

If the answer to the assurance above is yes for any or all managed care entities, please answer the next assurance:

☐ The State assures that it if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

- Reimburses CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in the Federal matching rate; and
- Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report provided to CMS that summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

3.3.6 ☒ The State assures that each MCO, PIHP, and PAHP calculates and reports the medical loss ratio in accordance with 42 CFR 438.8. (42 CFR 457.1203(f))

3.4 Enrollment

☒ The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

- Accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the contract (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(1));
- Will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll (42 CFR 457.1201(d), cross-referencing to 42 CFR 438.3(d)(3)); and
- Will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. (42 CFR 457.1201(d), cross-referencing to 438.3(d)(4))

3.4.1 Enrollment Process

3.4.1.1 ☒ The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

3.4.1.2 ☒ The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM

entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))

☒ Yes
☐ No

If the State uses a default enrollment process, please make the following assurances:

☒ The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))

☒ The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably and does not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

3.4.2.1 ☒ The State assures that the State will notify enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2))

3.4.2.2 ☒ The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))

3.4.2.3 ☒ If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

3.4.2.4 MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.

☒ The State assures that contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b))

Guidance: Reasons for disenrollment by the MCO, PIHP, PAHP, PCCM, and PCCM entity must be specified in the contract with the State. Reasons for disenrollment may not include an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, PCCM or PCCM entity seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b)(2))

3.4.2.5 Enrollee Requests for Disenrollment.

Guidance: The State may also choose to limit disenrollment from the MCO, PIHP, PAHP, PCCM, or PCCM entity, except for either: 1) for cause, at any time; or 2) without cause during the latter of the 90 days after the beneficiary's initial enrollment or the State sends the beneficiary notice of that enrollment, at least once every 12 months, upon reenrollment if the temporary loss of CHIP eligibility caused the beneficiary to miss the annual disenrollment opportunity, or when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

Does the State limit disenrollment from an MCO, PIHP, PAHP, PCCM and PCCM entity by an enrollee? (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

☒ Yes
☐ No

If the State limits disenrollment by the enrollee from an MCO, PIHP, PAHP, PCCM and PCCM entity, please make the following assurances (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)):

☒ The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each

enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))

☒ The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))

☒ The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

3.4.2.6 ☒ The State assures that the State ensures timely access to a State review for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(2))

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 ☒ The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

3.5.2 ☒ The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))

3.5.3 ☒ The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

3.5.4 ☒ The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
- Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

3.5.5 ☒ If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

- The format is readily accessible.
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible.
- The information is provided in an electronic form which can be electronically retained and printed.
- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

3.5.6 ☒ The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:

- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area.
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language.
- Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area.
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees:
    - That oral interpretation is available for any language and written translation is available in prevalent languages.
    - That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
    - How to access the services in 42 CFR 457.1207, cross-referencing 42

CFR 438.10(d)(5)(i) and (ii).

3.5.7 ☒ The State assures that the State or its contracted representative provides the information specified in 42 CFR 457.1207, cross-referencing to 438.10(e)(2), and includes the information either in paper or electronic format, to all potential enrollees at the time the potential enrollee becomes eligible to enroll in a voluntary managed care program or is first required to enroll in a mandatory managed care program and within a timeframe that enables the potential enrollee to use the information to choose among the available MCOs, PIHPs, PAHPs, PCCMs and PCCM entities:

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance.
- The basic features of managed care.
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program.
- The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity.
- Covered benefits including:
  - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
  - For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, where and how to obtain the service.
- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan.
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68.
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

3.5.8 ☒ The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.

3.5.9 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:

- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).

3.5.10 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
  - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
  - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
  - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services.
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.
- The extent to which, and how, after-hours and emergency coverage are provided, including:
  - What constitutes an emergency medical condition and emergency services.
  - The fact that prior authorization is not required for emergency

services; and
    - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.
- Any restrictions on the enrollee's freedom of choice among network providers.
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers.
- Cost sharing, if any is imposed under the State plan.
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100.
- The process of selecting and changing the enrollee's primary care provider.
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
    - The right to file grievances and appeals.
    - The requirements and timeframes for filing a grievance or appeal.
    - The availability of assistance in the filing process; and
    - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee.
- How to access auxiliary aids and services, including additional information in alternative formats or languages.
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

3.5.11 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))

3.5.12 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

3.5.13 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directory as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))

3.5.14 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:

- Which medications are covered (both generic and name brand); and
- What tier each medication is on.

3.5.15 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c)).

Guidance: Requirements for marketing activities include, but are not limited to, that the MCO, PIHP, PAHP, PCCM, or PCCM entity does not distribute any marketing materials without first obtaining State approval; distributes the materials to its entire service areas as indicated in the contract; does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. (42 CFR 104(b))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.5 (3.5.16 through 3.5.18).

3.5.16 ☒ The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.

3.5.17 ☒ The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))

Guidance: States should also complete Section 3.9, which includes additional provisions about the notice procedures for grievances and appeals.

3.5.18 ☒ The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR

438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

Guidance: The State should also complete Section 3.10 (Program Integrity).

3.6.1 ☒ The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)

3.6.2 ☒ The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.3 ☒ The State assures that it:

- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
- Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete the remaining assurances in Section 3.6 (3.6.4 through 3.6.20.

3.6.4 ☒ The State assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.5 ☒ The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:

- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
- Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
- Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)

3.6.6 ☒ The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))

3.6.7 ☒ The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))

3.6.8 ☒ The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network.
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees.
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary.
- Establishing mechanisms to ensure compliance by network providers.
- Monitoring network providers regularly to determine compliance.
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

3.6.9 ☒ The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)

3.6.10 ☒ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of

capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

3.6.11 ☒ Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:

- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and
- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

3.6.12 ☒ Except that 438.210(b)(2)(iii) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the authorization of services requirements under 42 CFR 438.210, including that:

- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures.
- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual with appropriate expertise in addressing the enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

3.6.13 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

3.6.14 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the

individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))

3.6.15 ☒ The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP implements the policy. (42 CFR 457.1216, cross-referencing to 42 CFR 438.62)

3.6.16 ☒ The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs.
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee.
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services.
- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers.
- Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees.
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs.
- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

Guidance: For assurances 3.6.17 through 3.6.20, applicability to PIHPs and PAHPs is based a determination by the State in relation to the scope of the entity's services and on the way the State has organized its delivery of managed care services, whether a particular PIHP or PAHP is required to implement the

mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(a)(2))

3.6.17 ☒ The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.

3.6.18 ☒ The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))

3.6.19 ☒ The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:

- Is in accordance with applicable State quality assurance and utilization review standards.
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))

3.6.20 ☒ The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

3.7.1 ☒ The State assures that it has established a uniform credentialing and recredentialing policy that addresses acute, primary, behavioral, and substance use disorders providers and requires each MCO, PIHP and PAHP to follow those policies. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(b)(1))

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.7 (3.7.2 through 3.7.9).

3.7.2 The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:

☒ Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));

☒ MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));

☒ MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));

☒ If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and

☒ MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3 The State assures that each contracted MCO, PIHP, and PAHP complies with the sub contractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:

☒ The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.

☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;

☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to

comply with all applicable CHIP laws, regulations, including applicable sub regulatory guidance and contract provisions; and

☒ The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

3.7.5 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))

3.7.6 ☒ The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment's for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.7 ☒ The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.8 ☒ The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the State has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004)

3.7.9 ☒ The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e))

3.8 Beneficiary Protections

3.8.1 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))

3.8.2 ☒ The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))

3.8.3 ☒ The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:

- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))
- Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
- Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

Guidance: Only States with MCOs, PIHPs, or PAHPs need to complete Section 3.9. States with PCCMs and/or PCCM entities should be adhering to the State's review process for benefits.

3.9.1 ☒ The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 ☒ The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 ☒ The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?

☒ Yes
☐ No

Guidance: Only states that answered yes to assurance 3.9.4 need to complete the next assurance (3.9.5).

3.9.5 ☒ The State assures that the external medical review is:

- At the enrollee's option and not required before or used as a deterrent to proceed to the State review.
- Independent of both the State and MCO, PIHP, or PAHP.
- Offered without any cost to the enrollee; and
- Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))

3.9.6 ☒ The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))

3.9.7 ☒ The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))

3.9.8 ☒ The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))

3.9.9 ☒ The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.

3.9.10 ☒ The State assures that the notice of an adverse benefit determination explains:

- The adverse benefit determination.
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
- The procedures for exercising the rights specified above under this assurance.
- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR

438.404(b))

3.9.11 ☒ The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))

3.9.12 ☒ The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(a))

3.9.13 The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:

☒ Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

☒ Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

☒ All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

☒ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

☒ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

☒ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14 ☒ The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or

PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

3.9.15 ☒ The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

3.9.16 ☒ The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

3.9.17 ☒ The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))

3.9.18 ☒ The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

3.9.19 ☒ The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))

3.9.20 ☒ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 ☒ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:
  - The right to request a State review, and how to do so.
  - The right to request and receive benefits while the hearing is pending, and how to make the request.
  - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

3.9.22 ☒ For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))

3.9.23 ☒ The State assures that if it offers an external medical review:

- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review.
- The review is independent of both the State and MCO, PIHP, or PAHP; and
- The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))

3.9.24 ☒ The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))

3.9.25 ☒ The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:

- The right to file grievances and appeals.
- The requirements and timeframes for filing a grievance or appeal.
- The availability of assistance in the filing process.
- The right to request a State review after the MCO, PIHP or PAHP has

made a determination on an enrollee's appeal which is adverse to the enrollee; and

- The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

3.9.26 ☒ The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)

3.9.27 ☒ The State assures that if the MCO, PIHP, or PAHP, or the State review officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 CFR 457.1260, cross-referencing to 42 CFR 438.424(a))

3.10 Program Integrity

Guidance: The State should complete Section 11 (Program Integrity) in addition to Section 3.10.

Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the first seven assurances (3.10.1 through 3.10.7).

3.10.1 The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:

- ☒ Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;
- ☒ Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and
- ☒ Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as

appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280)

3.10.2 ☒ The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)

3.10.3 ☒ The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))

3.10.4 ☒ The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that includes all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility.
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP.
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

3.10.5 ☒ The State assures that each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(2))

3.10.6 ☒ The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))

3.10.7 ☒ The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))

3.10.8 ☒ The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))

3.10.9 ☒ The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

3.10.10 ☒ The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or

PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))

3.10.11 ☒ The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)

3.10.12 The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:

- ☒ Encounter data in the form and manner described in 42 CFR 438.818.
- ☒ Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.
- ☒ Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.
- ☒ Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.
- ☒ Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.
- ☒ The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13 The State assures that:

- ☒ It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))
- ☒ It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and

☒ It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

3.10.14 ☒ The State assures that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors provides: written disclosure of any prohibited affiliation under 42 CFR 438.610, written disclosure of and information on ownership and control required under 42 CFR 455.104, and reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. (42 CFR 457.1285, cross referencing 42 CFR 438.608(c))

3.10.15 ☒ The State assures that services are provided in an effective and efficient manner. (Section 2101(a))

3.10.16 ☒ The State assures that it operates a Web site that provides:

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services.
- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

3.11 Sanctions

Guidance: Only States with MCOs need to answer the next three assurances (3.11.1 through 3.11.3).

Intermediate sanctions are defined at 42 CFR 438.702(a)(4) as: (1) Civil money penalties; (2) Appointment of temporary management (for an MCO); (3) Granting enrollees the right to terminate enrollment without cause; (4) Suspension of all new enrollment; and (5) Suspension of payment for beneficiaries.

3.11.1 ☒ The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

3.11.2 ☒ The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.3 ☒ The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

Guidance: Only states with PCCMs, or PCCM entities need to answer the next assurance (3.11.4).

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?

☐ Yes
☐ No

Guidance: Only states with MCOs and states that answered yes to assurance 3.11.4 need to complete the next three assurances (3.11.5 through 3.11.7).

3.11.5 ☒ The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))

3.11.6 ☒ The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b))

3.11.7 ☒ The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review

Guidance: The State should complete Sections 7 (Quality and Appropriateness of Care) and 9 (Strategic Objectives and Performance Goals and Plan Administration) in addition to Section 3.12.

Guidance: States with MCO(s), PIHP(s), PAHP(s), or certain PCCM entity/ies (PCCM entities whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes - see 42 CFR 457.1240(f)) - should complete the applicable sub-sections for each entity type in this section, regarding 42 CFR 457.1240 and 1250.

3.12.1 Quality Strategy

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities need to complete section 3.12.1.

3.12.1.1 ☒ The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236.
- A description of:
  - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
  - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP.
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract.
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language.
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438.
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity.
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities.

- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a "significant change" for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

3.12.1.2 ☒ The State assures that the goals and objectives for continuous quality improvement in the quality strategy are measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(2))

3.12.1.3 ☒ The State assures that for purposes of the quality strategy, the State provides the demographic information for each CHIP enrollee to the MCO, PIHP or PAHP at the time of enrollment. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b)(6))

3.12.1.4 ☒ The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))

3.12.1.5 ☒ The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii).

3.12.1.6 ☒ The State assures that it will submit to CMS:
- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
- A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

3.12.1.7 ☒ Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:
- Make the strategy available for public comment; and
- If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))

3.12.1.8 ☒ The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next two assurances (3.12.2.1.1 and 3.12.2.1.2).

3.12.2.1.1 ☒ The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The elements of the assessment and program include at least:

- Standard performance measures specified by the State;
- Any measures and programs required by CMS (42 CFR 438.330(a)(2);
- Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);
- Mechanisms to detect both underutilization and overutilization of services; and
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1))

Guidance: A State may request an exemption from including the performance measures or performance improvement programs established by CMS under 42 CFR 438.330(a)(2), by submitting a written request to CMS explaining the basis for such request.

3.12.2.1.2 ☒ The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
- Planning and initiation of activities for increasing or sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

Guidance: Only states with a PCCM entity whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes need to, complete the next assurance (3.12.2.1.3).

3.12.2.1.3 ☐ The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:

- Standard performance measures specified by the State;
- Mechanisms to detect both underutilization and overutilization of services; and
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.2.2.

3.12.2.2.1 ☒ The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as

required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))

3.12.2.2.2 ☒ The State assures that it annually requires each MCO, PIHP, and PAHP to:
1) Measure and report to the State on its performance using the standard measures required by the State;
2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

3.12.2.2.3 ☒ The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:

- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and
- The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.3.

3.12.3.1 ☒ The State assures that it requires each MCO, PIHP, and PAHP to inform the state whether it has been accredited by a private independent accrediting entity, and, if the MCO, PIHP, or PAHP has received accreditation by a private independent accrediting agency, that the MCO, PIHP, and PAHP authorizes the private independent accrediting entity to provide the State a copy of its recent accreditation review that includes the MCO, PIHP, and PAHP's accreditation status, survey type, and level (as applicable); accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and expiration date of the accreditation. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(a) and (b)).

3.12.3.2 ☒ The State assures that it will make the accreditation status for each contracted MCO, PIHP, and PAHP available on the Web site required under 42 CFR 438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the

accrediting entity, accreditation program, and accreditation level; and update this information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete Section 3.12.4.

☒ The State assures that it will implement and operate a quality rating system that issues an annual quality rating for each MCO, PIHP, and PAHP, which the State will prominently display on the Web site required under 42 CFR 438.10(c)(3), in accordance with the requirements set forth in 42 CFR 438.334. (42 CFR 457.1240(d))

Guidance: States will be required to comply with this assurance within 3 years after CMS, in consultation with States and other Stakeholders and after providing public notice and opportunity for comment, has identified performance measures and a methodology for a Medicaid and CHIP managed care quality rating system in the Federal Register.

3.12.5 Quality Review

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5 and 3.12.5.1.

☒ The State assures that each contract with a MCO, PIHP, PAHP, or PCCM entity requires that a qualified EQRO performs an annual external quality review (EQR) for each contracting MCO, PIHP, PAHP or PCCM entity, except as provided in 42 CFR 438.362. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(a))

3.12.5.1 External Quality Review Organization

3.12.5.1.1 ☒ The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))

3.12.5.1.2 ☒ The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

Guidance: Only states with MCOs, PIHPs, or PAHPs need to complete the next three assurances (3.12.5.2.1 through 3.12.5.2.3). Under 42 CFR 457.1250(a), the State, or its agent or EQRO, must conduct the EQR-related activity under 42 CFR 438.358(b)(1)(iv) regarding validation of the MCO, PIHP, or PAHP's network adequacy during the preceding 12 months; however, the State may permit its contracted MCO, PIHP, and PAHPs to use information from a private accreditation review in lieu of any or all the EQR-related activities under 42 CFR 438.358(b)(1)(i) through (iii) (relating to the validation of performance improvement projects, validation of performance measures, and compliance review).

3.12.5.2.1 ☒ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1))

3.12.5.2.2 ☒ The State assures that if it elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will document the use of nonduplication in the State's quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)

3.12.5.2.3 ☒ The State assures that if the State elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will ensure that all information from a Medicare or private accreditation review for an MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42 CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

Guidance: Only states with PCCM entities need to complete the next assurance (3.12.5.2.4).

3.12.5.2.4 ☐ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
- A review, conducted within the previous 3-year period, to determine the PCCM entity's compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

Guidance: All states with MCOs, PIHPs, PAHPs, PCCMs or PCCM entities need to complete Sections 3.12.5.3.

3.12.5.3.1 ☒ The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))

3.12.5.3.2 ☒ The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).

3.12.5.3.3 ☒ The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:

- The EQRO has sufficient information to use in performing the review;
- The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;
- For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
- The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))

3.12.5.3.4 ☒ The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR

438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));
- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
  - Objectives;
  - Technical methods of data collection and analysis;
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
  - Conclusions drawn from the data;
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

3.12.5.3.5 ☒ The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))

3.12.5.3.6 ☒ The State assures that it finalizes the annual EQR technical report by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

3.12.5.3.7 ☒ The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.8 ☒ The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

3.12.5.3.9 ☒ The State assures that it makes the information specified in 42 CFR 438.364(a) for the annual EQR technical report available in alternative formats for persons with disabilities, when requested. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(3))

3.12.5.3.10 ☒ The State assures that information released under 42 CFR 438.364 for the annual EQR technical report does not disclose the identity or other protected health information of any patient. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(d))

Section 4. Eligibility Standards and Methodology

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

4.0. ☒ **Medicaid Expansion**

4.0.1. ☒ Ages of each eligibility group and the income standard for that group: Children ages 6 to 19 years old with household income 113-133% FPL

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

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option. Citizenship is verified via Data Match.

4.1.1 ☒ Geographic area served by the Plan if less than Statewide:
Georgia's Plan is available statewide to children in all 159 Georgia counties.

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

The plan will be available to children 0 through 18 years of age.
If the child is otherwise eligible, coverage will continue through the month of his/her nineteenth birthday, with an income no greater than 247% FPL.
Continuous eligibility is provided to targeted low-income children/teens who are pregnant, eligible, and enrolled in the state CHIP plan beginning on the day the pregnancy ends and ending on the last day of the 12 month Post-Partum period, which may extend beyond their nineteenth birthday, and with an income no greater than 247% FPL.
This Post-Partum coverage is available through March 31, 2027.

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

4.1.3 ☒ Income of each separate eligibility group (if applicable):
Eligible Children will have a family income not higher than 247% of the Federal Poverty Level, and not eligible for Medicaid.

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

4.1.4 ☒ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):
There is no resource test.

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state): Georgia residency is required. Residency is based on current circumstances. There is no requirement that a child must live in Georgia a specified length of time prior to application.

4.1.6 ☒ Disability Status (so long as any standard relating to disability status does not restrict eligibility): No child will be denied eligibility based on disability status.

4.1.7 ☒ Access to or coverage under other health coverage: Children with other creditable health coverage or are eligible for Medicaid are not eligible for PeachCare for Kids®.

4.1.8 ☒ Duration of eligibility, not to exceed 12 months: With the approval of the PeachCare application, a child will be eligible for twelve months as long as eligibility criteria continue to be met. The family will be notified of its responsibility to report changes in income, residency, or health insurance coverage. At the end of the twelve-month eligibility period, the family will be sent a letter detailing the information on the family's account pertinent to eligibility. The family will be required to report any changes to the information and provide verification of all sources of income at this time. Eligibility will be redetermined for another twelve-month period so long as the family provides the required documentation within the requested timeframe.

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.
The State requires individuals, as a condition of eligibility, to furnish their social security number, the State will also assist 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 has forgotten their SSN. The state does request non-applicant household members to voluntarily provide their SSN, however it is not required. Unborn children are exempt from providing SSN's.

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

4.1.9.2 ☒ Continuous eligibility
12 month continuous Post-Partum option
4.1.9.2- a. The State includes eligibility for Pregnant CHIP enrollees who meet the following eligibility criteria:

- Income does not exceed 247% of the FPL, and not eligible for Medicaid
- citizenship/immigration status
- identity
- age (under the age of 19)
- residency

4.1.9.2- b. Continuous eligibility is provided to targeted low- income children/teens who are pregnant, eligible, and enrolled in the state CHIP plan beginning on the day the pregnancy ends and ending on the last day of the 12 month Post-Partum period, with an income no greater than 247% FPL, unless:

- The individual or representative requests voluntary disenrollment
- The individual 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 the individual
- The individual dies

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1) "lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of

these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

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

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

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
(4) An alien who belongs to one of the following classes:
  (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
  (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
  (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
  (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
  (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
  (vi) Aliens currently in deferred action status; or
  (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an

applicant under the age of 14 who has had an application pending for at least180 days;
(6) An alien who has been granted withholding of removal under the Convention Against Torture;
(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☒ Elected for children under age 19

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)

Applying for PeachCare for Kids® is part of the overall Medical Assistance application process. There is one application for Medical Assistance. Based on your household composition, income, and other circumstances, the State will determine the most beneficial coverage for your child(ren). Children who fall under the Medicaid income limits will be put on the appropriate type of Medicaid. Children who fall within the PeachCare for Kids® income limits will be put on PeachCare for Kids®. No separate application is needed.

At the time of application approval, the family receives information requiring them to report changes in their income, place of residence or household size. If the family has remained PeachCare for Kids® eligible a verification request for renewal is sent 45 days prior to the renewal month. If these changes result in ineligibility, the integrated eligibility system reviews the account information for potential eligibility for the Medicaid program.

If the child is screened as ineligible for Medicaid and PeachCare for Kids® based on the information provided, the member is sent a notice of termination and closes the case. The notice specifies the reason for termination (e.g. excess income, etc.) The notice also specifies the applicant's opportunity to request a reconsideration of the decision and related procedures to submit any necessary documentation. If the

member is over the limit for PeachCare for Kids®, their information is automatically referred to the FFM.
Providing the family continues to meet all eligibility requirements and continues to pay the monthly premium as required, the child(ren) may be eligible for coverage for twelve (12) months.

Temporary suspension of timely processing of applications:
At State discretion, requirements related to timely processing of applications may be temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area.
Temporary suspension of timely processing of renewals:
At State discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area.
Temporary suspension of acting on certain changes in circumstance:
The State will temporarily delay acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by a State or Federally declared disaster such that processing the change in a timely manner is not feasible. The state will continue to act on changes in circumstance related to residency, death, voluntary termination of coverage, erroneous eligibility determinations, and becoming eligible for Medicaid.

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))
Due to a lack of funding, effective March 11, 2007, DCH closed PeachCare for Kids® to new enrollment. Receipt of federal funds from FFY2004 and FFY2005 redistribution and supplemental appropriations, provided sufficient resources to open enrollment. On June 14, 2007, a public notice was issued announcing the Department's intent to resume enrollment. Upon DCH Board approval, enrollment resumed effective July
12, 2007. However, enrollment is limited to 295,000 children. The enrollment limit will be reassessed based on the availability of federal funding once SCHIP is reauthorized.
While the cap is in place, enrollment will be monitored weekly. Children will only be activated for coverage when the number of active children is under the cap (295,000). Once the cap is reached, no pending accounts whether they are new, or reinstatements

will be activated to receive coverage. In the chance occurrence that the cap is reached during the processing of a family group, all eligible children will be given coverage. The eligibility system will include notes and updated correspondence that will be "turned on" if the cap is reached. Public notice on the enrollment cap was issued. In the event that the enrollment cap of 295,000 children is reached before adequate FFY08 is available and enrollment must be closed again, the following procedures will be in place:

- All correspondence, as well as the PeachCare for Kids® website, will be updated to indicate the capped enrollment status and explain what it will mean for members and potential members.

- Members whose participation in the program is suspended for failure to timely pay premiums or for failure to provide required income verification will be precluded from re-enrollment during any closed enrollment period. These members will receive additional notice by direct mail informing them of their review rights as required by governing regulations.

- Members enrolled and/or determined eligible prior to any closed enrollment period will not be impacted by this particular change so long as they continue to pay premiums timely and comply with any requests for information, including income, citizenship and identity verification.

- Members who are suspended during a closed enrollment period will be able to re-instate their accounts once enrollment is open so long as they bring their account into balance. They will not be required to submit a new application. These accounts will be given a special designation in the eligibility system as "pending closed enrollment."

- All individuals who submit an application during a closed enrollment period will receive a notice stating that PeachCare for Kids® is in closed enrollment but that they will be notified once the program is open to new enrollment.

- PeachCare will continue to accept applications during any closed enrollment period. The TPA would enter them into the system and continue to screen for potential Medicaid eligibility. Upon re-opening of enrollment, applications would continue processing based on date of application or reinstatement request.

