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

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

State/Territory:

Wyoming

(Name of State/Territory)

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

/s/

Brent D. Sherard, M.D., M.P.H., Director and State Health Officer
Wyoming Department of Health

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

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

Name: Patricia Guzman	Position/Title: CHIP Director
Name: Kellie Grady	Position/Title: Deputy CHIP Director
Name:	Position/Title:

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

Original State Plan:
Effective Date: 4/1/99
Implementation Date: 12/1/99

Amendment #1:
Effective Date: June 13, 2001
Implementation Date: Not implemented

Amendment #2:
Effective Date: July 1, 2002
Implementation Date: July 1, 2002

Amendment #3:
Effective Date: July 1, 2003
Implementation Date: July 1, 2003

Amendment #4:
Effective Date: July 1, 2005
Implementation Date: July 1, 2005

Amendment #5:
Effective Date: July 1, 2007
Implementation Date: July 1, 2007

Amendment #6:
Effective Date: October 1, 2009
Implementation Date: October 1, 2009

Amendment #7
Mental Health Parity, Medically Necessary Orthodontia & Medically Necessary & Dental Services
Effective Date: July 1, 2010
Implementation Date: July 1, 2010

Prospective Payment System to FQHC's and RHC's
Effective date: October 1, 2009
Implementation date: September 1, 2010

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

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

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

The Department of Health, Children's Health Insurance Program Office has primary responsibility for the operation of Kid Care CHIP. Wyoming has very little to no managed care in the state. Because of this Wyoming will rely primarily on one insurance plan for coverage under Kid Care CHIP.

An RFP is issued to private health insurance carriers every two to three years. Carriers are asked to propose plans that provide the **required** basic level of benefits that was set by Wyoming state statute and the Health Benefits Committee. A contract is awarded to one insurance company that in its proposal best addresses: price, level of benefits, provider network, outreach efforts, cost sharing, marketing, member rights, access to care, grievance procedures and continuation of a private pay basis if the family ceases to be eligible for CHIP.

Financing for Kid Care CHIP will be through Federal CHIP allotments matched by State General Funds.

Kid Care CHIP will follow the process described in the State Health Official letter (Page 3 – Supplemental Payments to FQHC and RHC Managed Care Subcontractors) to pay the supplemental payments to these organizations. Kid Care CHIP will be implementing an APM as part of this PPS requirement utilizing the Medicaid PPS rates that are already established in the state.

The supplemental payment amount will be calculated as follows:

- Our Contractor will pay their regular negotiated rate for each claim (so if they normally pay $85 for an office visit then they will pay $85). The Health plan will reimburse less than the APM and the supplement will pay up to PPS
- Then, each quarter, the contractor will run a report for Kid Care CHIP that shows every claim for each FQHC and RHC in the state and what they paid.
- Kid Care CHIP will then take the Medicaid PPS rate that is already established and compare that to the rate that contractor paid.
- Kid Care CHIP will then calculate what is owed based on the difference between what is paid by the contractor and what the PPS rate is. (If the contractor paid $85 to an FQHC and the PPS rate is $210.00, then Kid Care CHIP will pay $125.55 difference)
- Kid Care CHIP will then pay the FQHC or RHC a lump sum payment every four months to make up this difference of all claims paid by the contractor in the last quarter.

The FQHC's and RHC's have been sent information and agreements to sign. They are due back by August 16, 2010. We have been in contact with them and have not heard of any disagreements to date.

State funding will come from State General Funds. The General Funds appropriated for the PPS payment system are funds that are specifically allocated to the Department of Health, Kid Care CHIP program.

Kid Care CHIP will be implementing this process with payments effective in September 2010. This change is being made as the system to make the payments will not be ready on July 1, 2010 as originally expected.