Applications received during any enrollment freeze will be retained based on original date of receipt. For children referred to Medicaid, the original date of receipt will be the date the application was received by PeachCare for Kids®.

☐ 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.
Express lane eligibility will be applied to both applications and renewals.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.
The Department of Human Services, Division of Family and Children Services (DFCS) in the administration of the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF), Refugee Cash Assistance (RCA) Program. Women Infants and Children (WIC) and Childcare (CC) applicants will be informed that with their permission, their demographic and income information will be forwarded to the Division of Family and Children Services (DFCS) for an eligibility determination.

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.

The DFCS agency will use the Express Lane Eligibility option for initial determinations and redeterminations. DFCS agency will use the SNAP, TANF, RCA, CC or WIC income findings, calculated based on SNAP, TANF,

RCA, CC and WIC eligibility policies (income exclusions, disregards, household composition, deeming, etc.) to determine income eligibility for CHIP. DFCS will use other information collected by the SNAP, TANF, RCA, CC and WIC agencies on the program's application/renewal or through its verification processes to determine most other factors of CHIP eligibility (e.g. State residency). Any SNAP, TANF, RCA CC, or WIC eligible children, must also meet CHIP citizenship requirement.

The following summarizes differences in methodology between CHIP, SNAP, TANF, RCA, CC and WIC:

Budget Unit:

CHIP

- The DFCS agency uses Modified Adjusted Gross Income (MAGI) household composition subject to its state plan in determining eligibility. The MAGI Budget Group (BG) consists of tax filers and their tax dependents, or non-tax filers and in their home their spouses, children under the age of 19 (natural, biological, adopted or step), and for children under the age of 19, natural, biological, adopted and stepparents, and natural, biological, adopted and step siblings under the age of 19. The BG also includes any unborn child of an individual included in the BG who is pregnant.

SNAP

- The household composition consists of the individual, individual spouse, minor children under 18 who are under parental control of a household member other than their parent, parents, and their children under the age of 22 (biological, adopted or step), and/or all individuals who purchase and prepare meals together.

TANF

- The household composition consists of children within the specified degree of relationship to grantee relative. The following relationships meet the relationship requirement: parent (either by birth, legal adoption, or step relationship) , grandparent (up to great-great-great), sibling (half, whole, step), aunt/uncle (up to great-great), niece/nephew (including child and grandchild of niece/nephew), first cousin, first cousin once removed (the child of a first cousin), legal guardian, spouse of any person named in the above group even after the marriage is terminated by death or divorce, unless the child is born after termination of the marriage.

RCA

- The household composition consists of the individual, individual spouse, minor children under 18.

CC

The following individuals living in the household shall be included in the family unit:

- Biological, adopted, or stepchildren 17 years of age or younger.
- Children under legal or physical guardianship of the parent
- Spouse/parent residing in the home
- Unmarried adults living together with a mutual biological or legal child(ren) residing in the same household
- Spouse/parent temporarily absent from the household due to employment, military deployment, training, or education.
- Other household composition considerations for CC:
- For each child in Georgia's Division of Family and Children Services (DFCS) custody, the State shall be considered the parent, and the child will be authorized as a family unit of one.
- Siblings in Georgia's DFCS custody will be assigned to their own case.
- A parent 17 years of age or younger and their child shall be considered their own family unit.
- For the purposes of CC, a parent is defined as "a parent by blood, marriage, or adoption; a legal guardian; or another person standing in loco parentis (acting in the role of a parent or guardian). Parent also include any persons recognized by Georgia law or a competent court of jurisdiction as serving in loco parentis."

WIC

- A group of related or nonrelated individuals who live together as one household/economic unit. These individuals share income and consumption of goods or services.

Income Limit:

CHIP

- MAGI household income for children under 19, and above applicable Medicaid limits up to 247% of the federal poverty limit (FPL). For the Express Lane option, household income will be compared from 236% to 247% FPL.

SNAP

- Gross income at or below 130% FPL for most households, but after allowable deductions the net income is at or below 100% FPL.

TANF

- Income cannot exceed the Gross Income Ceiling (GIC) for their Assistance Unit (AU) size.

RCA

- Income cannot exceed the Gross Income Ceiling (GIC) for their Assistance Unit (AU) size.

CC

- For initial determinations, the gross applicable income of the family unit must be equal to or less than 50% of the current State Median Income (SMI) at the time of application. For redeterminations, if a family's gross applicable income increases but remains at or below the maximum allowable federal limit of 85% SMI, the family will continue to be eligible for the program.

WIC

- Gross income at or below 185% FPL for all households.

Income Disregards:

CHIP

- The DFCS agency uses MAGI income including income disregards and exclusions (e.g., Pre-tax, 1040 and 5% disregard) subject to it state plan in determining eligibility.

SNAP

- Income disregards are used to determine benefits level, not eligibility.
- 20% earned income deduction.
- Standard deduction
- Excess medical deduction
- Dependent care deduction
- Child support deduction
- Homeless shelter deduction

TANF

- Deductions are applied to earned income.

RCA

- None

CC

- The only deduction applied to income for CC is for self-employment (gross income minus verified, allowable expenses) which equals to the net income for self-employment. There are no other deductions applied to income for CC.

WIC

- None

Income Exclusions:

CHIP

- The DFCS agency uses MAGI income including income disregards and exclusion subject to it state plan in determining eligibility.

SNAP

The following income types are not included in MAGI but are included in SNAP:

- Child support
- Contribution
- Supplemental Security Income (SSI)
- Temporary Assistance for Needy Families (TANF)

TANF

The following income are not included in MAGI but are included in TANF:

- Child support
- Contribution

RCA

- Temporary Assistance for Needy Families (TANF) cash assistance
- disability/survivors and SSI benefits received by the Social Security Administration
- Low Income Housing and Energy Assistance Program (LIHEAP)
- Tax refunds
- Disaster Relief Assistance
- Relative care subsidy
- Any resettlement funds provided by the Resettlement Agencies.

CC

- Temporary Assistance for Needy Families (TANF) cash assistance
- Disability/survivors and SSI benefits received by the Social Security Administration,
- Adoption supplements
- Low Income Housing
- Energy Assistance Program (LIHEAP)
- Census Bureau income,
- in-kind donations

- Tax refunds
- Cash gifts
- Disaster Relief Assistance
- Relative care subsidy
- Income from a child 17 years of age or younger is also excluded.

WIC

- Military pay

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

The State elects the option for automatic enrollment without a separate CHIP Application, based on data obtained from other sources and with the child's or family's affirmative consent to the child's CHIP enrollment.

The applicant must meet identity, age, and residency requirements, for SNAP, TANF, RCA, CC or WIC and their income must be between 236% and 247% of the FPL, to be eligible for CHIP ELE consideration. Any SNAP, TANF, RCA CC, or WIC eligible children, must also meet CHIP citizenship requirement.
DFCS will verify citizenship through data matches or other allowable documents to determine CHIP eligibility

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.

If the applicant qualifies for SNAP, TANF, RCA, CC or WIC prior to ELE consideration, and meets the basic eligibility requirements for CHIP, the income will be used to determine the appropriate category of Medical Assistance for the child. If the income is between 236% - 247% the child will be enrolled in PeachCare for Kids®.

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
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.

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))
Georgia implemented an Integrated Eligibility System that automatically screens all applicants for Medicaid and CHIP eligibility and enrolls them in the appropriate class of assistance based on household circumstances.

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))
Georgia implemented an Integrated Eligibility System that automatically screens all applicants for Medicaid and CHIP eligibility and enrolls them in the appropriate class of assistance based on household circumstances.

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) Children that are covered by creditable health coverage are not eligible for PeachCare for Kids®.

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)) PeachCare for Kids® does not provide coverage under a premium assistance program

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))

There are no federally recognized tribes in Georgia. Recognizing that a member of a tribe may re-locate to the State, CHIP will exempt children who are members of federally recognized tribes from the cost-sharing requirements as stipulated in Section 2103(e)(1)(A). Children who identify themselves as American Indian or Native Alaskan on the CHIP application will be notified that, upon receipt of documentation of tribal membership, they will no longer be required to submit monthly premiums. Any premiums paid after October 1, 1999, will be reimbursed within 45 days of receipt of documentation of tribal membership.

The materials sent to all new enrollees will include information on the cost-sharing exemption for members of federally recognized American Indian or Native Alaskan tribes to ensure that those not indicating race on the application will be notified of this exemption.

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 DFCS agency will use the Express Lane Eligibility option for initial determinations and redeterminations. The DFCS agency will use the SNAP, TANF, RCA, CC or WIC income findings, calculated based on SNAP, TANF, RCA, CC and WIC eligibility policies (income exclusions, disregards, household composition, deeming, etc.) to determine income eligibility for Medical Assistance.

DFCS will verify citizenship through data matches or other allowable documents to determine CHIP eligibility.

☒ 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 Georgia Integrated Eligibility System (IES) will compare the household income to the highest Medicaid income threshold (205% FPL) applicable to a child (0-19) plus 30% which will equal to 235% FPL. If household income is over 235% FPL but at or below 247% FPL, the child should be evaluated for Express Lane CHIP (ELE PCK).
If a child is found eligible for Express Lane CHIP PeachCare for Kids (ELE PCK) from the ELE determination, the applicant will be provided a notice that the child may qualify for Medicaid and/or lower premiums if evaluated using the regular eligibility determination and provide an avenue on how to request a full eligibility determination. A separate application is not required. An applicant is no longer considered ELE if a full eligibility determination is requested by the applicant and is determined eligible.
Note: Children with third-party liability (TPL) are not eligible for PCK.

☒ 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):
Currently, Georgia's public child health insurance plans include PeachCare for Kids® and the Medicaid program administered by the Georgia Department of Community Health (DCH), Division of Medical Assistance (DMA). The Department has several approaches to identifying and enrolling eligible children. These approaches are described in the following paragraphs.

PeachCare for Kids®

PeachCare for Kids'® outreach effort was launched in September 1998. Outreach initiatives have included a wide array of mass-media and local grassroots efforts. PeachCare Kids® has had massive advertising, in both English and Spanish, through television, radio, newspaper, and outdoor billboard and transit advertising. In 2001 and 2002, PeachCare has teamed up with WSB Channel 2's, Atlanta's ABC affiliate, Family 2

Family Community Program. Through this partnership, PeachCare for Kids® is able to participate in hundreds of family-oriented community events in the metro Atlanta area. PeachCare also benefits from the extensive public service campaigns.

In 2000, the Department created a "minigrant" program to facilitate grassroots efforts to educate targeted populations about PeachCare for Kids® and Medicaid. The grantee organizations were diverse in the populations they served, including African-American, Hispanic, Asian and rural communities. An evaluation of the grantees showed a 16% increase in applications submitted over other similar counties during the same time, and a 19% increase in applications for the targeted populations.

In 2000, 2001, and 2002, the Department has teamed up with the Department of Education, Division of School Nutrition Services to distribute flyers, in English and Spanish, to each student during Back-to- School registration. The Right from the Start Medicaid (RSM) outreach staff worked with many elementary schools to be on site promoting PeachCare for Kids® and Medicaid to the parents.

PeachCare for Kids®, RSM, March of Dimes and Kmart stores partnered in 1999 and 2000 to promote PeachCare for Kids® and Medicaid. In 1999, outreach workers were at each Kmart store on the Saturday before Halloween educating parents while their children shopped for costumes and treats. In 2000, the outreach workers returned to Kmart on the Saturday before school started to talk to parents as they were getting their kids ready for the new school year.

The Department has created a simple, one-page mail-in application for PeachCare for Kids®,

available in English, Spanish, Vietnamese, Chinese, Korean and Somalian. The application is distributed by request through the PeachCare for Kids® call center and throughout the state in many hospitals, provider offices, Department of Families and Children offices, health departments, and libraries.

In 2001, the Department launched *www.peachcare.org*, a web-based application designed to provide parents with instant access to complete the enrollment process. In its first year, applications have been received for nearly 40,000 children through the website. The site has also been successful reaching families of Medicaid-eligible children. Nearly half of all web-based applicants have been eligible for the Medicaid program. The advantages of the website are numerous. It eliminates mail delays. It provides parents with instant confirmation that the application has been received and gives parents an estimation of potential eligibility. The website also generates a list of participating primary care physicians to assist parents in the selection of a doctor for their child.

Division of Family and Children Services (DFCS)

The Department of Medical Assistance has an interagency agreement with the Department of Human Resources (DHR) to provide, through its Division of Family and Children Services (DFCS), Medicaid eligibility determinations for all Medicaid coverage groups other than SSI cash assistance. For pregnant women and children, these coverage groups include Parent Caretaker, Medically Needy, Right From the Start Medicaid (RSM - Georgia's poverty level Medicaid program), and the Katie Beckett Deeming Waiver programs. These programs are offered in conjunction with other entitlement programs and supportive services that are offered by DFCS. DFCS is also responsible for Food Stamps, Temporary Assistance for Needy Families (TANF), Child Protective Services and Foster Care. The Medicaid application process is coordinated with that for cash assistance and employment related services available through TANF. Children in families seeking these services also have their Medicaid eligibility determined. The State of Georgia has 159 counties.

Each county has at least one DFCS office, and some counties have multiple sites for Medicaid eligibility intake. Some workers from these local DFCS offices are assigned to Federally Qualified Health Centers (FQHCs) and Disproportionate Share Hospitals.

While the bulk of the state's Medicaid determinations are made locally at the county DFCS offices, the RSM Outreach Project is an aggressive outreach program targeted at enrolling uninsured and underinsured poverty level pregnant women and children in Medicaid and PeachCare. This project operates under a separate interagency agreement between the Department of Community Health and the Department of Human Resources. The eligibility workers who are part of this project are housed in locations other than the local DFCS office.

Public Health Departments and Federally Qualified Health Centers

DCH also coordinates Medicaid enrollment efforts with the activities of the Division of Public Health, a part of the Department of Human Resources. Across the state, perinatal case management services and the Medicaid application process are linked. At the public health departments and federally qualified health centers, a pregnant woman can apply for Presumptive Medicaid eligibility and begin receiving prenatal services immediately. As part of this process, the pregnant woman applies for RSM Medicaid to ensure ongoing Medicaid eligibility. When the pregnant woman applies for RSM, any children in the family are also included on the application form and the form with the children's names are routed to DFCS for a determination of their eligibility along with that of the pregnant woman.

The Division of Public Health, through its local health departments, and the federally qualified health centers administer the Special Nutritional Program for Women, Infants and Children (WIC). This program provides nutritious food to supplement the regular diet of pregnant women, breast- feeding women, infants, and children under age five who meet state income standards. Generally, on the initial visit to either of these facilities, the pregnant woman is certified for Presumptive Medicaid eligibility, applies for regular Medicaid for herself and her children, and receives WIC for herself and any children under the age of five (5). The PeachCare for Kids® program also recognizes the WIC program as an Express Lane agency.

Other State Initiatives For Special Needs Children

The following programs are some of the State's own initiatives to provide health care to special needs children. All are administered by the Department of Human Resources, three by the Division of Public Health, two by the Division of Mental Health, Mental Retardation and Substance Abuse and one by an interagency team. As mentioned previously, RSM outreach workers are stationed in many county public health departments or visit on a routine basis to process Medicaid applications. Uninsured children who present to these programs for their services are referred to outreach workers or county DFCS offices to have a Medicaid eligibility determination completed.

Division of Public Health "Babies Can't Wait"

"Babies Can't Wait" or the Early Intervention Program is Georgia's statewide interagency service delivery system for children from birth to three years who have developmental delays or disabilities. This program guarantees that all children, regardless of their disability, have access to services that will enhance their development. Services are provided by agencies and individuals from both the public and private sectors. Some are offered at no cost. For others, state funds are available to assist families that have been determined unable to pay. Medicaid eligible children may participate in this program. 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

Children's Medical Services

Children's Medical Services (CMS), formerly the Crippled Children's Program, provides medical care to low-income children with disabling conditions or chronic diseases. It also provides specialized health care for certain disorders, e.g., chronic lung disease, craniofacial anomalies, and cystic fibrosis. Eligibility is based on the age of the child (0-21 years), type of medical condition, Georgia residency and annual family income. Some services are covered by Medicaid and Medicaid eligible children may participate in this program. CMS serves approximately 15,000 to 16,000 children yearly.

Department of Behavioral Health and Developmental Disabilities

Core and Specialty Services include evaluation/assessment, diagnosis, counseling and medication, therapy (individual, group, and family), community support services, crisis assessments, and physician services. These services are provided in clinics and other locations as needed, including homes, schools, detention facilities, and other community settings.

Crisis Services include crisis stabilization and mobile crisis response services.

Mobile Crisis Response Services (MCRS) provides community-based, face-to-face crisis response 24 hours a day, seven days a week to individuals in an active state of crisis. MCRS offers short-term, behavioral health services for persons in need who may have been unable to successfully maintain stability.

Psychiatric Residential Treatment (PRTF) Services provide comprehensive mental health and substance abuse treatment to children, adolescents, and young adults ages 5-21 who, due to severe emotional disturbance, are in need of quality active treatment that can only be provided in an inpatient treatment setting and for whom alternative, less restrictive forms of treatment have been tried and found unsuccessful or are not medically indicated.

Uninsured children who present to these programs for their services are referred for a Medicaid eligibility determination, but services are provided to uninsured or underinsured children on a sliding fee scale and are not denied due to inability to pay.

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 appropriate.

The state is implementing the Express Lane Eligibility option to provide a simplified determination process and expedited enrollment of eligible children into CHIP. The state agency will obtain information from approved SNAP,

TANF, RCA, CC, and WIC applications to provide streamlined eligibility determinations for CHIP (PCK). DCH will work together with other state agencies, community partners, and social media platforms to encourage enrollment of low-income residents of Georgia.

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 of Georgia has one public-private program designed to provide health care to uninsured children; however, this program does not offer "creditable coverage." The PeachCare for Kids® and Medicaid program's eligibility processes have a significant role in the efforts of the program. The application process for The Georgia Partnership for Caring Program begins with the RSM Outreach Project worker.

Georgia Partnership for Caring Foundation

The Georgia Partnership for Caring Foundation (GPCF) was established in 1994 and represents a unique partnership between state government and the private sector. The mission of GPCF is to establish a free health care referral program for Georgians who cannot afford private health insurance but are not eligible for governmental medical assistance such as PeachCare for Kids®, Medicaid or Medicare. Funding has been provided by grants from individuals, associations, and the Departments of Human Resources and Community Health.

The program includes the limited voluntary services of physicians, nurse practitioners, dentists, ophthalmologists, optometrists, physician's assistants, hospitals, pharmacists, pharmaceutical manufacturers, and many health provider groups and agencies. These volunteers are not paid for their services or products, but are committed to assisting Georgians obtain access to needed health care coverage. The program is available in about three-fifths of Georgia's counties. **GPCF is not insurance coverage.** It is not for emergencies or urgent care situations. Application processing time averages 1 month. As previously stated, RSM outreach workers are involved in the referral and application process for GPCF. They perform the screening function to determine that individuals who are referred to GPCF are not eligible for Medicaid.
The Georgia Partnership for Caring Program ended in 2010.

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

As part of its effort to decrease the number of uninsured children, Georgia targets children who are under the age of nineteen (19), who have family income that is at or below 247% of the Federal Poverty Level (FPL), and who do not have other creditable health coverage. PeachCare for Kids® health benefit coverage is provided to these children through a state child health insurance program that is administered by the DCH, the same agency that administers the Medicaid program.

PeachCare enrolls only eligible, targeted low-income children because marketing, outreach and eligibility determination efforts will be completely coordinated for PeachCare for Kids® and Medicaid, so that those children who are eligible for Medicaid will be enrolled in Medicaid rather than PeachCare. The marketing and outreach efforts target all children at or below 247% of the FPL. RSM outreach workers have available all pertinent information for both Medicaid and PeachCare for Kids ®. The outreach workers have a variety of program information on both creditable and non-creditable coverage and other ways to access health care services. The marketing and outreach efforts are coordinated with based organizations and health care providers.

In 2017, Georgia implemented an Integrated Eligibility System so that applying for PeachCare for Kids® is part of the overall Medical Assistance application process. When you apply for Medical Assistance, based on your household composition, income, and other circumstances, we will determine the most beneficial coverage for your child(ren). Children who fall under the Medicaid income limits will be put on the appropriate type of Medicaid. Children who fall within the PeachCare for Kids® income limits will be put on Peachcare for Kids®. No separate application is needed.

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.
The Division of Public Health, through its local health departments, and the federally qualified health centers administer the Special Nutritional Program for Women, Infants and Children (WIC). This program provides nutritious food to supplement the regular diet of pregnant women, breast- feeding women, infants, and children under age five who meet state income standards. Generally, on the initial visit to either of these facilities, the pregnant woman is certified for Presumptive Medicaid eligibility applies for regular Medicaid for herself and her children, and receives WIC for herself and any children under the age of five (5). The PeachCare for Kids® program also recognized the WIC program as an Express Lane agency.

Express Lane Eligibility was implemented effective April 1, 2011, and ended April 1, 2016

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, out stationed 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)

PeachCare for Kids® Outreach Through RSM Outreach

Outreach efforts are completely coordinated for PeachCare for Kids® and Medicaid, so that those children who are eligible for Medicaid will be reached and enrolled in Medicaid and those children eligible for PeachCare can be reached and enrolled in PeachCare. The outreach efforts target all children at or below 247% of the FPL. To build on and enhance our outreach efforts, Georgia utilizes our nationally recognized RSM outreach strategies for PeachCare for Kids®. With over 143 representatives statewide, RSM outreach workers have been specifically trained in doing outreach for PeachCare for Kids®. RSM outreach workers have available all pertinent information for both Medicaid and PeachCare for Kids®. The outreach workers also have a variety of program information on both creditable and non-creditable coverage and other ways to access health care services. The order of priority for the outreach workers are first to locate uninsured children, second to determine eligibility for Medicaid, third to provide information and assistance regarding

enrollment in PeachCare for Kids®, fourth to provide information on the Georgia Partnership for Caring Foundation and DHR public health care programs and services. The outreach efforts are also coordinated with community- based organizations, health care providers, GF CMO plans and the enrollment broker.

RSM Outreach Project

The Right From the Start Medicaid (RSM) Project began in July 1993 as Georgia's response to the high infant mortality rate and to improve health care access for all children and pregnant women.

The Department of Community Health (DCH) and the of Human Resources (DHR) entered into an agreement to place eligibility workers in community settings. The agreement provides for 143 eligibility workers. These currently have offices in departments, hospitals, clinics, day care centers, schools, community action agencies and other locations in the community. A major feature of the program is the availability of staff during non-traditional work hours so that clients may apply for RSM without having to lose time from their jobs or from school. Non-traditional hours are defined as any time other than 8 a.m. to 5 p.m. Monday through Friday.

Outreach staff are housed throughout Georgia and, although not housed in all 159 counties, provide Medicaid enrollment information and access to the Medicaid application process in every county. This involvement with potential Medicaid clients on a local level greatly enhances Georgia's outreach efforts. Outreach staff also actively pursue collaboration with other agencies and groups in their communities in order to maximize involvement at the local level and to educate other agencies in the basics of Medicaid eligibility and the availability of Medicaid services and to provide for mutual referral systems. Most of the local RSM project staff has partnerships with the county health departments, local schools, pregnancy centers, battered women's shelters, Head Start programs and the health care community in their areas.

Workers and supervisory staff make presentations regularly to community groups, medical providers and employers. RSM project staff often participate in health fairs and other local activities in order to reach potential Medicaid clients. Staff have utilized creative techniques for distributing information to the public. Medicaid flyers have been sent home with school age children and workers have visited day care centers to pass out brochures. Employer contacts have resulted in opportunities to distribute literature through personnel offices and at employee forums, and to accept applications at job sites.

Outreach Publications

PeachCare for Kids® published informational brochures in both English and Spanish to educate and encourage enrollment. The brochures give a brief description of benefits available through PeachCare and a summary of PeachCare eligibility requirements. The brochures are distributed at outreach activities throughout the state and are available at doctor's offices, DFCS, Department of Labor career centers, health departments, community centers, and daycare centers.

Back-to-School Outreach

To enhance back to school outreach activities, PeachCare for Kids® partners with the Georgia Department of Education to distribute a program flyer to every child in the public school system. Through this effort, nearly every parent of a school-age child in the state receives information about PeachCare for Kids®. To date, we distribute over 1.6 million brochures at the beginning of each school year.

Georgia Families

The Georgia Families Care Management Organizations (CMOs)

The CMO plans are permitted to perform the following marketing activities:

•Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);

•Make telephone calls, mailings and home visits only to Members currently enrolled in the Contractor's plan, for the sole purpose of educating them about services offered by or available through the Contractor;

•Distribute brochures and display posters at Provider offices and clinics that inform patients that the clinic or Provider is part of the CMO plan's Provider network, provided that all CMO plans in which the Provider participates have an equal opportunity to be represented; and

•Activities that benefit the entire community such as health fairs or other health education and promotion activities.

If the CMO performs an allowable activity, the CMO shall conduct these activities in the entire Service Region. The State must approve all CMO marketing materials prior to their use. All materials are in compliance with the information requirements in 42 CFR 438.10.

The GF Enrollment Broker (EB)

The GF EB conducts an outreach and educational campaign to promote community awareness of GF and inform Potential Members about the managed care benefits available, including preventive care and Health Check services. The EB ensures that outreach activities reach non- English-speaking populations, populations with hearing impairments, and populations with vision impairments.

Outreach Materials

The EB develops print ads, public service announcements, post card mailings and other outreach

materials targeted to GF eligible populations in each Service Region.

The outreach materials are designed to be understandable to GF eligible populations and written at a 5th grade reading level.

The outreach materials are also available in Spanish and as determined by DCH, other non-English prevalent languages spoken by five percent (5%) of the Medicaid population in a Service Region.

Collaboration with Others

The EB regularly collaborates with other State agencies and community- based advocacy and service groups that are involved in programs and activities targeted at GF eligible population.

Section 6. Coverage Requirements for Children's Health Insurance

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

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

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

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

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

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

6.1.4.3. ☐ Coverage that the State has extended to the entire Medicaid population

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

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

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)

6.2.1. ☒ Inpatient services (Section 2110(a)(1))
Inpatient services include medical and surgical services delivered during a hospital stay. Inpatient services are covered in full. See 6.2.10 for coverage for psychiatric hospital services. Prior approval is needed

for some services.

6.2.2. ☒ Outpatient services (Section 2110(a)(2))
Outpatient services include outpatient surgery, clinic services and emergency room care. Outpatient services are covered in full. Prior approval is needed for some services.

6.2.3. ☒ Physician services (Section 2110(a)(3))
Physician services include services provided by a participating physician for the diagnosis and treatment of an illness or an injury. Physician services are covered in full. Prior approval is needed for some services.

6.2.4. ☒ Surgical services (Section 2110(a)(4))
Surgical services are covered in full. See 6.2.1 for inpatient surgical services and 6.2.2 for outpatient surgical services. Prior approval is needed for certain procedures.

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

Rural Health Clinic Services (RHC) and Federally Qualified Health Center Services

Rural Health Clinic (RHC) Services are defined in section 1905(a)(2)(B) of the Social Security Act (the Act). Federally Qualified Health Center (FQHC) Services are defined in section 1905(a)(2)(C) of the Social Security Act (the Act). FQHC and RHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, clinical social workers and visiting nurses and other ambulatory services included in the state plan. RHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife, and, for visiting nurse care, and related medical supplies other than drugs and biologicals.

EPSDT limitations may be exceeded if medically necessary. Medical necessity must be properly documented.

Limitations

Services are subject to retrospective reduction or denial if adequate medical justification is not provided in medical records. Preventive health visits for individuals under the age of 21 must align with the EPSDT Program's requirements. Additional office visits must be based on medical necessity

that is properly documented.

Non-Covered Services

1. Ancillary services unrelated to the establishment of a diagnosis or treatment of the patient.
2. Routine physical examination or immunization unless in conjunction with the EPSDT Program.
3. Experimental services or procedures or those not recognized by the profession or the U.S. Public Health Service as universally accepted treatment.
4. Additional non-covered services are listed in the Part II, Policies and Procedures for Rural Health Clinic Services Manual.

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))
Prescribed drugs (from participating rebate manufacturers) and supplies approved by DMA and dispensed by an enrolled pharmacist are covered in full. Some drugs require prior approval or have therapy limitations. Prescriptions or refills are limited to six per month per enrollee. There are procedures in place that allow a member to receive medically necessary prescriptions in excess of six (6) per month

6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))
The following non-prescription drugs are covered up to a maximum allowable cost: Multi-vitamins and multiple vitamins with iron, enteric coated aspirin, diphenhydramine, insulin, NIX, iron, meclizine, insulin syringes, insulin delivery unit systems (NOVO pen for example) and urine test strips. No other over-the-counter medications are covered.

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))
Radiology services are covered in a hospital setting or in a physician's office only. Note: laboratory and radiological services are covered as two separate services.

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9)) These services are covered in full. This includes Childbirth Education Services, Lactation Consultants, a series of 8 classes regarding the birth experience and tools to prepare for a healthier pregnancy, birth and 12-month continuous postpartum period.
Full benefits are provided for a pregnant or postpartum individual under this option. This includes all items and services covered under the state plan that are not less in amount, duration, or scope than, or are determined by the Secretary to be substantially equivalent to, the medical assistance available for

an individual described in subsection 1902 (a)(10)(A)(i) of the Act.

6.2.10. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
Durable medical equipment and supplies prescribed by a physician are covered. Prior approval is required for custom molded shoes and for repairs to certain prosthetic devices. Hearing aids are allowed every three years without prior approval. Medical necessity for hearing aids must be approved by Children's Medical Services. This prior approval is based upon the completion of a hearing evaluation by the prescribing physician or other licensed practitioner. Medical equipment purchases and one-way mileage for delivery in excess of $200.00 require prior approval. See Vision Care under 6.2.28 for eyeglasses.

6.2.11. ☒ 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.

6.2.12. ☒ 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.

6.2.13. ☒ Nursing care services (Section 2110(a)(15))
Nursing care services are covered as follows. The Nurse Practitioner Services Program reimburses for a broad range of medical services provided by participating Pediatric, Family, Adult, and OB/GYN Nurse Practitioners, as well as Certified Registered Nurse Anesthetists (CRNA). Nurse Midwife services are also covered and include primary care services in addition to obstetrical care.

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

6.2.15. ☒ 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)

Dental and oral surgical services are covered as follows: 2 visits (initial or periodic) for dental exams/screens and 2 emergency exams during office hours and two emergency exams after office hours per calendar year are allowed; 2 cleanings per calendar year; 1 restorative (filling) procedure per tooth per restoration; the maximum number of surfaces covered is four (4); sealants for first and second permanent molars only; orthodontic services with prior approval.

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

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

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

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

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

Physical, occupational and speech pathology therapy are covered as follows: One hour per day, up to 10 hours per calendar month per physical therapy; one hour per day up to ten hours per calendar month per occupational therapy; one session per day up to ten sessions per calendar month per speech therapy.

With prior approval these limits may be exceed.

6.2.21. ☒ Hospice care (Section 2110(a)(23))
Covered under a plan of care when provided by an enrolled hospice provider

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

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

6.2.22.1 ☒ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

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.

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

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

6.2.25. ☒ Medical transportation (Section 2110(a)(26))
Emergency ambulance services are covered for an enrollee whose life and/or health are endangered. Non-emergency transportation is also covered.

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.

6.2.26. ☒ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

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

Health Check: Regular physical examinations (screening), health tests, immunizations, and treatment for diagnosed problems are covered. Screening requirements are based on the recommendations for preventive pediatric health care adopted by the American Academy of Pediatrics. Treatment is covered within the limitations on covered services.

Vision Care: Services including eyeglasses, refractions, dispensing fees, and other refractive services are covered. Medically necessary diagnostic services are also covered. Limitations are: 1 refractive exam, optical device, fitting, and dispensing fee within a calendar year; additional such services require prior approval. Prior approval is also required for other services including but not limited to: contact lenses, trifocal lenses, oversized frames, hi-index and polycarbonate lenses.

Children's Intervention Services: Services covered for children from birth through 18 years of age are audiology, nursing, nutrition, occupational

therapy, physical therapy, social work, speech- language pathology and developmental therapy instruction. Written prior approval is required for medically necessary Children's Intervention Services once the annual service limitations listed in the *Policy and Procedure Manual* have been reached. Individualized Family Service Plan is required to document medical necessity for amount, duration and scope of services. Note that children 18 years of age are not covered under these program services.

Family Planning: Covered services include initial and annual examinations, follow-up, brief and comprehensive visits, pregnancy testing, birth control supplies, and infertility assessment.

Pregnancy-Related Services: Covered services that help reduce infant mortality by providing home visits that assess the mother and child and teach the mother about specific subjects that will reduce infant mortality.

Podiatry: Services covered are diagnosis, medical, surgical, mechanical, manipulative and electrical treatment of ailments of the foot or leg as authorized within the Georgia statute governing podiatric services.

Physician's Assistant Services: Covered services are limited to primary care services and anesthesiologist's assistant services authorized in the basic primary care job description, approved by the Georgia Composite State Board of Medical Examiners.

End Stage Renal Disease (ESRD) Dialysis: Services and procedures designed to promote and maintain the functioning of the kidney and related organs are covered when provided by a provider enrolled in the ESRD program. Acute renal dialysis services are covered under other programs.

Effective March 11, 2021, and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan:

COVID-19 Vaccine:

☒ The state provides coverage of COVID-19 vaccines and their administration, in accordance with the requirements of section 2103(c)(11)(A) of the Act.

COVID-19 Testing:

☒ The state provides coverage of COVID-19 testing, in accordance with the

requirements of section 2103(c)(11)(B) of the Act.

[X] The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

[X] The state assures that coverage includes all types of FDA authorized COVID-19 tests.

COVID-19 Treatment:

[X] The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:

- [X] The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
- [X] The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and
- [X] The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

[X] The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without amount, duration, or scope limitations, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

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

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

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

covered CHIP populations:

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

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

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

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

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

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

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

The Georgia Division of Medical Assistance Plans Contract with each CMO requires that provider utilize the AAP 2019 Bright Futures "Recommendations for Pediatric Health Care" Periodicity Schedule as the periodicity schedule for EPSDT visits and services which reimburses pediatricians and pediatric extenders to provide developmental screenings, including behavioral health

screenings. The state provides guidance for providers to utilize the training resources/references that are recommended by the AAP/BF and the training resources are referenced in Georgia's EPSDT manual for pediatric providers. These trainings refer providers to validated screening and assessment tools required by the state. The plans are responsible for conducting provider education and training on screening and assessment tools which are required by the state, as well as disseminating information on the tools.

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

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH ☒ Psychosocial treatment

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.2- BH ☒ Tobacco cessation

Provided for: ☒ Substance Use Disorder

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH ☒ Medication Assisted Treatment

Provided for: ☒ Substance Use Disorder

6.3.2.3.1- BH ☒ Opioid Use Disorder

6.3.2.3.2- BH ☒ Alcohol Use Disorder

6.3.2.3.3- BH ☐ Other

6.3.2.4- BH ☒ Peer Support

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.5- BH ☒ Caregiver Support

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.6- BH ☒ Respite Care

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.7- BH ☒ Intensive in-home services

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.8- BH ☒ Intensive outpatient

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.9- BH ☒ Psychosocial rehabilitation

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH ☒ Day Treatment

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.3.1- BH ☒ Partial Hospitalization

Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH ☒ Residential Treatment

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.4.2- BH ☒ Detoxification

Provided for: ☒ Substance Use Disorder

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

6.3.5- BH ☒ Emergency services

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.5.1- BH ☒ Crisis Intervention and Stabilization

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.6- BH ☒ Continuing care services

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.7- BH ☒ Care Coordination

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.7.1- BH ☒ Intensive wraparound

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.7.2- BH ☒ Care transition services

Provided for ☒ Mental Health ☒ Substance Use Disorder

6.3.8- BH ☒ Case Management

Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.9- BH ☐ Other

Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.4- BH Assessment Tools

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

☒ ASAM Criteria (American Society Addiction Medicine)
☒ Mental Health ☒ Substance Use Disorders

☒ InterQual
☒ Mental Health ☒ Substance Use Disorders

☒ MCG Care Guidelines
☒ Mental Health ☒ Substance Use Disorders

☐ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☐ Mental Health ☐ Substance Use Disorders

☒ CASII (Child and Adolescent Service Intensity Instrument)
☒ Mental Health ☒ Substance Use Disorders

☒ CANS (Child and Adolescent Needs and Strengths)
☒ Mental Health ☒ Substance Use Disorders

☐ State-specific criteria: Substance Use Disorder Screenings listed below
☐ Mental Health ☐ Substance Use Disorders

☐ Plan-specific criteria: Mental Health Screenings listed below (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Other (please describe)

☐ Mental Health ☐ Substance Use Disorders

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

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

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

All Providers are responsible for completing all assessments as recommended by the AAP/Bright Futures and USPSTF guidance as well as documenting their findings, and if indicated, document any follow-up assessment, therapeutic intervention used, referrals made, and treatments received. Providers are contractually required to cooperate with QI activities, including, but not limited to, investigation of Potential Quality of Care issues, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) audits. Georgia's Division of Case Management and Quality Improvement tracks the use of screening and assessment tools as well as outcomes.

With regard to specific behavioral health assessments, both DCH and the MCO Plans partner with Georgia's mental health authority, the Department of Behavioral Health and Developmental Disabilities (DBHDD). Coordination includes use of the training materials offered through the partnership and reliance on a shared primary workforce to deliver children's behavioral health services since most behavioral health providers work both in the fee-for-service Medicaid sector, which is operationally managed by DBHDD, and the managed care sector. DCH holds an administrative contract with DBHDD to operationalize behavioral health services through the shared provider network, which includes provider training opportunities. These trainings refer providers to validated screening and assessment tools required by the state. Similarly, both Fee-for-Service Medicaid and the MCO Plans delivering services in CHIP authorize ongoing behavioral health services using assessment information offered by enrolled behavioral health providers via state required validated tools such as those noted above.

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

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

The CMO (MCO) contracts under which PeachCare for Kids® members receive behavioral health services include the following requirements and provide a clear mechanism for member information access including how to submit complaints should the Managed Care Plan fall short in meeting member needs in this or any other area:

a. Each Contractor shall produce and make available all marketing materials in English and all prevalent, non-English languages spoken within the State of Georgia.

b. Plan for interpretive services and written materials, to meet the needs of Members whose primary language is not English, using qualified medical interpreters (both sign and spoken languages), and make available easily understood Member oriented materials, including the posting of signage in the languages of the commonly encountered group and/or groups represented in the service area;

c. The translator must be fluent in both the original source language and the target language and must translate the language to make it understandable. Translation Services may also include the use of computer tools or technology.

d. Each Contractor shall notify its Members of the availability of oral interpretation services and to inform them of how to access oral interpretation services. There shall be no charge to the Member for interpretation services.

e. Each Contractor shall have a comprehensive written Cultural Competency Plan describing how the Contractor will ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency, hearing impairment, a speech or language disorder, physical disabilities, developmental disabilities, differential abilities, or diverse cultural and ethnic backgrounds. The Cultural Competency Plan must describe how the Providers, individuals and systems within the CMO will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual Members and protects and preserves the dignity of each.

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

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

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

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

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

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

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

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

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

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

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

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

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

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

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice (§457.496(f)(1)(i)).

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for the different benefit types, please specify the benefit type(s) to which

each standard is applied. If "Other" is selected, please provide a description of that standard.

☒ International Classification of Disease (ICD)

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines

☐ Other (Describe:)

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

☒ Yes

☐ No

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

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

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

☒ Yes

☐ No

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

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of §457.496(b) related to deemed compliance.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☒ All children covered under the State child health plan

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

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

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

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (§457.496(b)(2)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

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

☒ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan (Section 1905(r)).

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

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

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

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

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

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

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

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

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

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

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

6.2.3.1.1 MHPAEA The state assures that:

☐ The State has classified all benefits covered under the State plan into one of the four classifications.

☐ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the state use sub-classifications to distinguish between office visits and other outpatient services?

☐ Yes

☐ No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

☐ The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to "classification(s)" includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

☐ Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits. However if a state does provide any mental health or substance use disorders, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan.

Annual and Aggregate Lifetime Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan (§457.496(c)).

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☐ No dollar limit is applied

Guidance: If there are no aggregate lifetime or annual dollar limit on any mental health or substance use disorder benefits, please go to section 6.2.5-MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☐ Yes (Type(s) of limit:)

☐ No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits (§457.496(c)(1)).

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (457.496(c)).
The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits (457.496(c)(3)).

☐ The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable, as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (§457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least1/3 and less than 2/3 of all

medical/surgical benefits, the State assures the following (§§457.496(c)(4)(i)(B); 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with §§457.496(c)(4)(i)(B) and 457.496(c)(4)(ii). Please include the state's methodology as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (§457.496(c)(2)(i); (§457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes (Specify:) ☐ No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply financial requirements to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

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

☐ Yes

☐ No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (§457.496(d)(3)(i)(C))

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (§457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology as an attachment to the State child health plan.

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

☐ Yes

☐ No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose that type of QTL on mental health or substance use disorder benefits in

that classification. (§457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in §§457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in §457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (§457.496(d)(3)(i)(E))

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§457.496(d)(2)(i))

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

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements (§§457.496(d)(4); 457.496(d)(5)).

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☐ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits, provider reimbursement rates and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in §457.496(d)(4)(ii).

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the state or MCE contracting with the State provide coverage of services provided by out of network providers?

☐ Yes

☐ No

6.2.6.2.2- MHPAEA If yes, please assure the following:

☐ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

☐ State

☐ Managed Care entities

☐ Both

☐ Other

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

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

☐ State

☐ Managed Care entities

☐ Both

☐ Other

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

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

6.5-Vaccine coverages

Guidance: States are required to provide coverage for age-appropriate vaccines and their administration, without cost sharing. States that elect to cover children under the State plan (indicated in Section 4.1) should check should also check box 6.5.2. States that elect to cover the from-conception-to-end-of-pregnancy population (previously referred to as the "unborn") under the State plan should also check box 6.5.3.

6.5.1- Vaccine coverage for targeted low-income children.
☒The State provides coverage for age-appropriate vaccines and their administration in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), without cost sharing. (Section 2103(c)(1)(D)) (42CFR 457.410(b)(2) and 457.520(b)(4)).

6.5.2- Vaccine coverage for targeted-low-income pregnant individual.
☐The State provides coverage for approved adult vaccines recommended by the ACIP, and their administration, without cost sharing. (SHO # 23-003, issued June 27, 2023); (Section 2103(c)(12))

6.5.3-Vaccine coverage for from-conception-to-end-of-pregnancy population option. ☐The State provides coverage for age appropriate (child or adult) vaccines and their administration in accordance with the recommendations of the ACIP, without cost- sharing, to benefit the unborn child.

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-childcare, 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) ☒ Other: HEDIS measures that are not on the Core Set

7.1.3. ☒ Information strategies

7.1.4. ☒ Quality improvement strategies

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-childcare, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))
To encourage utilization of primary and preventive care, PeachCare for Kids® does not have any co-payments for services for children under the age of 6 years old. Additionally, premiums are not required for children under the age of six, ensuring that all children up to the age of six in households with incomes up to 247% of the federal poverty level have access to care without any cost to the family.

PeachCare for Kids® sends each child a birthday postcard each year that wishes them a healthy year and reminds their parents of the well-childcare available through PeachCare.

PeachCare for Kids® monitors the members' appropriate Early Periodic Screening, Diagnostic and Testing (EPSDT) utilization. Each CMO must provide quarterly reports to DCH documenting the number of initial newborn visits, the number of members who received all scheduled EPSDT services on the periodicity schedule, the number of members who received any dental services, number of members that received an initial health visit and screening within 90 days of enrollment, the number of diagnostic and treatment services, including referrals, and the number and rate of lead screening for children.

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))
All members are enrolled in Georgia Families (GF), a managed care program. GF PCPs are required to have care accessible to their members 24 hours a day.

Members are informed in member handbooks mailed to each family upon enrollment, "If your child is in an emergency situation, call 911 or go immediately to the nearest hospital emergency room. You do not need prior approval from your child's doctor if your child has a serious or disabling illness or injury. Be sure to call your doctor if your child has a serious or disabling illness or injury. Be sure to call your doctor as soon as you can after your child has received care."

The Georgia Health Policy Center (GHPC), Georgia State University, has done an annual evaluation of the claims submitted for services received by PeachCare for Kids® members. The results of the survey are shared with DCH staff and analyzed to monitor access, utilization and trends in utilization as the program matures. The GHPC has also conducted the Consumer Assessment of Health Plan Satisfaction (CAHPS) survey on behalf of PeachCare for Kids®. This survey assesses the parents' perceptions about the availability and quality of care their children have received.

Additionally, each CMO is required to provide quarterly timely access reports that

monitor the time lapsed between a Member's initial request for an office appointment and the date of the appointment. The CMOs are also required to submit a Provider Network Adequacy and Capacity Report that demonstrates that the Contractor offers an appropriate range of preventive, Primary Care and specialty services that is adequate for the anticipated number of enrollees for the service are and that its network of providers is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. Additionally, on an ad hoc basis DCH can request of each CMO a report of the availability of certain services and the coverage and authorization of services.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))
The Georgia Health Policy Center (GHPC), Georgia State University, has done an annual evaluation of the claims submitted for services received by PeachCare for Kids® members. The results of the survey are shared with DCH staff and analyzed to monitor access, utilization, and trends in utilization as the program matures. The GHPC also conducts the Consumer Assessment of Health Plan Satisfaction (CAHPS) survey on behalf of PeachCare for Kids®. This survey assesses the parents' perceptions about the availability and quality of care their children have received, including access to specialist care. Through these evaluations, PeachCare monitors access to specialist care for all members, including those with special or chronic conditions.

All children enrolled in PeachCare for Kids® are assigned a CMO and primary care provider (PCP) through GF. The PCP's role is to assess, treat, and coordinate specialty care for the PeachCare members under their care.

PeachCare for Kids® members who are identified as in need of special health care services by receiving care through CMS or Georgia Pediatric Program (GAPP) are excluded from GF and covered under PeachCare for Kids® on a fee for service basis.

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.

As mentioned earlier, each CMO has written Utilization Management Policies and Procedures that have been reviewed and approved by DCH. Also, on a monthly basis CMO will provide to DCH a report of the availability of certain services and the

coverage and authorization of services.

The CMO must submit Prior Authorization and Pre-Certification Reports that summarize all requests in the preceding month for Prior Authorization and Pre-Certification. The Report includes, at a minimum, the following information:

- Total number of requests for Prior Authorization and Pre-Certification requested by type of service;
- Total number of requests for Prior Authorization and Pre-Certification processed within fourteen (14) Calendar Days for standard Service Authorizations;
- Total number of requests for extension of the fourteen (14) Calendar Days for standard Service Authorizations;
- Total number of requests for Prior Authorization and Pre-Certification processed within twenty-four (24) hours for expedited Service Authorizations;
- Total number of requests for the extension of the twenty-four (24) hours for expedited Service Authorizations;
- Total number of requests for authorization processed within thirty (30) Calendar Days for determination for services that have been delivered;
- Total number of requests approved by type of service; and
- Total number of requests denied by type of service.

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
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))

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:
Premiums are not required for children ages 0-5 years old. American Indians/Alaska natives and children in Foster Care are also exempt from paying a premium. For children ages 6-18, the premiums are detailed in the table below:

FPL	One Child	Family Cap
139%-158%	11.00	$16.00
159%-170%	22.00	$44.00
171%-190%	24.00	$49.00
191%-210%	29.00	$58.00
211%-231%	32.00	$64.00
232%-247%	36.00	$72.00

The State assures that continuous eligibility is provided through an individual's 12-month Post-Partum period regardless of non-payment of premiums, or an individual becoming eligible for Medicaid.

At State discretion, premiums may be waived for CHIP applicants and/or beneficiaries who meet income and other eligibility requirements and who reside and/or work in State or Federally declared disaster areas for a specified period of time.

Through Georgia's DRAL dated May 10, 2023, the state waived premiums for all CHIP enrollees through December 31, 2023. The state will continue waiving premiums through 9/30/2024.

8.2.2. ☐ Deductibles:

8.2.3. ☒ Coinsurance or copayments:

Copayments are not required for children ages 0-5 years old. American Indians/Alaska natives and children in Foster Care are also exempt from paying copayments. For children ages 6-18, the copayments are detailed in the table below:

Category of Service	Co-Payment
Ambulatory Surgical Centers / Birthing	$3.00
Durable Medical Equipment	$1.00 and $3.00
Federally Qualified Health Centers	$2.00
Free Standing Rural Health Clinic	$2.00
Home Health Services	$3.00
Hospital-based Rural Health Center	$2.00
Inpatient Hospital Services	$12.50
Oral Maxillofacial Surgery	Cost-Based
Orthotics and Prosthetics	$3.00
Outpatient Hospital Services	$3.00
Pharmacy - Preferred Drugs	$0.50
Pharmacy - Non-Preferred Drugs	Cost-Based
Physician Assistant Services	Cost-Based
Physician Services	Cost-Based
Podiatry	Cost-Based
Vision Care	Cost-Based

Cost-Based Co-Payment Schedule	
Cost of Service	
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

The State assures that continuous eligibility is provided through an individual's 12-month post-partum period regardless of non-payment of premiums, or an individual becoming eligible for Medicaid.

At State discretion, cost sharing may be temporarily waived for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or Federally declared disaster area.

Effective March 11, 2021, and through the last day of the first calendar quarter that begins one

year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan, the state elects to waive all cost sharing for all CHIP benefits.

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))

PeachCare for Kids® publicizes the cost sharing requirements in its brochures, applications, website, mass media campaigns and other outreach materials. If a parent applies for a child/ren and the child/ren is determined eligible, if applicable, a letter is sent indicating that a payment must be received for the child/ren to be enrolled in the program. The letter includes the specific amount due, depending on the number of children over 6 in the household, and the due date for premium payments for enrollment to be initiated and maintained monthly. Once eligibility is determined, and the child/ren are enrolled, Georgia Families provides an information packet that includes copayment amounts, if applicable.

The Board of Community Health, a nine-person board appointed by the Governor, governs the Department of Community Health. The board meets regularly on a monthly basis and is open to the public. Any proposed changes to premiums or copayments must be approved by the Board. Public notice will also be issued and posted at all Department of Family and Children Services and Right from the start Medicaid Offices statewide. The notice will also be sent to regional newspapers and

posted on the Department of Community Health and PeachCare for Kids® websites.