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

~~First Level of Benefits: Services furnished in a hospital, including a state-operated mental hospital; a residential or other 24-hour therapeutically planned structural service; or a partial hospitalization program are covered. Twenty-one days of inpatient mental health benefits are covered per benefit year. Partial hospitalization benefits may be exchanged for inpatient days at a rate of one inpatient day for two partial treatment days. A partial hospitalization program that is operated by a hospital shall comply with the standards for a partial hospitalization program that are published by the American Association for Partial Hospitalization.~~

~~The following specific limitations apply to coverage depending upon the child's diagnosis and the treatment setting. A child who has applied for or been found eligible for Kid Care CHIP prior to becoming a patient in an IMD will be covered by Kid Care CHIP within the individual benefit limits specified in this section. However, a child who is a patient in an institution for mental disease who did not apply for Kid Care CHIP prior to admission is not eligible for Kid Care CHIP until he or she is discharged from the IMD.~~

~~No limits to inpatient mental health shall be imposed on children diagnosed with the following disorders as defined by the American Psychiatric Association: Schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, autism.~~

~~Second Level of Benefits:~~

~~The second level of benefits provides for an additional nine (9) days of care, for a total of thirty (30) days per benefit year, with pre-approval and case management by the Insurance Company. The insurance Company will work closely with the provider to ensure treatment plans are in place and managed.~~

Mental Health or substance abuse disorders diagnosed will be covered. Mental Health or substance abuse benefits will be provided in parity with meidcal/surgical benefits to the extent provided in the following categories: inpatient, outpatient, in-network, out of network, emergency and prescription drugs.

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

~~First Level of Benefits: Professional outpatient mental health services up to a maximum of twenty visits per year are covered. The visits can be furnished in a variety of community based settings or in a mental hospital.~~
~~Partial hospitalization benefits are paid as described in the inpatient mental health benefits section.~~

~~No limits to outpatient mental health benefits shall be imposed on children diagnosed with the following disorders as defined by the American Psychiatric Assoc:~~
~~Schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, autism.~~

~~Second Level of Benefits:~~

~~The second level of benefits provides for an additional twenty (20) outpatient visits per benefit year, for a total of forty (40) days per benefit year, with pre-approval and case management by the insurance Company. The insurance company will work closely with the provider to ensure treatment plans are in place and managed. Providers will have the capability to bill for partial (30 minutes or less) and full (more than 30 minutes) sessions. This capability only applies to the second level of benefits.~~

Mental Health or substance abuse disorders diagnosed will be covered. Mental Health or substance abuse benefits will be provided in parity with meidcal/surgical benefits to the extent provided in the following categories: inpatient, outpatient, in-network, out of network, emergency and prescription drugs.

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

Kid Care CHIP will provide a State Defined Dental Benefit Package. This package will include requirements from section 2103(c)(5) of CHIPRA, including "coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions."
Benefits include:
Exams, cleanings, bitewing x-rays, fluoride treatments, sealants, full mouth x-rays, space maintainers, fillings, simple extractions, gold or porcelain crowns for teenagers with adult or permanent dentition, full mouth debridement for teenagers with permanent dentition, partials for teenagers with permanent dentition and missing anterior teeth, sedation for younger children, emergency treatment for the relief of pain, medically necessary dental services and medically necessary orthodontics. Annual maximum is $1,000 per benefit year. Preventive and diagnostic services (Exams, cleanings, fluoride, space maintainers, sealants and x-rays) are subject only to frequency limitations and are not included in the child's yearly benefit maximum. The $1,000 is not a hard cap and medically necessary dental services will be covered above the $1,000 annual maximum with pre-authorization.

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

~~The combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 in a 12-month period, until a lifetime inpatient maximum benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000. Costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract and are not subject to the lifetime limits.~~

Mental Health or substance abuse disorders diagnosed will be covered. Mental Health or substance abuse benefits will be provided in parity with meidcal/surgical benefits to the extent provided in the following categories: inpatient, outpatient, in-network, out of network, emergency and prescription drugs.