A banner message would be sent to PeachCare for Kids® providers statewide to inform them of any changes in premium amounts and/or copayment amounts.

The PeachCare for Kids® Third Party Administrator would issue notices to all currently enrolled families to notify them of any changes in the premium or copayment amounts.

PeachCare for Kids® will emphasize cost-sharing rules and regulations in its provider education and communications. Out of pocket expenses that exceed the 5% cap will be reimbursed to the family after review of all cost sharing documentation for the family. At the end of the first 12 months of eligibility, eligibility will be re-determined. The 5% cap will be recalculated for the family and the monitoring cycle will start over again. At the point of application approval and review, families will be informed, by mail, of the 5% cost sharing maximum.

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

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

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

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

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

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

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

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

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

☐ Yes (Specify:)

☒ No

Guidance: If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

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

☐ Yes

☒ No

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

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

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

Guidance: Please include the state's methodology as an attachment to the State child health plan.

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

☐ Yes

☐ No

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

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in §457.496(d)(3)(i)(B)(1)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

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

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

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

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

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

limit. The MMIS and the Care Management Organization (CMO) will track all cost-sharing. When a family reaches 4.5% of their income for the eligibility period, the system will send the family a notice that no further cost-sharing is required for the remainder of the eligibility period. Each year consists of 12 months beginning with the approval month or the month of eligibility redetermination.

If out of pocket expenses still somehow manage to exceed 5% of the cap, the coverage will be reimbursed to the family. Families are notified of the premiums and co-pays when their applications are initially approved and when changes are reported that result in premium changes. Information about premiums and co-pays, including the 5% cap, is posted on the PeachCare for Kids® website, the Department of Community Health web-site and the Care Management Organization websites.

Families are not required to keep track of their expenses since they are tracked electronically by the agency, but if at any point, the family believes that their out of pocket expenses have exceeded 5% for the year, they may contact PeachCare for Kids® to request a review of their expenses.

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):

PeachCare for Kids® notifies enrolled American Indian and Alaska Native families of the cost sharing exclusion by letter. The letter instructs families to mail their official tribal documentation to PeachCare for review. Once the documentation is reviewed, a letter is sent to families to confirm receipt. This letter also notifies the families that they are no longer required to pay a monthly premium or make co- pays. If official tribal documentation is not submitted, families must continue to make premium payments and co-pays.

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)):

Applicants will be given forty-five (45) days from the date the application is processed to make their initial premium payment. When the initial premium payment is received, the applicant will be enrolled in PeachCare for Kids®, and eligibility will be effective the first day of the month in which the application was submitted. There will be one late notice sent to the applicant if their initial premium payment has not been received within thirty (30) days of initial authorization of the application. The notice will notify the member that their case will be denied if their premium payment is not received by the 45*th* day. The denial letter will be sent with timely notice which includes an explanation of the applicants Fair Hearing Rights. If the initial premium payment is not received the case will be denied.

Late notices will not be sent after the initial premium payment is received. Enrollees do

not lose coverage for non-payment of premiums after the initial premium payment is received for each new enrollment period, which includes the initial eligibility determination at application and annual renewals.
PCK members submitting renewal and documentation timely will be given 30 days from the date the renewal is processed to make their initial premium payment for the new period of eligibility. When the initial premium payment is received, eligibility will be effective the first day of the month following the renewal month. There will be one late notice sent to the member if their initial premium payment has not been received within 15 days of the authorization at renewal. The notice will notify the member that their case will be closed if their premium payment is not received by the 30*th* day. The notice will be sent with timely notice which includes an explanation of the applicants Fair Hearing Rights. Families who are closed due to non-payment of premium are notified and informed of their right to a review of the termination.
Applicants that do not return their renewal timely will be terminated and provided a Ninety (90) day reconsideration period to submit their renewal. A new application is not required during this 90-day reconsideration period. PCK members submitting renewal and documents during the reconsideration period will be given 30 days from the date the renewal is processed to make their initial premium payment for the new period of eligibility. The period of eligibility will begin on the first day of the month after the termination date once premium payment is received. If premium payment is not received the case remains terminated.

There is no lock out period for non-payment of premiums.

Exception to Disenrollment for Failure to Pay Premiums
At State discretion, premiums will be waived, and CHIP coverage will be available regardless of whether the family has paid their outstanding premium for existing beneficiaries and new applicants who reside and/or work in a State or Federally declared disaster area.

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

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

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

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

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

The five strategic objectives of PeachCare for Kids® are to:

1. Increase insurance coverage among Georgia's low-income children
2. Increase the percentage of low-income children with timely access to a regular source of care.
3. Promote utilization of preventative care including Health Check (EPSDT) services.
4. Increase access to Behavioral Health Services.
5. Improve patient satisfaction with 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))

Objective 1: Increase insurance coverage of Georgia's low-income children.

Performance goals:
1.1 Increase enrollment of uninsured PeachCare for Kids® eligible children with family income at or 247% of the federal poverty level by 0.5% annually until the state achieves 90% of all eligible children in our CHIP program.

Objective 2: Increase the percentage of low-income children with timely access to a regular source of care.

Performance goals:
2.1 Maximize the number of PeachCare for Kids® members who report timely access to needed care to achieve and maintain 90% by increasing the percentage of children surveyed by 0.25% annually.

2.2 Increase the number of PeachCare for Kids® members who have primary care doctors to 90% by increasing the percentage by 0.25% annually.

Objective 3: Promote utilization of preventative care including Health Check (EPSDT) services.

Performance goals:
3.1 Increase the number of PeachCare for Kids® children and adolescents by 0.5% annually until we reach 80% of enrollees receiving recommended well visits that include Health Check (EPSDT) services.

3.2 Increase the number of PeachCare for Kids® children and adolescents receiving age-appropriate immunizations by 0.5% until 90% is achieved and maintained annually.

3.3 Increase the percentage of PeachCare for Kids® eligible young women who are identified as sexually active are receiving at least one Chlamydia screening by 0.5% annually until a target goal of to 80% is achieved and maintained.

3.4 Increase the number of children enrolled in PeachCare for Kids® ages 5-18 who adhere to having their asthma medication managed through appropriate care by 0.5% annually to achieve and maintain 90%.

3.5 Reduce the number of PeachCare for Kids® preventable hospitalizations by 0.05% annually until to 25% is reached and maintained.

3.6 Reduce the number of PeachCare for Kids® Emergency Room visits by 0.05% annually until 25% is reached and maintained.

Objective 4: Increase access to behavioral health services.

Performance goals:
4.1 Increase the number PeachCare for Kids® enrollees screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the first three years of life by 0.5% annually to achieve and maintain 80%.

4.2 Increase the number of PeachCare for Kids® enrollees receiving recommended screening for depression with an appropriate follow-up plan by 5% annually to achieve and maintain 80%.

4.3 Increase by 0.5% annually the number of PeachCare for Kids® enrollees newly prescribed ADHD medication who had at least 3 follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD Medication was dispensed until 80% is achieved and maintained.

4.4 Increase by 0.5% annually the number of PeachCare for Kids® enrollees ages 1-17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as a first line treatment until 80% is achieved and maintained.

Objective 5: Improve patient satisfaction with care.

Performance goals:

5.1 Increase the number of PeachCare for Kids enrolled children who rated their personal doctors with a score of 8, 9, or 10 by 0.25% with a target goal of 95% annually.

5.2 Increase the number of children enrolled in PeachCare for Kids who rated their health plans with a score of 8, 9, or 10 by 0.25% to a target goal of 95% is achieved and maintained annually.

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))

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.
Child Core Set and CAHPS Assessment

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

9.3.7.1. ☒ Immunizations

9.3.7.2. ☒ Well childcare

9.3.7.3. ☒ Adolescent well visits

9.3.7.4. ☒ Satisfaction with care

9.3.7.5. ☒ Mental health

9.3.7.6. ☒ Dental care

9.3.7.7. ☒ Other, list: Ambulatory Care, ED visits, Access to Primary Care Practitioners, and low birth weights

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)

Georgia's performance goals are measured utilizing several data sources which includes, Enrollment and Uninsured Data, Eligibility Data, Annual CAHPS Report, claims data. As part of our monitoring and oversight efforts, Georgia requires CMO's to provide data and conduct comprehensive reviews of EPSDT, network access, utilization management, prior authorizations, and timely access to services. These activities include:

- An examination of claims data to interpret utilization trends and patterns.
- Analysis of Prior Authorization approvals and denials, as well as turnaround times
- Validation of provider network access reports. This includes a review of network deficiency reports and provider directory listings.
- Evaluation of trends in access to care; and
- Utilization of secret shopper calls to validate appointment wait times, and timely access to services

In addition to the activities above, the DCH assesses performance outcomes for the PeachCare population using select HEDIS and Child Core Set measures.

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)

PeachCare for Kids® will comply with the annual assessment by submitting a report, utilizing the Framework for Annual Evaluation developed by the National Academy for State Health Policy in conjunction with state SCHIP staff and CMS. This report will be completed by PeachCare staff. Independent evaluators will be responsible for measuring PeachCare for Kids® progress in meeting the performance measures defined in Section 9 "Strategic Objectives and Performance Goals and Administration" and for nationally mandated measures as they become available.

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))

Initial Public Involvement

In 1996, the Georgia Coalition for Health was asked by the Governor to examine approaches for reforming Medicaid in Georgia. The Coalition sponsored extensive research on the views of the stakeholders in the state's Medicaid system – healthcare providers, Medicaid members and Georgia citizens. Three separate but complementary processes—focus groups, community forums and community dialogues—offered the opportunity for about 6,000 Georgians to express their views.

This unique process of obtaining stakeholder input served as a foundation for convening people with varied perspectives and expectations, raising awareness about those perspectives, identifying areas of agreement and disagreement, and working together to find solutions to difficult problems.

Georgia H e a l t h Decisions was commissioned by the Coalition to conduct research to learn what changes citizens would support in the state's Medicaid program. Citizen input was gathered through focus groups in all areas of the state, with almost 500 people participating. Focus group participants were randomly chosen to represent all socio-economic segments of Georgia's population. Eleven focus groups were composed of Medicaid members, and six others were made up of healthcare providers. Further, Georgia Health Decisions conducted 200 open community forums throughout the state in which 5,000
Georgians had the opportunity to express their concerns about Medicaid reform.

In addition, the Georgia Health Policy Center engaged 14 communities across Georgia in Medicaid community dialogues. The objectives of the dialogues were to ensure a process for obtaining input from Medicaid consumers and health care providers around the state; to clarify an understanding

of the issues related to Medicaid reform and the ramifications of those issues; and, to identify examples of system disincentives that could be corrected by changes in policy.

The consumers and advocates participating in the dialogues were identified by a coalition of consumers and advocates incorporated under the name Healthcare for a Lifetime. This group represents the four primary populations that receive Medicaid: low-income Mothers and children, older people, people with physical disabilities, and people with mental retardation, mental illness, or those with substance abuse problems. The providers were selected by the Healthcare Providers Council and included representation from hospitals, physicians, nursing, dentistry, nursing homes, home health, pharmacy, public health, community health and others. County Commissioners as well as members of the legislature were also invited to attend. Overall, 443 consumers and advocates and 234 providers participated for a total of 677 statewide participants. The meetings were open to the public and at every Dialogue there were observers who did not participate in the discussions yet had the advantage of moving among groups and hearing all four conversations.

These statewide, public conversations on Medicaid contributed to dispelling barriers between consumers and providers; the process also indicated where consumers, advocates and providers stand on major issues and where they are willing to negotiate. The main themes identified through the process are summarized below. These themes served as a reference and defining force for developing general Medicaid reform recommendations and many are reflected in Georgia's proposal for implementing the Title XXI program.

Citizens

The citizens, both Medicaid members and members of the general public, expressed a wide variety of views, but agreed on a few basic themes.

- Vulnerable people should be protected. Citizens generally believe in the concept of a health care safety net and are willing to pay taxes to provide health care to people who need help.

- Only truly needy individuals should qualify for Medicaid. Citizens want to make sure that eligibility is strictly defined and enforced to stop abuse.

- Nothing should be free. Citizens want all adult Medicaid members to make some financial contribution toward their care, generally favoring a sliding scale based on income. They believe welfare recipients should work. They also want to make sure that families contribute to the cost of caring for disabled children and, perhaps, elderly parents.

- Health care should be accessible to all Georgians. Citizens worry about rising health care costs and their own ability to get affordable coverage, even if they now have health benefits, they worry about losing them. People are also concerned about the uninsured and would like to broaden Medicaid reform to also offer affordable coverage for this group.

Medicaid Members

In the community dialogues, Medicaid members generally shared the opinions of the general population, as described above, but also expressed some specific concerns.

- Medicaid costs should not be cut by reducing eligibility, since not enough truly needy people are covered today.
- There should be no stigma attached to receiving Medicaid, and any managed care plans used in the program should serve both Medicaid members and non-Medicaid patients.
- Prevention and education should be integral components of any benefits package.

Providers

In addition to participating in the focus groups and community dialogues, many health care providers were interviewed for a separate study as part of a detailed analysis of the current health care delivery system in Georgia. Key findings from that research are summarized below:

- The delivery system is in rapid transition. Organized health plans are widespread in the state, displacing traditional fee-for-service reimbursement plans. Hospitals and other providers are restructuring, merging and forming networks to compete with insurer-sponsored managed care organizations.

- A quick-budget-fix approach to Medicaid reform could harm public health and actually raise costs in the long run. Providers would support a serious, well- reasoned reform effort, developed through a fair process that listens to providers' concerns, and includes realistic transition periods.

- Any reform plan should include performance standards, outcome measures, accountability, competition, and choice (for both members and providers). Providers should be able to at least break even financially if they participate in Medicaid, and a small profit would be appropriate as recompense for taking risk.

- Providers who have traditionally served the Medicaid population with demonstrated quality should be included in a managed care or any other delivery system.

  About six months after this public input process was completed, the Georgia Coalition for Health Board, concerned about the effects of Medicaid reform on uninsured children, asked the Health Policy Center to study mechanisms for providing coverage to this target population. In response to this charge, the Policy Center applied for (and was subsequently awarded) a Robert Wood Johnson Foundation grant to replicate the Florida Healthy Kids program. The Coalition also allocated funding to the Center to conduct preliminary planning activities so that Georgia could position itself for implementing the Healthy Kids program as well as the impending federal children's health insurance legislation.

From May through December 1997, the Center established several advisory committees with representation from key agencies and organizations around the state. (It should also be noted that, according to the reviewers from the Robert Wood Johnson Foundation, one of the most impressive components of the initial grant and the subsequent planning efforts was the inclusive process for obtaining input from affected stakeholders into the design of the program.) The committee structure included a primary broad-based Children's Health Insurance Advisory Committee and four subcommittees, each governed by specific charges that addressed the major programmatic issues of benefits package, eligibility criteria, program design, and local collaboration. There were a total of 40 individuals on the full advisory committee and four subcommittees, however, these meetings were open to and attended by several additional visitors and observers. There were about 25 meetings of the full advisory group and the subcommittees between April and December. Membership on these groups was comprised of representatives from the following agencies and organizations:

- Association of County Commissioners of Georgia
- Augusta/Richmond County Community Partnership
- Caring Program for Children
- Chatham-Savannah Youth Futures Authority
- Child Psychologist
- Children's Hospitals (Egleston, Hughes-Spalding, Scottish Rite)
- Council on Maternal and Infant Health
- Department of Education
- Department of Medical Assistance (Division of Maternal and Child Health, Eligibility and Quality Control, and Strategic Planning)
- Division of Family and Children Services
- Division of Mental Health/Mental Retardation/Substance Abuse
- Division of Public Health (Division Director, Child and Adolescent Health Unit, Gwinnett County Health District, DeKalb County Board of Health)
- Georgia Academy of Family Physicians
- Georgia Association for Primary Health Care
- Georgia Chapter/American Academy of Pediatrics
- Georgia Dental Association

- Georgia Partnership for Caring
- Georgia Policy Council for Children and Families
- Georgians for Children
- Governor's Office of Planning and Budget
- Healthy Mothers, Healthy Babies Coalition of Georgia
- March of Dimes
- Office of the Commissioner of Insurance
- Tanner Medical Center
- The Family Connection
- United Healthcare
- Wachovia Bank of Georgia Compensation and Benefits Branch
- West Georgia Medical Center

In addition, separate group meetings were held with child advocates, health plan representatives, and public health district officers to explain the program and obtain input about specific components of the program design for CHIP. During December, January, February and March, several legislative hearings were held in both the Senate and House of Representatives. The hearings focused on the Governor's proposal for implementing Title XXI in Georgia. At these hearings, child advocates, state agencies, pediatricians and other health care providers provided testimony.

Public Notice

At the regular meeting of the Board of Medical Assistance on April 8, 1998, DMA staff provided a public briefing for the Board on the status of the Georgia CHIP planning process. Again, at the regular meeting of the Board on May 13, 1998, the DMA presented detailed information to the Board and the public about the proposed Georgia CHIP, and gave opportunity for public comment. The May meeting had been extensively publicized with a notice mailed to a large mailing list of stakeholders in Medicaid and CHIP, in addition to regularly published meeting notices.

Ongoing Public Involvement

The House Appropriations Committee created the Medical Assistance Study Committee in June 1997. It was charged with conducting a comprehensive study of the Medicaid system in Georgia. The rationale was for a core group of people on the Appropriations Committee to learn as much as possible about the complexities of the budget item known as Medicaid.

Identifying problems and finding opportunities in Georgia's Medicaid system were main challenges of the committee. To meet these, a series of hearings were conducted around the state, sixteen (16) in all. They began in the summer and ended in the fall of 1997. Georgia is comprised of one hundred fifty-nine counties, urban and rural. Input was gathered from big metropolitan areas, such as Atlanta and Savannah, and small rural areas, such as Greensboro and Moultrie, to name a few. Providers and their respective associations, professional health care associations, community groups, patient advocates, Medicaid recipients, and interested citizens were invited to share their concerns with the committee.

Through the hearings, the Committee identified significant findings in fifteen different areas ranging from reimbursement to providers to health care for those with disabilities. Along with the findings, recommendations were made to DMA. A copy of the Committee's report is on file with DMA. Members of the Committee took lead roles in drafting the Georgia CHIP legislation. The Medical Assistance Study Committee has since become a standing committee of the House Appropriations Committee, which is now known as the DCH Subcommittee of the House Appropriations Committee.

The Department of Community Health is governed by a nine-person board appointed by the Governor. The Board has an active role in developing and approving DCH's proposed budget, setting priorities for the Department and working with DCH to affect policy and process to improve the health care delivered to its membership. During the budget development process, DCH holds public forums throughout the state for public input. The DCH has additional advisory committees. The Physician Advisory Committee provides a forum for health care providers and advocates to improve the health care delivery to Medicaid and PeachCare for Kids® members.

Georgia Families

In February 2003, the State issued a request for information seeking

comprehensive proposals to redesign the Medicaid program to improve quality and provider accountability while achieving budget predictability and cost containment. Over 42 responses were received. For the next several months, meetings were held with providers, consumer groups, insurance representatives and other stakeholders to design a new program.

In October 2003, a diverse team of stakeholders, including senior executives from healthcare provider organizations and advocacy groups, assembled for several days to discuss state strategies to promote quality healthcare, enhanced access, shared member and provider responsibility, improved efficiency, and better cost management.

In August 2004, the State announced that it would implement a mandatory managed care program using Care Management Organizations. From September 2004 through October 2004, the State held stakeholder sessions with physician and hospital providers, senior associations, children and family coalitions, and others to ensure participation and input from all groups affected by the new mandatory managed care program.

Upon implementation of the program, the State will continue to utilize providers from the various medical advisory committees, recipients involved in NET advisory committees, staff liaisons to advocacy groups that include both providers and recipients, and member satisfaction survey.

Express Lane Eligibility effective April 1, 2011-

The Georgia Department of Community Health evaluated the feasibility of the options designed to facilitate enrollment and retention in the Medicaid and PeachCare for Kids® program and to receive bonus payments as outlined in the Children's Health Insurance Program Reauthorization Act of 2009, section 203. Express Lane Eligibility was chosen as one of Georgia's 5 of 8 efforts to enroll more eligible children in Medicaid and PeachCare for Kids® programs.

On December 6, 2010 Medicaid and CHIP (PeachCare for Kids®) representatives met with the Public Health agency to discuss requirements for Express Lane Eligibility and to develop a plan for data file exchanges. A meeting was also scheduled with the TPA (Policy Studies, Inc.) for PeachCare for Kids® on January 12, 2010 & February 4, 2011. Additional meetings were held with these groups to discuss the implementation.

WIC applicants will be informed that with their permission, their demographic and income information will be forwarded to the PeachCare for Kids®/Medicaid agency for an eligibility determination.

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))

There are no nationally recognized American Indian tribes or organizations in the state of Georgia. Recognizing that a member of a tribe may re-locate to the State, CHIP will exempt children who are members of federally recognized tribes from the cost-sharing requirements as stipulated in Section 2103(e)(1)(A). PeachCare for Kids®, however, does not charge cost-sharing to enrolled members who are members of federally-recognized American Indian or Alaskan Native tribes.

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).

On February 8, DCH announced that it would quit enrolling new members in PeachCare for Kids® effective March 11, 2007. State code allows for these changes to be made administratively, but public notice was provided in compliance with state laws. A public notice with comment period was published in regional newspapers, posted on the Department of Community Health's website and made available for review at each county Department of Family and Children Services office. A widely attended public hearing was held on February 23, 2007. Current members, including those "locked-out" of coverage, will be notified by direct mail. The Department also issued a press release and is communicating with providers and stakeholders on the change. On March 8, 2007, the Board of Community Health approved the implementation of the closed enrollment period.

Upon receipt of additional federal funds, DCH issued a public notice announcing that enrollment would resume effective July 12, 2007, pending Board approval. The public notice further stated that in order to ensure that the funding adequately supports the cost of health care for members through September 30, 2007, enrollment will be limited to 295,000 children. The enrollment limit will be reassessed upon passage of SCHIP reauthorization legislation. Public comments were accepted for 30 days and a public hearing was held on June 27, 2007.

The following documents are enclosed in Attachment 2:

- Public Notices
- Letter to PeachCare Families
- Message to Providers
- DCH Press Release

To reflect the new verification requirements, the PeachCare for Kids® website, applications and all correspondence were updated to inform members of the required documentation. The information required has always been information that the Department could seek from individuals in order to determine eligibility and was requested as deemed necessary. This is clearly stated in the PeachCare application. A new application was used beginning July 1, 2007 which requested that applicants send in their proof of income with the application. Furthermore, a public notice was issued on August 24, 2007. Per state policies, the public notice was published in newspapers across the state, on the DCH web and in all DFCS offices. The public notice is enclosed in Attachment 3.

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.

There are no nationally recognized American Indian tribes or organizations in the state of Georgia. PeachCare for Kids®, however, does not charge cost-sharing to enrolled members who are members of federally recognized American Indian or Alaskan Native tribes.

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)

- 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

CHIP Budget

STATE:	**FFY Budget**
Federal Fiscal Year	
State's enhanced FMAP rate	**76.23%**
Benefit Costs	
Insurance payments	**$516,260,452.52**
STATE:	**FFY Budget**
Managed care	**$516,260,452.52**
per member/per month rate	**$210.39**
Fee for Service	**$0.00**
Total Benefit Costs	**$516,260,452.52**
(Offsetting beneficiary cost sharing payments)	**($2,665,999.80)**
Net Benefit Costs	**$513,594,452.72**
Cost of Proposed SPA Changes – Benefit	**($26,309,145.60)**
Cost of Coverage for Pregnant Women	**$0**
Administration Costs	
Personnel	**$603,329.96**
General administration	**$241,228.05**
Contractors/Brokers	**$17,647,445.97**
Claims Processing	**$0.00**
Outreach/marketing costs	**$0.00**
Health Services Initiatives	**$0.00**
Other	**$8,908.54**
Total Administration Costs	**$18,500,912.52**
10% Administrative Cap	**$57,066,050.30**
Federal Share	**($20,055,461.69)**
State Share	**($6,253,683.91)**

Cost of Proposed SPA Changes	**($26,309,145.60)**
Federal Share	**$405,616,296.92**
State Share	**$126,479,068.32**
Total Costs of Approved CHIP Plan	**$532,095,365.24**

Section 10. Annual Reports and Evaluations

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

10.1. **Annual Reports.** The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (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 complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

Upon any adverse action as described in 42 CFR § 457.1130 (a), the parent or authorized representative (A/R) will be notified by mail of the reason for the adverse action and how to request a review if they believe the decision is in error. The notice of such action will meet the requirements of 457.340(e) and 457.1180. The opportunity for continued enrollment of a suspended or terminated enrollment will meet the requirements of 457.1170. If a hearing notice is required, it will meet the requirements of 457.1140.

A written request for an initial administrative review may be submitted to the TPA, Division of Family and Children Services (DFCS) and forwarded to the Right from the Start Group (RSM Group) for processing which must be completed within 5 days. The request must be submitted within thirty (30) days of the written notification in which s(he) disagrees. If a verbal request is made, the parent or A/R must submit a written request within fifteen (15) days of the original request. If the written request is not received, no further action is required. If the RSM group is able to review the case and determine eligibility was determined correctly, discuss the complaint with the parent or A/R, and a mutual agreement is made, the parent or A/R may choose to withdraw the hearing request. If the RSM group is unable to obtain a hearing withdrawal either verbally or in writing from the parent or A/R, a hearing notice will be mailed to the parent or A/R in which they will have 10 days to respond. If no response is received, the administrative review is considered complete and no further action is required. If the parent or A/R is not satisfied with the outcome of the administrative review, s/he can request a fair hearing which will be submitted to the Legal Services Office (LSO). If the RSM group finds the case was processed incorrectly, it will be corrected, and the same procedures as stated above will be followed accordingly.

The LSO will submit the hearing request to the Georgia Office of State Administrative Hearings (OSAH). OSAH will notify the parent or A/R of the time, place, and date of the hearing. Both the parent or A/R and RSM

representative, on behalf of the state, can be present at the hearing. Each will be allowed to present their case to the Administrative Law Judge. The decision of the Administrative Law Judge will be provided in writing and will be final. The final decision could take up to 90 days from the date of the written request. There will be no further administrative recourse for the parent or A/R or RSM worker.

NOTE: All hearing requests must be forwarded to the Legal Services Office (LSO) regardless of when the request was received. Untimely requests for a hearing will not be considered or forwarded to OSAH except for good cause. All hearing requests, oral or written, including requests received more than 30 days after notification is issued, must be forwarded to LSO within three (3) business days. The decision of the Administrative Law Judge will be the final administrative recourse available to the parent or A/R. If at any level of the appeal, the child(ren) is/are determined eligible for enrollment in PeachCare for Kids®, the enrollment will become effective retroactive to the first day of the month in which the completed application, including any additional information affecting the outcome of the program's decision is received.

The State assures that in the review process, parents or A/R will have the opportunity to fully participate in the review process; decisions are made in writing; and impartial reviews are conducted in a reasonable amount of time and consideration is given for the need for expedited review when there is an immediate need for health services.

Applicant and Enrollee Protections for ELE include

- If a child is found eligible but subject to premiums, based on an income finding from an Express Lane agency, the State must provide notice that the child may qualify for lower premiums if evaluated using the State's regular eligibility determination procedures and receive information concerning how to request such an evaluation.
- Children who are determined eligible and enrolled in CHIP using the screening threshold option for screening and enrollment, the State must provide notice to the family that the child may be eligible for Medicaid if evaluated using the State's regular eligibility determination procedures. The notice must specify the process for requesting such an evaluation and the differences between Medicaid and CHIP, including differences in benefits and cost sharing.
- Children who are found to be over the income threshold of 247% must be notified that they may be eligible for CHIP if evaluated using the State's regular eligibility determination procedures. The notice must specify the process for requesting such an evaluation and the differences between Medicaid and CHIP, including differences in benefits and cost sharing.
- After a full Medical Assistance eligibility determination, if the applicant is over income for CHIP or any other category of Medical Assistance their information will be electronically submitted to the Federally Facilitated Marketplace (FFM). The customer will be notified of this action and how to obtain coverage.
- The state assures that all eligibility/renewal notices will provide information to applicants on how to request a review of their determination or how to file a state hearing.

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

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

The State assures that each Care Management Organization (CMO) has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. Upon receiving an adverse benefit determination, a parent, or Authorized Representative (A/R) may notify the CMO if the parent believes that the service should be covered. The notice of adverse benefit determination will meet the requirements of 457.1260(c).

The parent or A/R may file a grievance with their CMO at any time. The parent or A/R has sixty (60) calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the CMO. An appeal request may be submitted either orally or in writing. The CMO will send written notification of receipt of an Appeal request within ten (10) business days. The CMO will research all aspects of the case including reviewing medical policy, the claims system and any documentation submitted by the physician. The CMO will assure that all reviews are conducted by a health care professional who was not involved in any prior review of the decision, and who has appropriate clinical expertise, as determined by DCH, in treating the member's condition, as provided in 457.1150. The parent and or their A/R have the right to provide documentation or explanation of the member's medical need for consideration during the Appeal.

A parent or A/R may request an expedited appeal of an adverse benefit determination for certain health care services and treatment. Expedited Appeals may be filed by phone or in writing. Appeals will be expedited when the provider indicates, or the CMO determines that following the standard timeframe could seriously harm the participants life, health or ability attain, maintain, or regain maximum function.

The CMO will notify the member of the Appeal decision within thirty (30) days from the day the Appeal is received, and 72 hours when there is an expedited Appeal. If an Appeal request for benefits is approved, the CMO will provide the member, their doctor, or the ordering health partner with the appropriate notice. If the CMO upholds the adverse benefit determination, the member will be notified in a final adverse determination notice. This notice will be in writing and will include all information regarding the member's right to request an Independent Medical Review and instructions on how to request the review in accordance with 42 CFR 457.1260(e)(1) and (4).

All Children's Health Insurance Program (CHIP) Independent Medical Review requests must be made through the Department of Community Health, Medical Assistance Plans. The State will send written notification of receipt of an Independent Medical Review request within ten (10) business days. The review is independent of both the State and CMO and is offered without any cost to the enrollee. The Department of Community Health will request all documentation from the CMO/Provider that was utilized to make their determination. The parent and or their A/R have the right to provide documentation or explanation of the member's medical need for consideration during the Review with the Independent Medical Review Committee. The Independent Medical Review Committee will provide their determination within 90 days from the time a review is requested for a standard review in accordance with (42 CFR 457.1160(b)(1)), and 72 hours from the time a review is requested for an expedited review in accordance with (42 CFR 457.1160(b)(2)). The Committee has the right to request any additional information if needed to provide an appropriate determination. The State may extend the 72-hour time frame by up to 14 days if the enrollee requests an extension.

If the Independent Medical Review Committee upholds the adverse benefit determination, the

member will be notified in an adverse benefit determination notice. If an Independent Medical Review request for benefits is overturned by the Independent Medical Review Committee, the Department of Community Health will provide the member, their provider, and the CMO with the appropriate notice. This notice will be in writing.

This review is the final recourse regarding the denial.

In reference to the Review process for Health Service Matters, the state also assures:

- The parent or A/R can request an extension of the time frame to resolve a standard or expedited Appeal up to fourteen (14) calendar days. The CMO may also request up to fourteen (14) additional days to resolve a standard or expedited Appeal, however the CMO must provide the Department of Community Health (DCH) evidence that the delay is necessary, if requested by DCH. The CMO must notify the member, in writing, immediately when they request an extension and include the reason for the extension, and the date that a decision must be made.

- The state will allow individuals who have requested an Independent Medical Review the ability to withdraw their request via any of the modalities available for requesting Telephonic withdrawals of an Independent Medical Review may be submitted, but must be followed by a written, signed withdrawal. The state will ensure that written confirmation of the request to withdraw the Independent Medical Review is sent within 5 days of the date of receipt of withdrawal request.

- The state will ensure that CMO's will meet the requirements of handling grievances per 42 CFR 438.406, which requires that members be given reasonable assistance in completing forms and taking other procedural steps related to an appeal.

- Consistent with 42 CFR 457.1130(c), The State is not required to provide an opportunity for an Independent Medical Review of a matter if the sole basis for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

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.

Key for Newly Incorporated Templates

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

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

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

GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

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

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and pre-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.

Attachment 1
PeachCare for Kids®
Application

Links to Application

www.peachcare.org
www.gateway.ga.gov

Georgia Department of Human Services

Application for Benefits

If you need help filling out this application, ask us or call 1-877-423-4746. If you have a hearing impairment, call GA Relay at 1-800-255-0135. Our services are free.

What Services Do We Offer at the Division of Family and Children Services (DFCS)?

DFCS offers the following services:

Food Assistance

Food Stamps are benefits that you can use to buy food at any store that has the EBT/*Quest* sign. We will subtract the price of your food purchase from your Food Stamp account.

Cash Assistance/Employment Support Services

Temporary Assistance for Needy Families (TANF) provides cash assistance to families with dependent children for a limited time. Parents or caretakers who are included in the grant are required to participate in a work program.
Cash Assistance program also provides financial assistance to refugee households who are not eligible for the TANF program.

Medical Assistance

Medicaid, for those who are eligible, may help pay medical bills, doctor's visits, and Medicare premiums.

Community Outreach Services

For more information about Community Outreach Services, please visit our website at: http://www.dfcs.dhr.georgia.gov or call 1-877-423-4746.

How Do I Apply for Benefits?

Step 1. Fill out the application.

Read the questions carefully and give accurate information. Sign and date the application.

Step 2. Turn in the application. You will need to tear off pages 1 -3 and keep it for yourself.

Mail, fax, or bring in pages 4-8 of this application to your local Division of family & Children Services (DFCS) office. If you or the person for whom you are applying is eligible for benefits, Food Stamps or TANF benefits will be provided from the date that we receive the application with your name, address, and signature on it.

If you apply for Food Stamps, and/or Medicaid you can file an application for benefits with only your name, address and signature. However, it may help us to process your application quicker if you complete the entire form.

Step 3. Talk with us.

You may need to complete an interview with a case manager. If so, we will give you an appointment. This interview can be completed by phone.

Frequently Asked Questions

How long does it take to get benefits?

Food Stamps:	up to 30 days
TANF:	up to 45 days
Medicaid:	10 to 60 days

You may be able to get Food Stamps within 7 days if you qualify. See page 5.

How much will I get?

Your income, resources, and family size determine benefit amounts. We will be able to give you specific information once we determine your eligibility.

How will I get my benefits?

For Food Stamps and TANF, you will get an Electronic Benefit Transfer (EBT) card to access your benefits. For Medicaid, you will receive a Medicaid card for each eligible member.

What information will I need to provide?

It is a good idea to provide the following:

- Proof of identity for the applicant if applying for Food Stamps and/or TANF. Proof of identity for everyone requesting Medicaid if applying for Medicaid. Ex: An identification card (ID) or driver's license (DL)
- Proof of US citizenship/qualified immigrant status for everyone requesting benefits
- Social Security numbers of everyone requesting assistance
- Proof of income *for example*, pay stubs, child support payments, and income award letters
- Proof of expenses like child care receipts, medical bills, medical transportation costs, and child support payments

You will be given time to return any information to our office. If you need help getting this information, please tell us.

How do we use the applicant's personal information?

You only have to provide Social Security Numbers (SSN) and citizenship or immigration status for persons who want to apply for benefits. This information will be used to check the income and eligibility verification system (IEVS). We will also match your information against other Federal, state and local agencies to verify your income and eligibility. If a household member does not want to give us information about their SSN, citizenship, or immigration status, other household members may still receive benefits.

Can someone else apply for me?

Yes, for Food Stamps and Medicaid, you may ask someone to apply for you.
For TANF, anyone can apply but the parent or caretaker must be interviewed.

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"In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the **Food and Nutrition Act of 2008** and USDA policy, discrimination is also prohibited on the basis of religion or political beliefs."

To file a complaint of discrimination, you may contact USDA or HHS.

Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9411 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY).

Write HHS, Director, Office of Civil Rights, Room 509-F, 200 Independence Avenue, S.W., Washington, D.C., 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY).

USDA and HHS are equal opportunity providers and employers

You may also file a complaint of Discrimination by contacting the DFCS Civil Rights Program, Two Peachtree Street, N.W., Suite 19-248, Atlanta, Georgia 30303 or call (404) 657-3735 or fax (404) 463-3978.

Under the Department of Community Health (DCH) policy, Medicaid cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or political or religious beliefs. To report Medicaid eligibility or provider discrimination, call the Georgia Department of Community Health's Office of Program Integrity (local 404-463-7590) (toll free) 800-533-0686.

What Do the Words Used in this Application Mean?

This chart explains the words we have used in this application.

Caretaker	A parent, relative or legal guardian who applies for and receives TANF with children in his or her care.
Grantee Relative	A parent, relative or legal guardian who applies for and receives TANF in his or her name on behalf of the children.
Disqualified	The action taken to remove an individual from a Food Stamp or TANF case because they did not tell the truth and received benefits that they should not have received.
Electronic Benefit Transfer (EBT)	The system used in Georgia to pay benefits to individuals who are eligible for Food Stamps. Individuals receiving assistance are issued an EBT debit card, which is used to access their food stamp accounts.
EPPICard debit MasterCard	New debit card issued by Xerox for individuals receiving cash assistance in Georgia. The EPPICard debit MasterCard will be accepted for purchases and cash withdrawals anywhere the MasterCard is accepted.
Household Members	Individuals who live in your home. For Food Stamps, individuals who live together and purchase and prepare their meals together.
Income	Payments such as wages, salaries, commissions, bonuses, worker's compensation, disability, pension, retirement benefits, interest, child support or any other form of money received.
Migrant Farm Workers	Individuals who are seasonal farm workers and move from one home base to another to work or look for farm work.
Resources	Cash, property, or assets such as bank accounts, vehicles, stocks, bonds, and life insurance.
Seasonal Farm Workers	Individuals who work at certain times of the year planting, picking or packing produce. They are hired on a temporary basis when a job requires more workers than the farm employs on a regular basis.



What Do the Words Used in this Application Mean? (cont'd)

This chart explains the words we have used in this application.

Trafficking in the SNAP/Food Stamp Program	*Trafficking* SNAP benefits means: (1) Buying, selling, stealing, or otherwise exchanging SNAP benefits issued and accessed via EBT cards, card numbers and PIN numbers or by manual voucher and signature, for CASH or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; (2) The exchange of firearms, ammunition, explosives, or controlled substances; (3) Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount; (4) Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food; (5) Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food.
Qualified Alien/Immigrant	A *qualified alien/immigrant* is a person who is legally residing in the U.S. who falls within one of the following categories: a person lawfully admitted for permanent residence (LPR) under the Immigration and Nationality Act (INA); *Amerasian* immigrant under section 584 of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988; a person who is granted asylum under section 208 of the INA; *Refugees*, admitted under section 207 of the INA; A person *paroled* into the US under section 212(d)(5) of the INA for at least one year; A person whose *deportation* is being withheld under section 243(h) of the INA as in effect prior to April 1, 1997 , or section 241(b)(3) of the INA, as amended; a person who is granted *conditional entry* under section 203(a)(7) of the INA as in effect prior to April 1, 1980; *Cuban or Haitian* immigrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980; *victims of human trafficking* under section 107(b)(1) of the Trafficking Victims Protection Act of 2000; *battered immigrants* who meet the conditions set forth in section 431 (c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended; *Afghan or Iraqi* immigrants granted special immigrant status under section 101(a)(27) of the INA (subject to specified conditions); *American Indians* born in Canada living in the U.S. under section 289 of the INA or non-citizens of federally-recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and *Hmong or Highland Laotian tribal members* that rendered assistance to U.S. personnel by taking part in military or rescue operation during Vietnam Era (8/05/1964 – 5/07/1975).
Applicant	An individual who chooses to apply for or to receive public assistance/benefits
Non-applicant	An Individual who chooses NOT to apply for or to receive public assistance/benefits; non-applicants are not required to provide an SSN, citizenship or immigration status.
Assistance Unit	An assistance unit includes *eligible* individuals who live together and receive public assistance/benefits together.

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What Am I Applying For? Check all that apply:

- ❑ **Food Stamps**
  The Food Stamp program helps meet the food and nutritional needs of eligible households.
- ❑ **Temporary Assistance for Needy Families (TANF)**
  Temporary Assistance for Needy Families (TANF) provides temporary monthly cash payments, single cash payments, or other support services, to strengthen eligible families with children. If you are the child's parent, or the caretaker who would like to be included in the grant, we will require you to participate in a work program.
- ❑ **Refugee Cash Assistance**
  The Refugee Cash Assistance program provides financial assistance to refugee households who are not eligible for the TANF program. The term refugee includes refugees, Cuban/ Haitian Entrants, victims of human trafficking, Amerasians, and unaccompanied refugee minors.
- ❑ **Medicaid**
  Medicaid offers medical coverage to elderly, blind or disabled adults, pregnant women, children, and families. When you apply, we will look at all Medicaid programs and decide which ones you may be eligible to receive.

Tell Us About The Applicant

Does the applicant or person applying on behalf of the applicant need assistance when communicating with us? If so check all that apply.

( ) TTY ( ) Braille ( ) Large Print ( ) E-mail ( ) Video Relay) ( ) Sign Language Interpreter _____

( ) Foreign Language Interpreter (specify language) _____ ( ) Other _____

Please fill out the chart below about the applicant.

First Name	Middle Initial	Last Name	Suffix
Street Address Where You Live		Apt	
City	State	Zip Code	
Mailing Address (if different)			
City	State	Zip Code	
Main Telephone Number	Other Contact Number	E-Mail address (optional)	
Signature	Date		
Witness Signature if signed by 'X'	Date		
For Office Use Only	Date Received By The County		

Georgia Department of Human Services

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Do I Qualify to Get Food Stamps Faster?

Answer these questions about the applicant and all household members to see if you can get Food Stamps within 7 days.

1. Are you or any household member a migrant or seasonal farm worker? ❑ Yes ❑ No

2. Total **Gross earned income** that will be received for this month: $_____
   Employer Name _____
   Employment Begin Date _____ Employment End Date_____
   Rate of Pay _____ Hours Worked Weekly _____ wk/bi-wk/semi-mo/mo (circle one)

3. Total **Gross unearned income** that will be received for this month: $_____
   Type of Unearned Income _____ Amount _____ wk/bi-wk/semi-mo/mo (circle one)
   Type of Unearned Income _____ Amount _____ wk/bi-wk/semi-mo/mo (circle one)

4. Total earned and unearned income for this month: $_____

5. How much money do you and all household members have in cash or in the bank? $ _____

6. How much do you and all household members pay for rent or mortgage? $ _____

7. How much do you and all household members pay for electric, water, gas, etc.? $ _____

Can I Choose Someone to Apply for Food Stamps or Medicaid for me?

Complete this section only if you want someone to fill out your application, complete your interview, and/or use your EBT card to buy food when you cannot go to the store. If you are applying for Medicaid, you can choose more than one person to apply for medical assistance on your behalf.

Name: _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Name: _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

For Medicaid, do you want this individual to have a copy of your Medicaid card? ❑ Yes ❑ No

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Tell Us about the Applicant and All Household Members

Please fill out the chart below about the applicant and all household members. The following federal laws and regulations: The Food and Nutrition Act of 2008, 7 U.S.C. § 2011-2036, 7. C.F.R. § 273.2, 45 C.F.R. § 205.52, 42 C.F.R. § 435.910, and 42 C.F.R. § 435.920, authorize DFCS to request your and your household members social security number(s). If anyone in your household does not want to give us information about his or her citizenship, immigration status, or social security numbers, then that person can be designated as a non-applicant. This means that the person will not be considered an applicant and will not be eligible for benefits. However, other household members may still be able to receive benefits, if they are otherwise eligible. If you want us to decide whether any household members are eligible for benefits, you will still need to tell us about their citizenship or immigration status and give us their SSN. You will still need to tell us about your income and resources to determine the eligibility and benefit level of the household. Individuals will not be reported to the United States Citizenship and Immigration Services (USCIS) Systematic Alien Verification for Entitlements (SAVE) system if they do not give us their citizenship or immigration status. However if immigration status information has been submitted on your application, this information may be subject to verification through the SAVE system and may affect the household's eligibility and benefit level.

NAME First Middle Initial Last	Relation -ship to You	Is this person applying for benefits? (Y/N)	Birth Date Format (--/--/--)	Social Security Number **(Applicants Only)**	Sex (M/F)	Hispanic/ Latino? **(Optional)** (Y/N)	Race Code **(Optional)** (See codes Below)	Are you a U.S citizen, qualified alien/immigrant or Hmong/Highland Laotian Immigrant? **(Applicants only)** (Y/N)
	SELF							

Race Codes (Choose all that apply):
AI – American Indian/Alaska Native **AS** – Asian **BL** – Black/African American
HP – Native Hawaiian/Pacific Islander **WH** – White

By providing Race/Ethnicity information, you will assist us in administering our programs in a non-discriminatory manner. Your household is not required to give us this information and it will not affect your eligibility or benefit level.

Tell Us More about the Applicant and All Household Members

We need more information about the applicant and all household members in order to decide who is eligible for benefits. Please answer only the questions about the benefits you want to receive on the page below.

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1. Has anyone received any benefits in another county or state? ❑ Yes ❑ No

   If yes:
   Who:_____
   Where: _____
   When: _____

2. Has anyone been convicted of giving false information about where they live and who they are to get multiple FS benefits in more than one area after 8/22/96? ❑ Yes ❑ No

   If yes:
   Who: _____
   Where: _____
   When: _____

3. Did anyone in your household voluntarily quit a job or voluntarily reduce his/her work hours below 30 hours per week within 30 days of the date of application? ❑ Yes ❑ No
   If yes, who quit? _____
   Why did he/she quit? _____

4. Is anyone pregnant? *Please provide proof of pregnancy if available. ❑ Yes ❑ No
   (This question does not apply to Food Stamp only applicants)
   Who: _____
   Due Date: _____

5. For Medicaid, does anyone have any unpaid medical bills for the last 3 months? ❑ Yes ❑ No
   (This question does not apply to Food Stamp or TANF only applicants)

6. Is anyone disqualified from the Food Stamp or TANF Program? ❑ Yes ❑ No
   If yes:
   a. Who: _____
   b. Where: _____

7. Is anyone trying to avoid prosecution or jail for a felony? (Food Stamps and TANF Only) ❑ Yes ❑ No

   If yes, who: _____


8. Is anyone violating conditions of probation or parole? (For Food Stamps and TANF only) ❑ Yes ❑ No
   If yes, who: _____

9. Does anyone have a felony conviction because of behavior related to the possession, use or distribution of a controlled drug substance after 8/22/96 (FS and TANF only) or a violent felony (TANF only)? ❑ Yes ❑ No
   If yes:
   Who: _____
   When: _____

10. Have you or any household member been convicted of trading Food Stamp benefits for drugs after 8/22/96? ❑ Yes ❑ No
    If yes:
    Who: _____
    When: _____

11. Have you or any household member been convicted of buying or selling Food Stamp benefits over $500 after 8/22/96? ❑ Yes ❑ No
    If yes:
    Who: _____
    When: _____

12. Have you or any household member been convicted of trading Food Stamp benefits for guns, ammunition or explosives after 8/22/96? ❑ Yes ❑ No
    If yes:
    Who: _____
    When: _____

13. Has anyone used TANF funds or the EPPIC Card at the following establishments, liquor stores, casinos, poker rooms, adult entertainment business, bail bonds, night clubs, salons/taverns, bingo halls, race tracks, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons.?
    If yes:
    Who: _____ ❑ Yes ❑ No
    When: _____

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Food Stamp Program Penalties

Any household member who breaks any of the food stamp rules on purpose can be barred from the Food Stamp Program for one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. She/he may also be subject to prosecution under other applicable Federal and State laws. She/he may also be barred from the Food Stamp Program for an additional 18 months if court ordered.

Any household member who intentionally breaks the rules may not get Food Stamps for one year for the first offense, two years for the second offense, and permanently for the third offense.

If a court of law finds you or any household member guilty of using or receiving food stamp benefits in a transaction involving the sale of a controlled substance, you or that household member will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

If a court of law finds you or any household member guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition or explosives, you or that household member will be permanently ineligible to participate in the Food Stamp Program upon the first offense of this violation.

If a court of law finds you or any household member guilty of having trafficked benefits for an aggregate amount of $500 or more, you or that household member will be permanently ineligible to participate in the Food Stamp Program upon the first offense of this violation.

If you or any household member is found to have given a fraudulent statement or representation with respect to identity (who they are) or place of residence (where they live) in order to receive multiple Food Stamp benefits, you or that household member will be ineligible to participate in the Food Stamp Program for a period of 10 years.

For All Medicaid, Food Stamps and TANF Applicants:

I have read and completed everything on this form that applies to the applicant and the applicant's household. I certify, under penalty of perjury, all the information that I provided is true and complete as far as I know. I understand I can be punished by law if I do not tell the complete truth.

Applicant's Signature	Date
Authorized Representative's Signature	Date
Case Manager's Name and Signature	Date

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Health Coverage Addendum

Please answer the following questions if you are applying for Health Coverage
(Please complete all three pages of this form)

1. If you are an adult applying for Health Coverage for your dependent child(ren), do you want to receive Health Coverage for yourself? ❑ Yes ❑ No
2. Is anyone in the household pregnant? ❑ Yes ❑ No If yes, how many babies are expected during this pregnancy? _____
3. Is anyone applying for health coverage blind or disabled? ❑ Yes ❑ No
   If yes, please list_____
4. Does anyone have other health insurance that covers anyone in your household? ❑ Yes ❑ No
5. If you answered yes to question 5 above, please complete the following information:

Name of Policy holder	Health Insurance Company Name, Address and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical)	Name of Persons Covered	Effective Date	Policy Number

6. Is anyone listed on this application offered health coverage from a job? Check yes even if the coverage is from someone else's job, such as a parent or spouse.
   ❑ Yes If yes, you'll need to complete Attachment A. Is this a state employee benefit plan? ❑ Yes ❑ No
7. Have you or anyone listed on this application lost any health coverage in the last 2 months?
   ❑ Yes If yes, why was it lost? _____
   ❑ No
8. Was anyone in your household in Foster Care at age 18? ❑ Yes ❑ No
9. Does anyone in the household have any unpaid medical bills from the last 3 months? ❑ Yes ❑ No
10. Is anyone in your household American or Alaska Native? ❑ Yes ❑ No
    If Yes, complete Attachment B.

If you are applying for Aged, Blind or Disabled Medicaid please answer questions 11-16 and complete the Resources section. Otherwise, skip to the tax filer questions on page 3.