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

~~The combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 in a 12 month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000. Costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract and are not subject to the lifetime limits.~~

Mental Health or substance abuse disorders diagnosed will be covered. Mental Health or substance abuse benefits will be provided in parity with meidcal/surgical benefits to the extent provided in the following categories: inpatient, outpatient, in-network, out of network, emergency and prescription drugs.

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

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

There are three levels of cost sharing: Plan A for enrollees up to 100% of the federal poverty level & Native American Children; Plan B for enrollees 101% through 150% of the federal poverty level; and Plan C for enrollees 151% through 200% of the federal poverty level.

8.2.1. Premiums: No premiums will be charged to families.
8.2.2. Deductibles: No deductibles will be charged to families
Coinsurance or copayments:

Plan A:
No Co-payments for Services

Plan B:

	Benefits	Co-payments
Total Family Out of Pocket Maximum per Benefit Year		5% of the family's gross yearly income**
Medical and Vision Out of pocket maximum per benefit year		$200 per child
	Office visits (including mental health)	$5
	Well Child Exams	No-copayment required
	Immunizations	No co-payment required
	Lab and X-ray	No-co-payment required
	Outpatient Hospital	$5
	Inpatient Hospital	$30
	Emergency Room	$5
Pharmacy out of pocket maximum per benefit year		$100 per child
	Generic prescriptions	$3
	Brand name prescriptions	$5
Dental out of pocket maximum per benefit year		$15 per child $15 per child - orthodontics
	Preventive and Diagnostic	No co-payment required

	Services (exams, cleanings, flouride, sealants)	
	Basic and Major Services (fillings, extractions, etc)	$5 per visit
	Medically Necessary Orthodontics	$5 per visit

**Kid Care CHIP will send families an approval letter telling them the out of pocket maximum amount for their family.

Plan C:

	Benefits	Co-payments
Total Family Out of Pocket Maximum per Benefit Year		5% of the family's gross yearly income**
Medical and Vision Out of pocket maximum per benefit year		$300 per child
	Office visits (including mental health)	$10 per child
	Well Child Exams	No Co-payment Required
	Immunizations	No Co-payment Required
	Lab and X-ray	No Co-payment Required
	Outpatient Hospital	$10
	Inpatient Hospital	$50
	Emergency Room	$25
Pharmacy out of pocket maximum per benefit year		$200 per child
	Generic prescriptions	$5
	Brand Name prescriptions	$10
Dental out of pocket maximum per benefit year		$75 per child $75 per child - orthodontics
	Preventive and Diagnostic Services (exams, cleanings, flouride, sealants)	No co-payment required
	Basic and Major Services (fillings, extractions, etc)	$25 per visit
	Medically Necessary Orthodontics	$25 per visit

Kid Care CHIP mailed cost sharing updates to families on April 30, 2010 that outlined upcoming changes to the program. This document was also provided to provider offices and any other organization partnering with Kid Care CHIP to conduct outreach and enrollment activities. Revisions to our benefit books from both Blue Cross Blue Shield and Delta Dental of Wyoming were also mailed to families in June 2010. These revisions outline the upcoming changes to the benefits and cost sharing in Kid Care CHIP.

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

As indicated in section 4.4.5 Kid Care CHIP works directly with the tribes, the Tribal Health Services and the Indian Health Service to inform Native Americans in Wyoming about Kid Care CHIP. The representatives of the tribes and organizations in the state have been in all state-wide partnerships and individual relationships have been made, which assures their input in the design of an effective outreach and marketing campaign for Kid Care CHIP that will be acceptable to the tribes.

Kid Care CHIP presented upcoming changes to Indian Health Services, Wind River Health Systems and other organizations on the reservation in May 2010.

Kid Care CHIP attempted to present to the Joint Tribal Councils, twice (once in May and once in June) but due to Tribal Council cancellations & recent flooding we were unable to present to them in person. We have contacted their offices but have not received any comments back from the Tribal Council on the documents we provided to them.

The meeting with Wind River Health Systems was attended by Indian Health Services, Tribal Council Members, Wind River Health Systems, Public Health, School officials, WIC and Head Start officials.