11. Are you or your spouse currently covered by Medicare?
    ❑ Yes ❑ No If Yes please list, _____
12. Are you applying for Medicaid to cover unpaid medical bills from the three months prior to a Supplemental Security Income (SSI) application?
    ❑ Yes ❑ No If yes, date of SSI application: _____
13. Are you applying for someone who is now deceased and has unpaid medical bills within the last three (3) months?
    ❑ Yes ❑ No
14. Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?
    ❑ Yes ❑ No

15. Are you applying for Medicaid for a person over the age of 18 whose SSI check has stopped?
❑ Yes ❑ No

16. Are you applying for Medicaid to help pay for community based waiver services such as Community Care Services, NOW/COMP, Hospice Care, Independent Care Waiver or the Deeming Waiver (Katie Beckett)?
❑ Yes ❑ No

Resources: Check all resources (assets) owned by you, your spouse, your dependents or jointly owned with someone else. Attach additional pages if necessary.

Checking Accounts	❑ Yes ❑ No	Funeral Plans/Prepaid Burial Item	❑ Yes ❑ No
Savings Accounts	❑ Yes ❑ No	Burial Plots or Contracts	❑ Yes ❑ No
Government Bonds	❑ Yes ❑ No	Stocks and Bonds	❑ Yes ❑ No
Trust Funds	❑ Yes ❑ No	Other (IRA, CD, etc.)	❑ Yes ❑ No
Real Property/Homeplace Property			❑ Yes ❑ No
Have you or your spouse given away any assets for less than its value?			❑ Yes ❑ No

If you answered yes to any of these questions, please describe below.

Type of Resource	Account/Policy Number	Value	Name of Bank, Insurance Company, etc.

Does anyone in the household own a vehicle? If so, please describe below. ❑ Yes ❑ No

Vehicle Make	Model	Year	Amount Owed

Do you or your spouse have a life insurance policy? ❑ Yes ❑ No
If yes, please complete the following information.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? ❑ Yes ❑ No
If yes, who? (list each person who plans to file)_____

2. Will any of the tax filers listed file jointly with a spouse? ❑ Yes ❑ No If yes, please list spouse's name:_____

3. Will any of the tax filers claim any dependents on their tax return? ❑ Yes ❑ No If yes, please list name(s) of dependents:_____

4. Will anyone be claimed as a dependent on someone else's tax return? ❑ Yes ❑ No If yes, please list the name of the tax filer and the dependent: (Filer)_____
(Dependent)_____
How is the tax dependent related to the tax filer? _____

Income and Earnings: List all types of earnings and income that your household receives. List the income amount before deductions such as taxes, insurance or Medicare premiums , health insurance, dental, and vision premiums or Spending accounts are taken out.

Income Type	Gross amount	How often? (weekly, every 2 weeks, monthly, etc.)	Name of Person Receiving
Wages/Salary			
Current Employer:			
Wages/Salary			
Current Employer:			
Self Employment			
Unemployment Benefits			
Social Security Income			
SSI			
Worker's Compensation			
Pension/Retirement Benefits			
Veterans Benefits			
Child Support			
Alimony			
Contributions			
Other Income (please specify)			

Does anyone expect any change in monthly income? ❑ Yes ❑ No
If yes, please list who expects the change, the type of income that is changing, and the date it is expected to change below.

_____

Deductions: Check all that apply, and give the amount and how often you pay it.

❑ Alimony $_____ How often? _____ ❑ Other Deductions $_____ How often?_____

❑ Student loan interest $_____ How often?_____

Assignment of Rights of Payment for Medical Support and Other Medical Care:
(If you are applying on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described below, as a condition of his/her eligibility for Medicaid.) As a condition of my eligibility, I agree to assign to the State all rights to medical support and to payment for medical care from any third party (hospital and medical benefits). I agree to cooperate with the state in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days. I agree to give the State the right to require an absent parent to provide medical insurance, if available. I understand I must get medical support from the absent parent if it is available and must cooperate with the Division of Child Support Services in obtaining this support. If I do **not** cooperate, I understand I may lose my Medicaid benefits, and only my child(ren) will receive benefits unless good cause is established.

I certify, under penalty of perjury, that all the information listed is truthful to the best of my knowledge.

_____ _____
Signature Date

DECLARATION OF CITIZENSHIP/IMMIGRATION STATUS

Georgia Department of Human Services
Division of Family and Children Services

I understand that the Georgia Division of Family and Children Services (DFCS) may require verification from the United States Department of Homeland Security (DHS) of my and/or my child(ren)'s citizenship or immigration status when seeking benefits. Information received from DHS may affect my or my child(ren)'s eligibility.

Please fill out and sign **ONE** or **BOTH** of the following statements as it pertains to the status of each person seeking benefits.

CHILDREN SEEKING BENEFITS

Name	Place of Birth (City, State, Country)	(Check applicable) U.S. Citizen	(Check applicable) Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)	Immigration Document ID # (If applicable)
					A-
					A-
					A-
					A-
					A-

I, _____, declare the child/children is/are a U.S. Citizens or a Qualified Immigrant.
(PRINT NAME)
I attest to the identity of the child/children listed above, and certify under penalty of perjury, that the information written and checked above is true.

_____ _____
SIGNATURE (PARENT/GUARDIAN) (DATE)

ADULT(S) SEEKING BENEFITS

Name	Place of Birth (City, State, Country)	(Check applicable) U.S. Citizen	(Check applicable) Lawfully Admitted Immigrant	Date Naturalized or Admitted into U.S. (If applicable)	Immigration Document ID # (If applicable)
					A-
					A-

I, _____, declare I am a U.S. Citizen or a Qualified Immigrant. I certify under
(PRINT NAME)
penalty of perjury, that the information written and checked above is true.

_____ _____
SIGNATURE (DATE)

Attachment 2:

PeachCare for Kids® Closed Enrollment
Public Information

PUBLIC NOTICE

Pursuant to 42 CFR § 457.65, the Georgia Department of Community Health is required to give public notice of any state plan amendment that limits or restricts eligibility in the State Children's Health Insurance Program, known as the Georgia's PeachCare for Kids® Program.

PEACHCARE FOR KIDS®

Pursuant to Title XXI of the Social Security Act, the PeachCare Program is a jointly funded state and federal insurance program for low-income children. Effective **March 11, 2007**, the Department will discontinue enrollment in the PeachCare for Kids® Program.

- Any new applications received or postmarked after **March 11, 2007** will not be processed for PeachCare eligibility.

- Members whose participation in the program is suspended for failure to timely pay premiums or for failure to provide required income verification will also be affected by this change and will be precluded from re-enrollment. These members will receive additional notice by direct mail as required by governing regulations.

- Members enrolled and/or determined eligible prior to **March 11, 2007** will not be impacted by this particular proposed change.

This change serves as an effort to sustain the PeachCare for Kids® Program so that low-income children currently enrolled in the program may continue to receive low-cost health insurance.

This public notice is available for review at each county Department of Family and Children Services office and will also be published in regional newspapers and on the Georgia Department of Community Health's website. An opportunity for public comment will be held on **February 23, 2007,** 10:00 a.m.-12:00 p.m., at the Floyd Room of the Twin Towers Building, 20th Floor, West Tower, 200 Piedmont Avenue, Atlanta Georgia. Individuals who are disabled and need assistance to participate during the meeting should call (404) 656-4479. Citizens wishing to comment in writing on the proposed changes should do so before **March 2, 2007** to the Board of Community Health, P.O. Box 38406, Atlanta, Georgia 30334.

Submitted comments will be available for review by the public at the Department of Community Health, Monday through Friday, 9:00 a.m. to 4:30 p.m., in Room 4074, 2 Peachtree Street, NW, Atlanta, Georgia 30303.

Comments from written and public testimony will be summarized and provided to the Board of Community Health prior to the **March 8, 2007** Board meeting. The Board will vote on the proposed change at the March meeting which will be held 10:30 a.m. at the Floyd Room of the Twin Towers Building, 20th Floor, West Tower, 200 Piedmont Avenue, Atlanta, Georgia.

NOTICE IS HEREBY GIVEN THIS 8TH DAY OF FEBRUARY, 2007
Rhonda M. Meadows, M.D., Commissioner

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

From: Commissioner Dr. Rhonda Medows, M.D.
Date: February 20, 2007
Re: PeachCare for Kids® Enrollment Freeze

It was with a heavy heart that I announced we will stop accepting new applications to enroll in the PeachCare for Kids® (PKC) program effective March 11, 2007. This freeze will then be in effect until further notice.

While we are no longer accepting new enrollees, I am writing to you as parents and guardians of children already enrolled in PKC to inform you that you should not be alarmed by this notification. This is NOT a notice announcing that the program is ending. As long as PKC has money to operate, your children will receive care under the terms of their current enrollment.

As a parent, I understand the importance of providing quality health care to your children, and I have notified providers that the enrollment freeze does not impact the health care services of current PKC members. Providers will continue to render health care services to current PKC members.

However, if you are required to pay a PCK premium, it is crucial that you make your monthly payment on time or your child(ren)'s coverage will be at risk. After March 11, 2007, any family whose participation in the program is cancelled for failure to pay premiums will no longer be re-enrolled during this period.

PCK, Georgia's State Children's Health Insurance Program, is a partnership between the state and federal government to provide comprehensive health care program for uninsured children living in Georgia. The state has committed its share of the funds; however, the program has a $131 million federal funding shortfall for Federal Fiscal Year 2007.

We continue to work with members of Congress, the members of our State Legislature and the Governor' office to resolve the funding needs of this very important program.

For additional information on the PeachCare for Kids® program, please access http://www.dch.ga.gov.

If you have any questions or concerns, please feel free to call **1-877-GAPEACH (1-877-427-3224)**

To: Providers of PeachCare for Kids® Health Care Services

From: Commissioner Dr. Rhonda Meadows, M.D.

Date: February 16, 2006

Re: PeachCare for Kids® Enrollment Freeze

It was with a heavy heart that I announced we will stop accepting new applications to enroll in the PeachCare for Kids® (PKC) program effective March 11, 2007. This freeze will then be in effect until further notice.

While we are no longer accepting new enrollees, I am writing to inform you that the enrollment freeze does not affect the rendering of services to current PKC members. This is NOT a notice announcing that the program is ending. As long as PCK has money to operate, **members of PCK will receive care** under the terms of their current enrollment.

PCK, Georgia's State Children's Health Insurance Program, is a partnership between the state and federal government to provide comprehensive health care program for uninsured children living in Georgia. The state has committed its share of the funds; however, the program has a $131 million federal funding shortfall for Federal Fiscal Year 2007.

We continue to work with members of Congress, the members of our State Legislature and the Governor' office to resolve the funding needs of this very important program.

For additional information on the PeachCare for Kids® program, please access http://www.dch.ga.gov.

If you have any questions or concerns, please feel free to call **1-800-766-4456**.

Equal Opportunity Employer

Rhonda M. Meadows, MD, Commissioner
2 Peachtree Street, NW
Atlanta, GA 30303-3159
Sonny Perdue, Governor www.dch.georgia.gov

FOR IMMEDIATE RELEASE CONTACT:

February 8, 2007 Dena' Brummer
404-463-5391

PeachCare for Kids® Enrollment Closes to New Members

Children currently enrolled continue to receive care

ATLANTA – Today, Georgia Department of Community Health Commissioner Dr. Rhonda Meadows informed the Board of Community Health that PeachCare for Kids® (PCK) will no longer accept new enrollees to the program as of March 11, 2007.

"We have seen this important program grow to cover over 270,000 children. It is a way for hard working parents to try to provide health care for their children," Dr. Meadows said. "We continue to wait for an act of Congress to occur so that we can provide care for the children currently enrolled in the program through October 2007."

PCK, Georgia's State Children's Health Insurance Program (SCHIP), is a partnership between the state and federal government to provide comprehensive health care program for uninsured children living in Georgia. The state has reserved its share of the funds needed; however, the program has a $131 million federal funding shortfall for Federal Fiscal Year 2007.

The announcement comes as the state is actively urging Congress to allot funds for the SCHIP shortfall that Georgia and 14 other states face. State projections show that PCK will run out of operating funds sometime in March 2007.

A public notice has been filed to cease the allowance of new members to the PCK program. Effective March 11, 2007, only those currently enrolled in the PCK program may continue to receive services via the state.

"Parents and guardians of children already enrolled in PCK should not be alarmed by this notification," Dr. Meadows said. "As long as the PCK has money to operate, your children will receive care under the terms of their current enrollment. We remain hopeful that Congress will fulfill its commitment to the SCHIP program."
For more information about the PeachCare for Kids® program, please access http://www.dch.ga.gov

PUBLIC NOTICE

Pursuant to 42 CFR § 457.65, the Georgia Department of Community Health is required to give public notice of any state plan amendment that limits or restricts eligibility in the State Children's Health Insurance Program, known as the Georgia's PeachCare for Kids™ Program.

PEACHCARE FOR KIDS

Pursuant to Title XXI of the Social Security Act, PeachCare for Kids™ is a jointly funded state and federal insurance program for low-income children. Effective July 1, 2007, the Department has modified its procedures for validating eligibility for the Program.

Income and citizenship information are a condition of eligibility for PeachCare for Kids™. This information has been accepted through self-declaration or upon request of documentation. To ensure appropriate enrollment in the program, effective July 1, 2007, the Department is requiring proof of income and citizenship status to determine eligibility.

Verification documents will be required for new applications received after July 1, 2007 and for all renewing accounts annually. Additionally, documentation may be sought at any time when changes in income are reported.

This public notice is available for review at each county Department of Family and Children Services office and will also be published in regional newspapers and on the Georgia Department of Community Health's website. Citizens wishing to comment in writing on the proposed changes should do so before September 26, 2007, to the Board of Community Health, P.O. Box 38406, Atlanta, Georgia 30334.

Attachment 3:
Public Notice- Co-pay Implementation

PUBLIC NOTICE

Pursuant to 42 C.F.R. § 457.525, the Georgia Department of Community Health is required to give public notice of any significant proposed change in its methods and standards for setting payment rates for services.

Copayments for Medicaid and New Copayments for PeachCare for Kids® Members

Effective for services provided on and after November 1, 2011 and subject to payment at fee-for-service rates, the Department will increase existing Medicaid co-payments to the current definition of nominal as defined in the Code of Federal Regulations 42 C.F.R. § 447.54. Additionally, the same co-payments will be applicable to PeachCare for Kids® members six (6) years of age and older. All other existing copayment exemptions will continue to apply. A copy of the proposed copayment rates is included in this public notice for illustrative purposes.

This action is anticipated to result in savings of approximately $3,397,100 in State funds in SFY 2012.

This public notice is available for review at each county Department of Family and Children Services office. An opportunity for public comment will be held on September 27, 2011, at the Department of Community Health (2 Peachtree Street, N.W., Atlanta, Georgia 30303) in the 5th Floor Board Room at 2:00 pm. Individuals who are disabled and need assistance to participate during this meeting should call (404) 656-4479. Citizens wishing to comment in writing on any of the proposed changes should do so on or before September 30, 2011, to the Board of Community Health, Post Office Box 1966, Atlanta, Georgia 30303.

Comments submitted will be available for review by the public at the Department of Community Health, Monday – Friday, 9:00 a.m. to 4:30 p.m., in Room 4074, 2 Peachtree Street, N.W., Atlanta, Georgia 30303.

Comments from written and public testimony will be provided to the Board of Community Health prior to the October 13, 2011, Board meeting. The Board will vote on the proposed changes at the Board meeting to be held at 10:30 a.m. at the Department of Community Health (2 Peachtree Street, N.W., Atlanta, Georgia 30303) in the 5th Floor Board Room.

NOTICE IS HEREBY GIVEN THIS 8th DAY OF September, 2011

David A. Cook, Commissioner

Medicaid and PeachCare for Kids®
Proposed CoPayment Schedule

Category of Service	Co-Payment	
	Current	Proposed Copayments
Advanced Nurse Practitioners	Cost-Based	
Ambulatory Surgical Centers / Birthing	$3.00	$3.65
Durable Medical Equipment	$2.00 and $3.00	$2.45 and $3.65
Federally Qualified Health Centers	$2.00	$2.45
Free Standing Rural Health Clinic	$2.00	$2.45
Home Health Services	$3.00	$3.65
Hospital-based Rural Health Center	$2.00	$2.45
Inpatient Hospital Services	$12.50	$25.00
Oral Maxillofacial Surgery	Cost-Based	
Orthotics and Prosthetics	$3.00	$3.65
Outpatient Hospital Services	$3.00	$3.65
Pharmacy - Preferred Drugs	$0.50	$0.65
Pharmacy - Non-Preferred Drugs	Cost-Based	
Physician Assistant Services	Cost-Based	
Physician Services	Cost-Based	
Podiatry	Cost-Based	
Vision Care	Cost-Based	

Cost-Based Co-Payment Schedule		
Cost of Service	Current	Proposed
$10.00 or less	$0.50	$0.65
$10.01 to $25.00	$1.00	$1.25
$25.01 to $50.00	$2.00	$2.45
$50.01 or more	$3.00	$3.65

Attachment 4:
Public Notice- Co-pay Decrease/Rounding

PUBLIC NOTICE

Pursuant to 42 C.F.R. § 447.205, the Georgia Department of Community Health is required to give public notice of any significant proposed change in its methods and standards for setting payment rates for services.

NEW CO-PAYMENTS FOR PEACHCARE FOR KIDS® MEMBERS

Effective for services provided on and after April 1, 2012, and subject to payment at fee-for-service rates, the Department will implement co-payments for covered services to PeachCare for Kids® members six (6) years of age and older. These copayments will be consistent with CMS-approved Medicaid co-payments and co-payment exemptions for adults.
This action is anticipated to result in state fund savings of $318,462 in the Amended SFY 2012 budget and $1,273,849 for SFY 2013.

ILLUSTRATIVE CO-PAYMENTS

Ambulatory Surgical Centers / Birthing	$3.00
Durable Medical Equipment	$1.00 or $3.00 (service based)
Federally Qualified Health Centers	$2.00
Free Standing Rural Health Clinic	$2.00
Home Health Services	$3.00
Hospital-based Rural Health Center	$2.00
Inpatient Hospital Services	$12.50
Oral Maxillofacial Surgery	Cost Based
Orthotics and Prosthetics	$3.00
Outpatient Hospital Services	$3.00
Pharmacy - Preferred Drugs	$0.50
Pharmacy - Non-Preferred Drugs	Cost Based
Physician Program Services	Cost Based
Podiatry	Cost Based
Vision Care	Cost Based

COST BASED CO-PAYMENTS

Cost of Service	Proposed Co-Payment
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

This public notice is available for review at each county Department of Family and Children Services office. An opportunity for public comment will be held on December 28, 2011, at 1 p.m. at the Department of Community Health (2 Peachtree Street, N.W., Atlanta, Georgia 30303) in the 5th Floor Board Room at 2:00 pm. Individuals who are disabled and need assistance to participate during this meeting should call (404) 656-4479. Citizens wishing to comment in writing on any of the proposed changes should do so on or before 5:00 p.m. on December 28, 2011, to the Board of

Community Health, Post Office Box 1966, Atlanta, Georgia 30303.
Comments submitted will be available for review by the public at the Department of Community Health, Monday – Friday, 9:00 a.m. to 4:30 p.m., in Room 4074, 2 Peachtree Street, N.W., Atlanta, Georgia 30303.

Comments from written and public testimony will be provided to the Board of Community Health prior to the January 12, 2012, Board meeting. The Board will vote on the proposed changes at the Board meeting to be held at 10:30 a.m. at the Department of Community Health (2 Peachtree Street, N.W., Atlanta, Georgia 30303) in the 5th Floor Board Room.

NOTICE IS HEREBY GIVEN THIS 8th DAY OF DECEMBER, 2011
David A. Cook, Commissioner

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

PUBLIC NOTICE

Pursuant to 47 CFR 457.65, the Georgia Department of Community Health, Medicaid Division, is required to give public notice of any proposed changes that implement cost-sharing charges, increases existing cost-sharing charges, or increases the cumulative cost-sharing maximum for PeachCare for Kids® members.

PeachCare for Kids® Premium Changes

Pursuant to Title XXI of the Social Security Act, PeachCare for Kids® is a jointly funded state and federal insurance program for low-income children. Effective April 1, 2015, the Department will implement an increase in premiums paid for participation in the program. The current premium rates are listed in the chart below.

FPL	One Child	Family Cap
100-150%	$10.00	$15.00
151-160%	$20.00	$40.00
161-170%	$22.00	$44.00
171-180%	$24.00	$48.00
181-190%	$26.00	$52.00
191-200%	$28.00	$56.00
201-210%	$29.00	$58.00
211-220%	$31.00	$62.00
221-230%	$33.00	$66.00
231-235%	$35.00	$70.00

Effective April 1, 2015, the premiums for PeachCare for Kids will change to the following amounts.

FPL	One Child	Family Cap
139%-158%	11.00	$16.00
159%-170%	22.00	$44.00
171%-190%	24.00	$49.00
191%-210%	29.00	$58.00
211%-231%	32.00	$64.00
232%-247%	36.00	$72.00

There is no premium for children under age six.

The estimated State Fiscal Year 2015 fiscal impact is a decrease of $108,474 total funds of which $25,101 is state funds. In State Fiscal Year 2016 the fiscal impact is a decrease of $433,896 of which $25,101 is state funds.

This public notice is available for review at each county Division of Family and Children Services office. An opportunity for public comment will be held on **February 17, 2015** at 10:30 am at the Department of Community Health (2 Peachtree Street, N.W., Atlanta, Georgia 30303) in the 5th Floor Board Room. Individuals who are disabled and need assistance to participate during this meeting should call (404) 656-4479. Citizens wishing to comment in writing on any of the proposed changes should do so on or before **February 24, 2015**, to the Board of Community Health, Post Office Box 1966, Atlanta, Georgia 30301-1966.

Attachment 5:
ACA SPA Updates

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Nathan Deal, Governor

Clyde L. Reese III, Esq., Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

December 2, 2013

Ms. Jennifer Ryan
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

RE: Renewal Waiver Request

Dear Ms. Ryan:

In response to CMS' guidance regarding targeted enrollment strategies that are available to states to help facilitate a streamlined enrollment process for 2014, Georgia requests to amend the CHIP and Medicaid renewal period in order to adopt the MAGI-based eligibility determination methods beginning on January 1, 2014. Georgia would like to extend the CHIP and Medicaid renewal periods.

Georgia requests a waiver under section 1902(e)(14)(A) in order to extend the dates for the state's **CHIP eligibility renewals** scheduled for January 1, 2014 through March 31, 2014 (three (3) months).

Georgia requests a waiver under section 1902(e)(14)(A) in order to extend the dates for the state's **Medicaid eligibility renewals** scheduled for January 1, 2014 through June 30, 2014 (six (6) months).

We believe this extension is needed in order establish income and eligibility determination systems that protect our beneficiaries. In addition, Georgia intends to delay action on income and household changes that may cause a negative adverse action beginning January 1, 2014 until the beneficiary's first regular renewal in 2014.

We are not requesting any modifications to the demonstration's budget neutrality agreement, as budget neutrality will not be affected by this amendment request.

If you have questions about this request, please contact Sheila Alexander for CHIP questions at 404-657-9506 or salexander@dch.ga.gov. Medicaid questions should be directed to Yvonne Greene at 404-463-2135 or ygreene@dch.ga.gov.

Sincerely,

Jerry Dubberly
Medicaid Chief

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

FEB 0 6 2014

Ms. Sheila Alexander
Program Director, Peach Care for Kids
Georgia Department Community Health
2 Peachtree, N.W., 3ih Floor
Atlanta, GA 30303

Dear Ms. Alexander:

I am pleased to inform you that your Title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number GA-13-0017 submitted on November 14, 2013 and related to Modified Adjusted Gross Income (MAGI) Eligibility has been approved with an effective date of January 1, 2014.

Establish 210l(f) Group:
SPA number GA-13-0017 describes the state's plan to provide coverage in its separate CHIP, as specified in the state's submission ofCS14: Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards. A copy of the approved state plan page (CS14) is attached and should be incorporated within a separate subsection under Section 4.1 of Georgia's approved CHIP state plan.

Your Title XXI project officer is Ms. LaVern Baty. She is available to answer questions concerning this amendment. Ms. Baty's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-5480
Facsimile: (410) 786-5882
E-mail: Lavern.Baty@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Baty and to Ms. Jackie Glaze, Associate Regional Administrator, Centers for Medicare & Medicaid Services, Region 4, Division of Medicaid and Children's Health Operations. Ms. Glaze's address IS:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional questions, please contact Ms. Linda Nablo, Director, Division of State Coverage Programs, at (410) 786-5143. We look forward to continuing to work with you and your staff toward the approval of your remaining MAGI Eligibility SPAs.

Sincerely,

Eliot Fishman
Director

Enclosures
cc: Jackie Glaze, ARA, CMS Region IV, Atlanta
Lynette Rhodes, Medicaid Operations, Department of Community Health

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Child Health Insurance Program
Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards CS14

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:

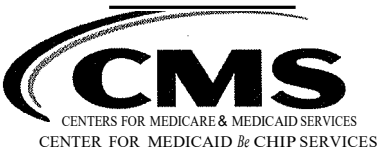
○ Cost sharing is the same as for children in the Medicaid program.

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

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



Children and Adults Health Programs Group

FEB 0 6 2014

Ms. Sheila Alexander
Program Director, Peach Care for Kids
Georgia Department Community Health
2 Peachtree, N.W., 37th Floor
Atlanta, GA 30303

Dear Ms. Alexander:

I am pleased to inform you that your Title XXI Children's Health Insurance Program (CHIP) state plan amendments (SPAs) numbered GA-13-0019 submitted on November 14,2013 and related to Modified Adjusted Gross Income (MAGI) Eligibility has been approved with an effective date of January 1, 2014.

SPA number GA-13-0019 is approved to clarify the state's non-financial eligibility policies on residency, citizenship, social security numbers, substitution of coverage, and non-payment of premiums. Copies of the approved state plan pages are attached and these approved pages supersede sections of Georgia's current state plan as detailed below:

New State Plan Page	Impact on Current State Plan Section
CS17: Non-Financial Eligibility-Residency	Section 4.1.5
CS18: Non-Financial Eligibility-Citizenship	Section4.1.0; 4.1-LR; 4.1.1-LR
CS19: Non-Financial Eligibility-Social Security Number	Section 4.1.9.1
CS20: Non-Financial Eligibility-Substitution of Coverage	Section 4.4.4
CS21: Non-Payment of Premiums	Section 8.7

Your title XXI project officer is Ms. LaVem Baty. She is available to answer questions concerning this amendment. Ms. Baty's contact information is as follows:

Centers for Medicare and Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-5480
Facsimile: (410) 786-5882

Official communications regarding program matters should be sent simultaneously to Ms. Baty and to Ms. Jackie Glaze, Associate Regional Administrator, Centers for Medicare & Medicaid Services, Region 4, Division of Medicaid and Children's Health Operations. Ms. Glaze's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional questions, please contact Ms. Linda Nablo, Director, Division of State Coverage Programs at (410) 786-5143. We look forward to continuing to work with you and your staff toward the approval of your remaining MAGI Eligibility SPAs.

Sincerely,

Eliot Fishman
Director

Enclosures

cc: Jackie Glaze, ARA, CMS Region IV
Lynette Rhodes, Medicaid Operations, Department of Community Health

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).	No
A policy related to individuals in the state only for educational purposes.	No

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

OMB Control Number: 0938-1148
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.	Yes
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.	Yes

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 month following the date that all other eligibility requirements are met and any required premiums are paid. (Citations: Georgia State Plan: Section 2.2, Page 6, Section 4.3, Page 3)

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).	No
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.	No

FEB 0 6 2014

CHIP Eligibility

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

OMB Control Number: 0938-1148
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. Yes

☑ 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.

PRA Disclosure Statement

CHIP Eligibility

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

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Substitution of Coverage **CS20**

457.310(b)(2) and (b)(3), 457.320(a)(9) and 2110(b)(1)(C) of the SSA

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	
+	Waiting Period	A member must wait 2 months	X

A waiting period during which an individual is ineligible due to having dropped group health coverage. Yes

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.
- ■ 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? Yes

CHIP Eligibility

		Describe	
	+	• Employer cancellation of the entire group plan; • Leave of absence without pay, or reduction of work hours; • Cancellation of a private health plan in which cost-sharing is expected to exceed 5% of the family's annual income; • Cancellation of COBRA or an individual insurance policy. • A child born during the two month waiting period.	X
	+		X

☐ 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.

PRA Disclosure Statement

V.20130718

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Non-Payment of Premiums **CS21**

42 CFR 457.570

Non-Payment of Premiums

Does the state impose premiums or enrollment fees? Yes

Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility? Yes

Does the state have a premium lock out period? Yes

Please describe the lock-out period:

A member's coverage can be cancelled due to premium non payment or at the parent's request. When a member's coverage is canceled due to non payment they become "Not Enrolled" with reason of lock out or non payment. The lock out period occurs after the member does not pay premiums for a period of two months, which is also known as the grace period. If the account is cancelled due to non payment, the member's coverage can be reinstated after the one month lockout period or payment of past due premiums, whichever occurs first.

What is the length of the time premium lock-out period?

Select a length of time:

- (•) One month
- ( ) Two months
- ( ) 90 days
- ( ) Other (not to exceed 90 days)

Are there exceptions to the required lock-out period? Yes

- [x] Individual's income decreased to a level where no premium is required or within Medicaid standards
- [ ] Other financial hardship
- [ ] Other

[x] The state assures that:

It does not require the collection of past due premiums or enrollment fees as a condition of eligibility for enrollment once the lock-out period has expired; and

It provides enrollees with an opportunity for an impartial review to address disenrollment from the program in accordance with section 457.1130(a)(3); and

The child will be reenrolled in CHIP during the lock-out period upon payment of past due premiums or enrollment fees.

PRA Disclosure Statement

CHIP Eligibility

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

FEB 2 1 2014

Ms. Sheila Alexander
Program Director, Peach Care for Kids
Georgia Department of Community Health
2 Peachtree, N.W., 37th Floor
Atlanta, GA 30303

Dear Ms. Alexander:

I am pleased to inform you that Georgia's Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), GA-13-0018, submitted on November 14,2013, has been approved. This SPA incorporates the MAGI-based eligibility process requirements in accordance with the Affordable Care Act. The effective date of this SPA is October 1, 2013.

The approval of SPA GA-13-0018 includes full approval of your state's alternative multi-benefit paper application. The state is using an interim alternative single streamlined online application and by December 31, 2014, will implement a revised alternative single streamlined online application that addresses our concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the new state plan pages and attachments to be incorporated within a separate section at the end of Georgia's approved CHIP State Plan:

- CS24
- Attachment 1 -State of Georgia's alternative multi-benefit paper application and health coverage addendum
- Attachment 2 – Statement of use with respect to the alternative single streamlined online application

This approval and the attachments supersede the following sections of the current CHIP State Plan:

- Section 4.3: Single, Streamlined Application Screen and Emoll Process
- Section 4.4: Renewals, Screening by Other Insurance Affordability Programs

CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. Your Title XXI project officer is Ms. Lavern Baty. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Baty's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Blvd.
Baltimore, MD 21244-1850
Telephone: (410) 786-5480
Facsimile: (410) 786-5882
E-mail: Lavern.Baty@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Baty and to Ms. Jackie Glaze, Associate Regional Administrator (ARA) in our Atlanta Regional Office. Ms. Glaze's address is:

Ms. Jackie Glaze
Office of the Regional Administrator
Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

If you have additional questions, please contact Linda Nablo, Director, Division of State Coverage Programs at (410) 786-5143.

We look forward to continuing to work with you and your staff.

Sincerely,

Eliot Fishman
Director

cc: Ms. Jackie Glaze, ARA, CMS Region IV, Atlanta

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

FEB 2 1 2014

Ms. Sheila Alexander
Program Director, P ach Care for Kids
Georgia Department of Community Health
2 Peachtree, N.W., 37th Floor
Atlanta, GA 30303

RE: CS24-Eligibility Process State Plan Amendment (SPA), GA-13-0018

Dear Ms. Alexander:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of Georgia's state plan amendment (SPA) transmittal GA-13-0018, which was submitted to CMS on November 14, 2013. Our review of this submission included a review of the online alternative single streamlined application developed by the state.

Until December 31,2014, the state is using an interim alternative single streamlined online application. This interim application needs to be revised to reflect the following changes.

Necessary Changes	Date by which changes will be completed:
Reference to 6 months in Former Foster Care questions will be removed in the next revision.	July 1, 2014
Questions regarding access to employer-sponsored coverage, beyond what is needed for Medicaid and CHIP, will only be asked of applicants above the inc me limit for Medicaid and CHIP. The information collected regarding access to employer-sponsored coverage will be updated in accordance with the model CMS application.	December 31, 2014

Please submit the revised alternative single streamline online application to CMS for review no later than December 1, 2014, to ensure approval by December 31, 2014. We continue to be available to provide technical assistance. If you have any questions about your application, please contact Victoria Collins at Victoria.Collins@cms.hhs.gov or (410) 786-2167.

We look forward to continuing to work with you and your staff.

Sincerely,

Linda Nablo

Linda Nablo
Director, Division of State Coverage Programs

cc: Ms. Jackie Glaze, ARA, CMS Region IV, Atlanta

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application	☒ Online Application
TRANSMITTAL NUMBER: GA-13-0018	**STATE:** Georgia

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, 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. Yes

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.

☑ 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

V.20130709

Georgia Department of Human Services

Application for Benefits

If you need help filling out this application, ask us or call 1-877-423-4746. If you have a hearing impairment, call GA Relay at 1-800-255-0135. Our services are free.

What Services Do We Offer at the Division of Family and Children Services (DFCS)?

DFCS offers the following services:

Food Assistance

Food Stamps are benefits that you can use to buy food at any store that has the EBT/*Quest* sign. We will subtract the price of your food purchase from your Food Stamp account.

Cash Assistance/Employment Support Services

Temporary Assistance for Needy Families (TANF) provides cash assistance to families with dependent children for a limited time. Parents or caretakers who are included in the grant are required to participate in a work program.
Cash Assistance program also provides financial assistance to refugee households who are not eligible for the TANF program.

Medical Assistance

Medicaid, for those who are eligible, may help pay medical bills, doctor's visits, and Medicare premiums.

Community Outreach Services

For more information about Community Outreach Services, please visit our website at: http://www.dfcs.dhr.georgia.gov or call 1-877-423-4746.

How Do I Apply for Benefits?

Step 1. Fill out the application.

Read the questions carefully and give accurate information. Sign and date the application.

Step 2. Turn in the application. You will need to tear off pages 1 and 2 and keep it for yourself.

Mail, fax, or bring in pages 3-6 of this application to your local Division of family & Children Services (DFCS) office. If you or the person for whom you are applying is eligible for benefits, Food Stamps or TANF benefits will be provided from the date that we receive the application with your name, address, and signature on it.

If you apply for Food Stamps, and/or Medicaid you can file an application for benefits with only your name, address and signature. However, it may help us to process your application quicker if you complete the entire form.

Step 3. Talk with us.

You may need to complete an interview with a case manager. If so, we will give you an appointment. This interview can be completed by phone.

Frequently Asked Questions

How long does it take to get benefits?

Food Stamps:	up to 30 days
TANF:	up to 45 days
Medicaid:	10 to 60 days

You may be able to get Food Stamps within 7 days if you qualify. See page 4.

How much will I get?
Your income, resources, and family size determine benefit amounts. We will be able to give you specific information once we determine your eligibility.

How will I get my benefits?
For Food Stamps and TANF, you will get an Electronic Benefit Transfer (EBT) card to access your benefits.
For Medicaid, you will receive a Medicaid card for each eligible member.

What information will I need to provide?
It is a good idea to provide the following:

- Proof of identity for the applicant if applying for Food Stamps and/or TANF. Proof of identity for everyone requesting Medicaid if applying for Medicaid. Ex: An identification card (ID) or driver's license (DL)
- Proof of US citizenship/qualified immigrant status for everyone requesting benefits
- Social Security numbers of everyone requesting assistance
- Proof of income for example, pay stubs, child support payments, and income award letters
- Proof of expenses like child care receipts, medical bills, medical transportation costs, and child support payments

You will be given time to return any information to our office. If you need help getting this information, please tell us.

How do we use the applicant's personal information?
You only have to provide Social Security Numbers (SSN) and citizenship or immigration status for persons who want to apply for benefits. This information will be used to check the income and eligibility verification system (IEVS). We will also match your information against other Federal, state and local agencies to verify your income and eligibility. If a household member does not want to give us information about their SSN, citizenship, or immigration status, other household members may still receive benefits.

Can someone else apply for me?
Yes, for Food Stamps and Medicaid, you may ask someone to apply for you.
For TANF, anyone can apply but the parent or caretaker must be interviewed.

"In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the **Food and Nutrition Act of 2008** and USDA policy, discrimination is also prohibited on the basis of religion or political beliefs."

To file a complaint of discrimination, you may contact USDA or HHS.

Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9411 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY).

Write HHS, Director, Office of Civil Rights, Room 509-F, 200 Independence Avenue, S.W., Washington, D.C., 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY).

USDA and HHS are equal opportunity providers and employers

You may also file a complaint of Discrimination by contacting the DFCS Civil Rights Program, Two Peachtree Street, N.W., Suite 19-248, Atlanta, Georgia 30303 or call (404) 657-3735 or fax (404) 463-3978.

Under the Department of Community Health (DCH) policy, Medicaid cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or political or religious beliefs. To report Medicaid eligibility or provider discrimination, call the Georgia Department of Community Health's Office of Program Integrity (local 404-463-7590) (toll free) 800-533-0686.

What Do the Words Used in this Application Mean?

This chart explains the words we have used in this application.

Caretaker	A parent, relative or legal guardian who applies for and receives TANF with children in his or her care.
Grantee Relative	A parent, relative or legal guardian who applies for and receives TANF in his or her name on behalf of the children.
Disqualified	The action taken to remove an individual from a Food Stamp or TANF case because they did not tell the truth and received benefits that they should not have received.
Electronic Benefit Transfer (EBT)	The system used in Georgia to pay benefits to individuals who are eligible for Food Stamps or TANF. Individuals receiving assistance are issued an EBT debit card, which is used to withdraw cash benefits and to access their food stamp accounts.
Household Members	Individuals who live in your home.
Income	Payments such as wages, salaries, commissions, bonuses, worker's compensation, disability, pension, retirement benefits, interest, child support or any other form of money received
Migrant Farm Workers	Individuals who are seasonal farm workers and move from one home base to another to work or look for farm work
Resources	Cash, property, or assets such as bank accounts, vehicles, stocks, bonds, and life insurance
Seasonal Farm Workers	Individuals who work at certain times of the year planting, picking or packing produce. They are hired on a temporary basis when a job requires more workers than the farm employs on a regular basis
Trafficking	Selling or trading Food Stamp benefits for profit
Qualified Alien/Immigrant	A *qualified alien/immigrant* is a person who is legally residing in the U.S. who falls within one of the following categories: a person lawfully admitted for permanent residence (LPR) under the Immigration and Nationality Act (INA); *Amerasian* immigrant under section 584 of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988; a person who is granted asylum under section 208 of the INA; *Refugees*, admitted under section 207 of the INA; A person *paroled* into the US under section 212(d)(5) of the INA for at least one year; A person whose *deportation* is being withheld under section 243(h) of the INA as in effect prior to April 1, 1997 , or section 241(b)(3) of the INA, as amended; a person who is granted *conditional entry* under section 203(a)(7) of the INA as in effect prior to April 1, 1980; *Cuban or Haitian* immigrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980; *victims of human trafficking* under section 107(b)(1) of the Trafficking Victims Protection Act of 2000; *battered immigrants* who meet the conditions set forth in section 431 (c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended; *Afghan or Iraqi* immigrants granted special immigrant status under section 101(a)(27) of the INA (subject to specified conditions); *American Indians* born in Canada living in the U.S. under section 289 of the INA or non-citizens of federally-recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and *Hmong or Highland Laotian tribal members* that rendered assistance to U.S. personnel by taking part in military or rescue operation during Vietnam Era (8/05/1964 – 5/07/1975).
Applicant	An individual who chooses to apply for or to receive public assistance/benefits
Non-applicant	An individual who chooses NOT to apply for or to receive public assistance/benefits; non-applicants are not required to provide an SSN, citizenship or immigration status.
Assistance Unit	An assistance unit includes *eligible* individuals who live together and receive public assistance/benefits together.

Georgia Department of Human Services

Application for Benefits



What Am I Applying For? Check all that apply:

- ❑ **Food Stamps**
  The Food Stamp program helps meet the food and nutritional needs of eligible households.

- ❑ **Temporary Assistance for Needy Families (TANF)**
  Temporary Assistance for Needy Families (TANF) provides temporary monthly cash payments, single cash payments, or other support services, to strengthen eligible families with children. If you are the child's parent, or the caretaker who would like to be included in the grant, we will require you to participate in a work program.

- ❑ **Refugee Cash Assistance**
  The Refugee Cash Assistance program provides financial assistance to refugee households who are not eligible for the TANF program. The term refugee includes refugees, Cuban/ Haitian Entrants, victims of human trafficking, Amerasians, and unaccompanied refugee minors.

- ❑ **Medicaid**
  Medicaid offers medical coverage to elderly, blind or disabled adults, pregnant women, children, and families. When you apply, we will look at all Medicaid programs and decide which ones you may be eligible to receive.

Tell Us About The Applicant

Does the applicant or person applying on behalf of the applicant need assistance when communicating with us? If so check all that apply.

( ) TTY ( ) Braille ( ) Large Print ( ) E-mail ( ) Video Relay) ( ) Sign Language Interpreter _____

( ) Foreign Language Interpreter (specify language) _____ ( ) Other _____

Please fill out the chart below about the applicant.

First Name	Middle Initial	Last Name	Suffix
Street Address Where You Live		Apt	
City	State	Zip Code	
Mailing Address (if different)			
City	State	Zip Code	
Home Telephone Number	Other Contact Number	E-Mail address	
Signature	Date		
Witness Signature if signed by 'X'	Date		
For Office Use Only	Date Received By The County		

Do I Qualify to Get Food Stamps Faster?

Answer these questions about the applicant and all household members to see if you can get Food Stamps within 7 days.

1. Are you or any household member a migrant or seasonal farm worker? ❑ Yes ❑ No

2. Total **Gross earned income** that will be received for this month: $_____
   Employer Name _____
   Employment Begin Date _____ Employment End Date _____
   Rate of Pay _____ Hours Worked Weekly _____ wk/bi-wk/semi-mo/mo (circle one)

3. Total **Gross unearned income** that will be received for this month: $_____
   Type of Unearned Income _____ Amount _____ wk/bi-wk/semi-mo/mo (circle one)
   Type of Unearned Income _____ Amount _____ wk/bi-wk/semi-mo/mo (circle one)

4. Total earned and unearned income for this month: $_____

5. How much money do you and all household members have in cash or in the bank? $ _____

6. How much do you and all household members pay for rent or mortgage? $ _____

7. How much do you and all household members pay for electric, water, gas, etc.? $ _____

Can I Choose Someone to Apply for Food Stamps or Medicaid for me?

Complete this section only if you want someone to fill out your application, and/or complete your interview, and/or use your EBT card to buy food when you cannot go to the store. You can choose more than one person.

Name: _____ Phone: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Name: _____ Phone: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____

For Medicaid, do you want this individual to have a copy of your Medicaid card? ❑ Yes ❑ No

Tell Us about the Applicant and All Household Members

Please fill out the chart below about the applicant and all household members. The following federal laws and regulations: The Food and Nutrition Act of 2008, 7 U.S.C. § 2011-2036, 7. C.F.R. § 273.2, 45 C.F.R. § 205.52, 42 C.F.R. § 435.910, and 42 C.F.R. § 435.920, authorize DFCS to request your and your household members social security number(s). If anyone in your household does not want to give us

information about his or her citizenship, immigration status, or social security numbers, then that person can be designated as a non-applicant. This means that the person will not be considered an applicant and will not be eligible for benefits. However, other household members may still be able to receive benefits, if they are otherwise eligible. If you want us to decide whether any household members are eligible for benefits, you will still need to tell us about their citizenship or immigration status and give us their SSN. You will still need to tell us about your income and resources to determine the eligibility and benefit level of the household. Individuals will not be reported to the United States Citizenship and Immigration Services if they do not give us their citizenship or immigration status.

NAME First Middle Initial Last	Relation -ship to You	Is this person applying for benefits? (Y/N)	Birth Date Format (- -/ - -/ - -)	Social Security Number **(Applicants Only)**	Sex (M/F)	Hispanic/ Latino? **(Optional)** (Y/N)	Race Code **(Optional)** (See codes Below)	Are you a U.S citizen, qualified alien/immigrant or Hmong/Highland Laotian Immigrant? **(Applicants only)** (Y/N)
	SELF							

Race Codes (Choose all that apply):
AI – American Indian/Alaska Native **AS** – Asian **BL** – Black/African American
HP – Native Hawaiian/Pacific Islander **WH** – White

By providing Race/Ethnicity information, you will assist us in administering our programs in a non-discriminatory manner. Your household is not required to give us this information and it will not affect your eligibility or benefit level.

Tell Us More about the Applicant and All Household Members

We need more information about the applicant and all household members in order to decide who is eligible for benefits. Please answer only the questions about the benefits you want to receive on the page below.

1. Has anyone received any benefits in another county or state? ❑ Yes ❑ No

   Who:_____
   What: _____
   Where: _____
   When: _____

2. Did anyone in your house hold voluntarily quit a job or voluntarily reduce his/her work hours below 30 hours per week since the last application or review? ❑ Yes ❑ No

   If yes, who quit? _____
   Why did he/she quit? _____

3. Is anyone pregnant? For TANF, please provide proof of pregnancy if available. ❑ Yes ❑ No

(This question does not apply to Food Stamp only applicants)

Who: _____

Due Date: _____

4. Is anyone disqualified from the Food Stamp or TANF Program? ❑ Yes ❑ No

a. Who: _____

b. Where: _____

5. Is anyone trying to avoid prosecution or jail for a felony? (For TANF and FS only) ❑ Yes ❑ No

Who: _____

6. Is anyone violating conditions of probation or parole? (For TANF and FS only) ❑ Yes ❑ No

Who: _____

7. Has anyone been convicted of a drug felony (For TANF and FS only) or violent felony (For TANF only)? ❑ Yes ❑ No

Who: _____

When: _____

I have read and completed everything on this form that applies to the applicant and the applicant's household. I certify, under penalty of perjury, all the information that I provided is true and complete as far as I know. I understand I can be punished by law if I do not tell the complete truth.

_____ _____

Applicant's Signature Date

_____ _____

Authorized Representative's Signature Date

_____ _____

Case Manager's Name and Signature Date

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

Children and Adults Health Programs Group

FEB 2 5 2014

Sheila Alexander
Program Director, Peach Care for Kids
Georgia Department' of Community Health
2 Peachtree Street, N.W., 37th Floor
Atlanta, GA 30303

Dear Ms. Alexander:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) numbered GA-13-0025 submitted on December 11, 2013 and related to Modified Adjusted Gross Income (MAGI) Eligibility has been approved with an effective date of January 1, 2014.

SPA number GA13-0025 converts the state's existing income eligibility standards to MAGI-equivalent standards, by age group, for children covered in its title XXI-funded Medicaid program. A copy of the approved state plan page (CS3) is attached, and should be incorporated into the state's approved CHIP state plan. This page supersedes the current Medicaid expansion Section (4.0) of the current CHIP state plan.

Your title XXI project officer is Ms. LaVern Baty. She is available to answer questions concerning this amendment. Ms. Baty's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-5480
Facsimile: (410) 786-5882
E-mail: Lavern.Baty@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Baty and to Ms. Jackie Glaze, Associate Regional Administrator, Centers for Medicare & Medicaid Services, Region 4, Division of Medicaid and Children's Health Operations. Ms. Glaze's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
Atlanta Federal Center, 4th Floor
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional questions, please contact Ms. Linda Nablo, Director, Division of State Coverage Programs at (410) 786-5143. We look forward to continuing to work with you and your staff toward the approval of your remaining MAGI Eligibility SPAs.

Sincerely,

Eliot Fishman
Director

Enclosures
cc: Jackie Glaze, ARA, CMS Region IV
Lynette Rhodes, Medicaid Operations, Department of Community Health

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)	
+	6	19	113	133	X

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.

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

Children and Adults Health Programs Group

MAR 3 1 2015

Dr. Linda Wiant
Chief of the Medicaid Assistance Plans
State of Georgia, Department of Community Health
2 Peachtree Street, NW, Suite 36450
Atlanta, GA 30303

Dear Dr. Wiant:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number 20, submitted on May 2, 2014, with additional information submitted on March 30, 2015, has been approved. The SPA has an effective date of January 1, 2014.

Through this SPA, Georgia reduces the number of premium bands in the state's CHIP program, PeachCare for Kids, from ten premium bands to six premium bands. The state also updates the federal poverty levels (FPLs) of the premium bands to be consistent with Modified Adjusted Gross Income (MAGI) eligibility levels and adjusts the premium amounts for inflation. This SPA also deletes obsolete information in the CHIP state plan and removes the cap on psychotherapy, which was previously limited to ten hours per month.

As you are aware, Georgia implemented proposed premiums on January 1, 2014 without prior approval by the Centers for Medicare & Medicaid Services (CMS). During review of the SPA, CMS identified errors in the methodology used to collapse the premium bands into fewer categories, which resulted in increasing the premiums for some families. In response, Georgia submitted a corrective action plan to reimburse families for the difference between the approved premiums and the increased premiums charged from January 1, 2014 through March 31, 2015.

Your title XXI project officer is Ms. Cassandra Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Lagorio's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
Facsimile: (410) 786-5943
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and to Ms. Jackie Glaze, Associate Regional Administrator in our Atlanta Regional Office. Ms. Glaze's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional questions, please contact Ms. Kelly Whitener, Director, Division of State Coverage Programs at (410) 786-0719.

We look forward to continuing to work with you and your staff.

Sincerely,

Eliot Fishman
Director

cc: Jackie Glaze, ARA, CMS Region IV

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

Children and Adults Health Programs Group

FEB 0 3 2016

Dr. Linda Wiant
Chief of the Medicaid Assistance Plans
State of Georgia, Department of Community Health
2 Peachtree Street, NW, Suite 36450
Atlanta, GA 30303

Dear Dr. Wiant:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) GA-15-0021, submitted on December 31, 2015, has been approved. Through this SPA, Georgia eliminates its Express Lane Eligibility (ELE) program. This SPA has an effective date of April 1, 2016. ELE is also eliminated in Medicaid, effective March 31, 2016.

Georgia implemented ELE on April 1, 2011 through a partnership with the Special Nutritional Assistance Program for Women, Infants, and Children (WIC). Georgia's ELE program is no longer needed due to the implementation of the state's integrated human services and health programs eligibility system, which assesses individuals' eligibility for Medicaid, CHIP, WIC and other programs through a single application.

Your title XXI project officer is Ms. Cassie Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Lagorio's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
Facsimile: (410) 786-5943
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and to Ms. Jackie Glaze, Associate Regional Administrator in our Atlanta Regional Office. Ms. Glaze's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

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7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

JAN 04 2018

Ms. Sheila Alexander
Program Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Ms. Alexander:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number GA-17-0024 submitted on November 7, 2017 has been approved. Through this SPA, Georgia adds non-emergency medical transportation, case management services, and enabling services as covered benefits under the CHIP state plan. This SPA has a retroactive effective date of July 1, 2017.

Your title XXI project officer is Ms. Cassie Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Lagorio's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and to Mr. Charles Friedrich, Acting Associate Regional Administrator (ARA) in our Atlanta Regional Office. Mr. Friedrich's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

If you have additional questions, please contact Mr. Manning Pellanda, Director, Division of State Coverage Programs at (410) 786-5143.

We look forward to continuing to work with you and your staff.

Sincerely,

Anne Marie Costello
Acting Director

cc: Jackie Glaze, ARA, CMS Region IV

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

Children and Adults Health Programs Group

MAR 22 2018

Ms. Sheila Alexander
Program Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37[111] Floor
Atlanta, GA 30303

Dear Ms. Alexander:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number GA-18-0025, submitted on February 20, 2018, has been approved. This SPA has a retroactive effective date of July 1, 2017.

Through this SPA, Georgia eliminates its one-month premium lock-out period and makes technical changes to the disenrollment procedures in Section 8.7 of the CHIP state plan. A copy of the approved CS21 page is attached to be incorporated into the state's approved CHIP state plan. This page supersedes the previous CS21 that was approved on February 6, 2014.

Your title XXI project officer is Ms. Cassie Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Lagorio's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and to Mr. Charles Friedrich, Acting Associate Regional Administrator (ARA) in our Atlanta Regional Office. Mr. Friedrich's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

We look forward to continuing to work with you and your staff.

Sincerely,

Anne Marie Costello
Director

cc: Charles Friedrich, Acting ARA, CMS Region IV

CHIP Eligibility

State Name: Georgia

OMB Control Number: 0938- 1148

Transmittal Number: GA - 18 - 0025

42 CFR 457.570

Non-Payment of Premiums

Does the state impose premiums or enrollment fees? Yes

Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility? Yes

Does the state have a premium lock out period? No

[X] The state assures that it provides enrollees with an opportunity for an impartial review to address disenrollment from the program in accordance with section 457.1130 (a)(3).

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.20160722

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Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

JUN 28 2018

Ms. Sheila Alexander
Program Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Ms. Alexander:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), GA-18-0026, has been approved. GA-18-0026 implements mental health parity regulations at 42 CFR 457.496 to ensure that treatment limitations and financial requirements applied to mental health and substance use disorder benefits are no more restrictive than those applied to medical/surgical benefits. This SPA has an effective date of October 2, 2017.

Section 2103(c)(6)(B) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(b), provides that if CHIP coverage includes Early, Periodic Screening, Diagnostic and Treatment (EPSDT) as defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the state plan will be deemed to satisfy parity requirements. Georgia has provided the necessary assurances and supporting documentation that EPSDT is covered under Georgia's CHIP program and provided in accordance with sections 1905(r) and 1902(a)(43) of the Act.

This approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

Your title XXI project officer is Ms. Cassie Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Lagorio's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services, Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and to Ms. Shantrina Roberts, Associate Regional Administrator (ARA) in our Atlanta Regional Office. Ms. Roberts's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional questions or concerns, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs, at (410) 786-0721. We look forward to continuing to work with you and your staff.

Sincerely,

Anne Marie Costello
Director

cc: Shantrina Roberts, ARA, CMS Region IV

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

Children and Adults Health Programs Group

SEP 13 2018

Ms. Stefanie Ashlaw
Interim Director, PeachCare for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Ms. Ashlaw:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number GA-18-0027, submitted on July 16, 2018, has been approved. Through this SPA, Georgia updates its review process for eligibility and enrollment matters to be consistent with the state's Medicaid appeals process. This approval relates only to reviews conducted under the CHIP state plan and does not indicate approval of the Medicaid eligibility and enrollment appeals process. This SPA has an effective date of July 1, 2018.

Your title XXI project officer is Ms. Cassie Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Lagorio's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services, Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and to Ms. Shantrina Roberts, Associate Regional Administrator (ARA) in our Atlanta Regional Office. Ms. Roberts's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional questions or concerns, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs, at (410) 786-0721. We look forward to continuing to work with you and your staff.

Sincerely,

Anne Marie Costello
Director

cc: Shantrina Roberts, ARA, CMS Region IV

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

Children and Adults Health Programs Group

JAN 1 7 2019

Ms. Stefanie Ashlaw:
Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Ms. Ashlaw:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), GA-18-0028, has been approved. GA-18-0028 demonstrates compliance with the CHIP managed care regulations at 42 CFR 457, Subpart L for utilization of a managed care delivery system. This SPA has an effective date of July 1, 2018.

Sections 2101(a), 2103(f)(3), 2107(b), and 2107(e) of the Social Security Act, as implemented through regulations at 42 CFR 457 Subpart L, describe the application of managed care requirements to CHIP. Georgia has provided the necessary assurances indicating that the state complies with the managed care requirements in the delivery of CHIP services and benefits covered under the state's separate child health plan as of July 1, 2018.

This SPA approval does not substitute for CMS review of any contracts between the state and managed care entities that serve the state's CHIP populations. All managed care contracts for CHIP populations in effect as of the state fiscal year beginning on or after July 1, 2018 must comply with the CHIP managed care regulations and be submitted for CMS review.

Your title XXI project officer is Ms. Cassie Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and to Ms. Shantrina Roberts, Associate Regional Administrator (ARA) in our Atlanta Regional Office. Ms. Roberts's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

We look forward to continuing to work with you and your staff.

Sincerely,

Anne Marie Costello
Director

cc: Ms. Shantrina Roberts, ARA, CMS Region IV, Atlanta

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services 7500 Security Boulevard,
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

May 7, 2020

Lynnette R. Rhodes, Esq.
Executive Director, Medical Assistance Plans Department of Community Health
2 Peachtree Street, 36th Floor Atlanta, Georgia 30303

Dear Ms. Rhodes:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) GA- 20-0029, submitted on April 10, 2020, has been approved. This amendment provides temporary adjustments to the state's enrollment and redetermination policies and cost sharing requirements in response to disaster events. This amendment has an effective date of March 1, 2020.

This amendment, as it applies to the COVID-19 public health emergency, makes the following changes effective March 1, 2020 through the duration of the emergency declaration, unless otherwise noted below:

- Waive requirements related to timely processing of applications;
- Waive requirements related to timely processing of renewals;
- Delay acting on changes in circumstances affecting eligibility, other than changes related to residency, death, voluntary termination of coverage, erroneous eligibility determinations, and becoming eligible for Medicaid;
- Waive all premiums and premium balances;
- Waive copayments for any in vitro diagnostic product described in section 2103(c)(10) of the Social Security Act and any other COVID-19 testing-related services, effective March 18, 2020; and
- Waive copayments for all other services, effective May 1, 2020.

In the event of a future disaster, this SPA provides Georgia with the authority to implement the approved, temporary policy adjustments by simply notifying CMS of its intent, the effective date and duration of the provision, and a list of applicable Governor or federally-declared disaster or emergency areas. While the state must provide notice to CMS, this option provides an administratively streamlined pathway for the state to effectively respond to an evolving disaster event.

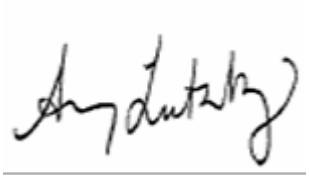
Your title XXI project officer is Jack Mirabella. They are available to answer questions concerning this amendment and other CHIP-related issues. Their contact information is as follows:

Centers for Medicare & Medicaid Services Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16 Baltimore, MD 21244-1850
Telephone: (410) 786-0435

E-mail: holly.mirabella@cms.hhs.gov

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

Sincerely,



Amy Lutzky

Acting Deputy Director

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

Children and Adults Health Programs Group

October 13, 2020

Lynnette R. Rhodes, Esq.
Executive Director, Medical Assistance Plans
Department of Community Health
2 Peachtree Street, 36th Floor
Atlanta, GA 30303

Dear Ms. Rhodes:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number GA-20-0030, has been approved. Through this SPA, Georgia has demonstrated compliance with section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. This SPA has an effective date of October 24, 2019.

Section 5022 of the SUPPORT Act added Section 2103(c)(5) to the Social Security Act (the Act) and requires child health and pregnancy related assistance to include coverage of services necessary to prevent, diagnose, and treat a broad range of behavioral health symptoms and disorders. Additionally, Section 2103(c)(5)(B) of the Act requires that these behavioral health services be delivered in a culturally and linguistically appropriate manner. Georgia demonstrated compliance by providing the necessary assurances and benefit descriptions that the state covers a range of behavioral health services in a culturally and linguistically appropriate manner.

Your Project Officer is Jack Mirabella. They are available to answer your questions concerning this amendment and other CHIP-related matters. Their contact information is as follows:

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

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

Sincerely,

Amy Lutzky
Acting Deputy Director

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

Children and Adults Health Programs Group

March 10, 2022

Stefanie Ashlaw
Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Ms. Ashlaw:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number GA-22-0031, submitted on February 25, 2022, has been approved. Through this SPA, Georgia has demonstrated compliance with the American Rescue Plan Act of 2021 (ARP). This SPA has an effective date of March 11, 2021 and extends through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period, as described in section 1135(g)(1)(B) of the Social Security Act.

Section 9821 of the ARP amended sections 2103(c)(11)(B) and 2103(e)(2) of the Act to mandate coverage of COVID-19 testing, treatment, and vaccines and their administration without cost-sharing or amount, duration, or scope limitations. Sections 2103(c)(11)(B) and 2103(e)(2) of the Act also require states to cover, without cost sharing, the treatment of conditions that may seriously complicate COVID- 19 treatment, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19. The state provided the necessary assurances to demonstrate compliance with the ARP in accordance with the requirements of sections 2103(c)(11)(B) and 2103(e)(2) of the Act. In addition, Georgia has elected to waive all copayments for all benefits for the duration of this SPA.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 457.65 that the state submit SPAs that are related to the COVID-19 public health emergency by the end of the state fiscal year in which they take effect. CMS is allowing states that submit SPAs after the last day of the state fiscal year to have an effective date in the prior state fiscal year, but no earlier than the effective date of the public health emergency. Georgia requested a waiver to obtain an earlier effective date and this letter approves the state's request for an effective date of March 11, 2021.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

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

Sincerely

Amy Lutzky Deputy Director
On Behalf of Anne Marie Costello, Deputy Director Center for Medicaid and CHIP Services

cc: Courtney Miller, Director, Medicaid and CHIP Operations Group
Jackie Glaze, Deputy Director, Medicaid and CHIP Operations Group

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Children and Adults Health Programs Group

August 25, 2022

Stefanie Ashlaw
Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Ms. Ashlaw:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number GA-22-0032, submitted on May 20, 2022, has been approved. This SPA is a companion to Georgia's Medicaid SPA, GA-22-0004, that was previously approved on August 11, 2022.

Through this SPA, Georgia implements the Express Lane Eligibility option established under section 2107(e)(1)(H) of the Social Security Act (the Act), which cross references to 1902(e)(13) of the Act. Section 1902(e)(13) of the Act permits states to rely on findings from an Express Lane agency to conduct simplified eligibility determinations and facilitate enrollment in Medicaid and CHIP. This SPA has an effective date of October 1, 2022.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

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

Sincerely,

Amy Lutzky
Deputy Director

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

Children and Adults Health Programs Group

October 26, 2022

Stefanie Ashlaw
Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Ms. Ashlaw:
Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number 22-0033, submitted on September 8, 2022, has been approved. Through this SPA, Georgia provides 12 months of continuous postpartum coverage to individuals enrolled in its separate CHIP, pursuant to section 9822 of the American Rescue Plan Act of 2021 (ARP). This SPA has an effective date of November 1, 2022 and extends through March 31, 2027, and is a companion to the Medicaid continuous postpartum coverage SPA, GA-22-0005-PPPG.

Section 9822 of the ARP added section 2107(e)(1)(J) to the Social Security Act, which requires states to provide continuous eligibility throughout an individual's pregnancy and 12-month postpartum period in CHIP if the state has elected this option in Medicaid. In Georgia, these provisions apply to targeted low income children who are pregnant. In addition, this SPA updates section 6.2.9 of the CHIP state plan to provide lactation services for pregnant and postpartum individuals.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16 Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (443) 934-2064. We look forward to continuing to work with you and your staff.

Sincerely,

Sarah deLone Director

Separate Child Health Insurance Program
CS27
General Eligibility - Continuous Eligibility

Mandatory 12-Month Postpartum Continuous Eligibility in CHIP for States Electing This Option in Medicaid

At state option in Medicaid, states may elect to provide continuous eligibility for an individual's 12-month postpartum period consistent with section 1902(e)(16) of the SSA. If elected under Medicaid, states are required to provide the same continuous eligibility and extended postpartum period for pregnant individuals in its separate CHIP. A separate CHIP cannot implement this option if not also elected under the Medicaid state plan.

State elected the Medicaid option to provide continuous eligibility through the 12- month postpartum period Yes

The 12-month postpartum continuous eligibility applies for the period beginning on the effective date of this SPA (no earlier than April 1, 2022) and is available through March 31, 2027.

[X] The state assures the extended postpartum period available to pregnant targeted low-income children or targeted low-income pregnant women under section 2107(e)(1)(J) of the SSA is provided consistent with the following provisions:

[X] Individuals who, while pregnant, were eligible and received services under the state child health plan or waiver shall remain eligible throughout the duration of the pregnancy (including any period of retroactive eligibility) and the 12-month postpartum period, beginning on the day the pregnancy ends and ending on the last day of the 12th month consistent with paragraphs (5) and (16) of section 1902(e) of the SSA

[X] Continuous eligibility is provided to targeted low income children who are pregnant or targeted low-income pregnant women (if applicable) who are eligible for and enrolled under the state child health plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:

- The individual or representative requests voluntary disenrollment.
- The individual 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 the individual.
- The individual dies.

Unlike continuous eligibility for children, states providing the 12-month postpartum period may not end an individual's continuous eligibility due to non-payment of premiums or becoming eligible for Medicaid.

[X] Consistent with section 2107(e)(1)(J) of the SSA, the state assures that continuous eligibility is provided through an individual's pregnancy and 12-month postpartum period regardless of non-payment of premiums, or an individual becoming eligible for Medicaid.

[X] Benefits provided during the 12-month postpartum period must be the same scope of comprehensive services consistent with the benefit package elected by the state under section 2103(a) of the SSA that is available to targeted low income children and/or targeted low-income pregnant women and may include additional benefits as described in Section 6 of the CHIP state plan.

Optional Continuous Eligibility for Children

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. No

PRA Disclosure Statement

V.20220204

November 21, 2023

Stefanie Ashlaw
Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Stefanie Ashlaw:
Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendments (SPAs) GA-23-0034 and GA-23-0035, submitted on November 3, 2023, have been approved. These SPAs have an effective date of January 1, 2024, and are companions to the Medicaid lawfully residing coverage SPA, GA-23-0002-VLP.

Through these SPAs, Georgia expands coverage to otherwise eligible lawfully residing, noncitizen targeted low-income children under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009.

A copy of the approved CS18 state plan page is attached to be incorporated into the state's approved CHIP state plan. This page supersedes the previous CS18 that was approved on February 6, 2014.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16 Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (443) 934-2064. We look forward to continuing to work with you and your staff.

Sincerely,

Sarah deLone Director

State Name: Georgia

OMB Control Number: 0938-1148

Transmittal Number: GA - 23 - 0034

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.
Yes

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date Yes 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 Yes in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3).

Otherwise, eligible children means children meeting the eligibility requirements of targeted low-income children with the exception of non-citizen status.

✓ The CHIP Agency provides assurance that lawfully residing children are also covered under the state's Medicaid program.

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.

 An individual is considered to be lawfully residing in the United States if he or she is lawfully present and meets state residency requirements.

 An individual is considered to be lawfully present in the United States if he or she is:

1. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings.

4. A non-citizen who belongs to one of the following classes:

   (i) Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively.

   (ii) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization.

   (iii) Granted employment authorization under 8 CFR 274a.12(c);

   (iv) Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended.

   (v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President.

   (vi) Granted Deferred Action status.

   (vii) Granted an administrative stay of removal under 8 CFR 241;

   (viii) Beneficiary of approved visa petition who has a pending application for adjustment of status.

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231,or under the Convention Against Torture, who:

   (i) Has been granted employment authorization; or

   (ii) Is under the age of 14 and has had an application pending for at least 180 days.

6. Has been granted withholding of removal under the Convention Against Torture.

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C.1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012, memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

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.20160722

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

Children and Adults Health Programs Group

February 28, 2024

Stefanie Ashlaw
Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor

Atlanta, GA 30303

Dear Stefanie Ashlaw:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) GA-24-0037, submitted on February 2, 2024, has been approved. This SPA has an effective date of July 1, 2023.

Through this SPA, Georgia updates its process for health services matters reviews to be consistent with the state's managed care appeals process and for the state's CHIP review process to demonstrate compliance with requirements at 42 CFR §§ 457.1120 – 457.1180.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (443) 934-2064. We look forward to continuing to work with you and your staff.

Sincerely,

Sarah deLone
Director

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

Children and Adults Health Programs Group

February 28, 2024

Stefanie Ashlaw
Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Stefanie Ashlaw:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number GA-24-0038, submitted on February 2, 2024, has been approved. Through this SPA,

Georgia has demonstrated compliance with the longstanding requirement in regulations at 42 CFR §§ 457.410(b)(2) and 457.520(b)(4) to cover age-appropriate vaccines. This SPA has an effective date of October 1, 2023.

Current regulations at 42 CFR §§ 457.410(b)(2) and 457.520(b)(4) require states to cover age-appropriate vaccines and their administration in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) without cost sharing. The state provided the necessary assurances to demonstrate compliance with both requirements.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

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

Sincerely,

Sarah deLone
Director

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

Children and Adults Health Programs Group

March 13, 2024,

Stefanie Ashlaw
Director, Peach Care for Kids
State of Georgia, Department of Community Health
2 Peachtree Street, NW, 37th Floor
Atlanta, GA 30303

Dear Stefanie Ashlaw:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) GA-24-0036, submitted on January 16, 2024, has been approved. This SPA has an effective date of July 1, 2023.

Through this SPA, Georgia updates its strategic objectives and performance goals related to:

- increasing CHIP enrollment;
- increasing access to care;
- promoting utilization of preventive care;
- increasing access to behavioral health services; and
- improving beneficiary satisfaction with care.

To measure progress on these goals, the state will utilize claims data, CAHPS survey data, and eligibility or enrollment data. This SPA also removes outdated objectives and goals from section 9 of the state plan.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (443) 934-2064. We look forward to continuing to work with you and your staff.

Sincerely,

Sarah deLone
Director

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services 7500 Security Boulevard,
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

June 27, 2024

Stefanie Ashlaw
Director, Peach Care for Kids
State of Georgia, Department of Community Health 2 Martin Luther King Jr. Drive, SE
19th Floor, East Tower Atlanta, GA 30334

Dear Stefanie Ashlaw:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number GA-24-0040, submitted on April 4, 2024, has been approved. This SPA has an effective date of March 1, 2024. This SPA is a companion to Georgia's Medicaid SPA submittal GA-24- 0002 that was previously approved on June 7, 2024.

Through this SPA, Georgia expands its Express Lane Eligibility agencies to include Childcare, Refugee Cash Assistance, and the Supplemental Nutrition Program for Women, Infants and Children. Section 2107(e)(1)(H) of the Social Security Act (the Act), which cross references to 1902(e)(13) of the Act, permits states the option to rely on findings from an Express Lane Eligibility agency to conduct simplified eligibility determinations and facilitate enrollment in Medicaid and CHIP.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16 Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

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

Sincerely,

Sarah deLone Director

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

Children and Adults Health Programs Group

July 22, 2024

Stefanie Ashlaw
Director, Peach Care for Kids
State of Georgia, Department of Community Health 2
Martin Luther King Jr. Drive, SE
19th Floor, East Tower Atlanta,
GA 30334

Dear Stefanie Ashlaw:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number GA-24-0039, submitted on February 8, 2024 with additional information received on July 16, 2024, has been approved. The companion SPA number GA-24-0041, submitted on May 2, 2024 has also been approved. The effective dates for these SPAs are January 1, 2024 and October 1, 2024, respectively.

Through GA-24-0039, Georgia provides 12 months of continuous eligibility (CE) coverage to individuals enrolled in its separate CHIP, pursuant to section 5112 of the Consolidated Appropriations Act, 2023 (CAA, 2023). Section 5112 of the CAA, 2023 amended titles XIX and XXI of the Social Security Act to require that states provide 12 months of CE for children under the age of 19 in Medicaid and CHIP. In Georgia, this provision applies to targeted low-income children. Further, Georgia confirms the state will not disenroll children from coverage due to late premium payments during or at the end of the CE period. A copy of the approved CS21 and CS27 state plan pages are attached to be incorporated into the state's approved CHIP state plan.

Through GA-24-0041, Georgia is aligning section 8.7 with companion SPA GA-24-0039 to update the description of timeframes, notice requirements, and consequences for an enrollee or applicant who does not pay a cost sharing charge. Also through this SPA, the state waives the collection of all CHIP premiums through September 30, 2024 and resumes premium collection effective October 1, 2024.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

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

Sincerely,

Sarah deLone Director

CHIP Eligibility

State Name: Georgia

OMB Control Number: 0938-1

Transmittal Number: GA - 24 - 0039

Separate Child Health Insurance Program Non-Financial Eligibility - Non-Payment of Premiums	**CS21**
42 CFR 457.570	
Non-Payment of Premiums	
Does the state impose premiums or enrollment fees?	Yes
Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility?	No

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.

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CHIP Eligibility

State Name: Georgia
Transmittal Number: GA - 24 - 0039

OMB Control Number: 0938- 1148

Separate Child Health Insurance Program
General Eligibility - Continuous Eligibility

CS27

2107(e)(1)(K) of the SSA and 42 CFR 457.342 and 435.926; 2107(e)(1)(J) and 1902(e)(16) of the SSA

Mandatory 12-Month Postpartum Continuous Eligibility in CHIP for States Electing This Option in Medicaid

At state option in Medicaid, states may elect to provide continuous eligibility for an individual's 12-month postpartum period consistent with section 1902(e)(16) of the SSA. If elected under Medicaid, states are required to provide the same continuous eligibility and extended postpartum period for pregnant individuals in its separate CHIP. A separate CHIP cannot implement this option if not also elected under the Medicaid state plan.

State elected the Medicaid option to provide continuous eligibility through the 12- month postpartum period Yes ☐

☒ The state assures the extended postpartum period available to pregnant targeted low-income children or targeted low-income pregnant women under section 2107(e)(1)(J) of the SSA is provided consistent with the following provisions:

☒ Individuals who, while pregnant, were eligible and received services under the state child health plan or waiver shall remain eligible throughout the duration of the pregnancy (including any period of retroactive eligibility) and the 12-month postpartum period, beginning on the day the pregnancy ends and ending on the last day of the 12th month consistent with paragraphs (5) and (16) of section 1902(e) of the SSA

☒ Continuous eligibility is provided to targeted low-income children who are pregnant or targeted low-income pregnant women (if applicable) who are eligible for and enrolled under the state child health plan through the end of the 12-month postpartum period who would otherwise lose eligibility because of a change in circumstances, unless:

☐ The individual or representative requests voluntary disenrollment.

☐ The individual 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 the individual.

☐ The individual dies.

Unlike continuous eligibility for children, states providing the 12-month postpartum period may not end an individual's continuous eligibility due to becoming eligible for Medicaid.

☒ Consistent with section 2107(e)(1)(J) of the SSA, the state assures that continuous eligibility is provided through an individual's pregnancy and 12-month postpartum period regardless of an individual becoming eligible for Medicaid.

☒ Benefits provided during the 12-month postpartum period must be the same scope of comprehensive services consistent with the benefit package elected by the state under section 2103(a) of the SSA that is available to targeted low-income children and/or targeted low-income pregnant women and may include additional benefits as described in Section 6 of the CHIP state plan.

CHIP Eligibility

Mandatory Continuous Eligibility for Children

The CHIP Agency must provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, for a 12-month continuous eligibility period.

☒ Consistent with section 2107(e)(1)(K) of the SSA, the state assures that continuous eligibility is provided to its targeted low-income children for a duration of 12 months, regardless of any changes in circumstances, unless:

- ☐ The child attains 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.
- ☐ The child becomes eligible for Medicaid.

The state elects to provide coverage to the from-conception-to-end-of-pregnancy (FCEP) population (otherwise known as the "unborn").

No

PRA Disclosure Statement

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