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

Public Notice for all cost sharing changes to Kid Care CHIP will be made according to State law. The public notice for the public meeting and rules will be published in Wyoming newspapers and the public meeting will be held within no less than thirty days prior to implementation. The published notice will advise of the changes being made to Kid Care CHIP cost sharing. As an additional step, the Department of Health will also address the cost sharing in the public notice for the administrative rule for Kid Care CHIP that will be issued prior to ~~October 1, 2009.~~ July 2010.

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

. Planned use of funds, including --

- Projected amount to be spent on health services;

- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.

. Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

SCHIP Budget Plan Template	**Wyoming**
	Federal Fiscal Year ~~2010~~ 2011 Costs
Enhanced FMAP rate	**65.00%**
Benefit Costs	
Insurance payments	
Managed care	
per member/per month rate @ # of eligibles FQHC & RHC Managed Care PPS payments Med. Necessary Ortho @ # of estimated eligibles	~~$214.13 @ 5980~~ $223.50 @ 5505 $150,000 $168,750
Fee for Service	
Total Benefit Costs	~~$15,040,491~~ $14,764,410 $150,000 $168,750
(Offsetting beneficiary cost sharing payments)	$0
Net Benefit Costs* **	~~**$15,040,491**~~ **$15,083,160**
Administration Costs	
Personnel	~~$552,850~~ $526,532
General administration	$ 72,669
Contractors/Brokers (e.g., enrollment contractors)	~~$136,950~~ $96,000
Claims Processing	Included in Premiums
Outreach/marketing costs	~~$53,417~~ $34,000

Other (Indirect/Rent)	$132,818
Total Administration Costs	**$~~948,704~~ $862,019**
10% Administrative Cost Ceiling	$~~1,508,332~~ $1,508,316
Federal Share (multiplied by enh-FMAP rate)	$~~10,392,977~~ $10,364,366
State Share	$ ~~5,596,218~~ $5,580,813
TOTAL PROGRAM COSTS	**$~~15,989,195~~ $15,945,179**

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

Funding:
State funding will come from one source: State General Funds.

*****Net Benefit Costs are based on enrollment by month multiplied by the premium of $~~214.13~~ $223.50.**

Below please find estimated enrollment for Kid Care CHIP by month * does not include FQHC/RHC PPS or Medically Necessary Orthodontia (10/10-9/11)

Month	Enrollment Number	Total Premium	Federal	State
10/10	5450	$1,218,075	$791,749	$426,326.25
11/10	5460	$1,220,310	$793,202	$427,108.50
12/10	5470	$1,222,545	$794,654	$427,890.75
1/11	5480	$1,224,780	$796,107	$428,673.00
2/11	5490	$1,227,015	$797,560	$429,455.25
3/11	5500	$1,229,250	$799,013	$430,237.50
4/11	5510	$1,231,485	$800,465	$431,019.75
5/11	5520	$1,233,720	$801,918	$431,802.00
6/12	5530	$1,235,955	$803,371	$432,584.25
7/12	5540	$1,238,190	$804,824	$433,366.50
8/12	5560	$1,242,660	$807,729	$434,931.00
TOTAL		**$14,764,410**	**$9,596,867**	**$5,167,543.50**

PPS for FQHC's and RHC's: In the first two quarters of FFY 2010, the difference between the payments made by Blue Cross Blue Shield and Delta Dental of Wyoming and the PPS rates established by Wyoming Medicaid equaled approximately $75,000. Since this is the data we have to date we are utilizing this to make our estimates for the next year. $75,000 x 2 = $150,000 for one year. $150,000 x 2 = $300,000 for two years.

Medically Necessary Orthodontia: $3,750 maximum per child x 45 children (estimated) = $168,750

Personnel
Kid Care CHIP will have seven positions dedicated to administering the program.

Supportive Services
General operations costs include equipment, travel, office supplies, and postage, printing, and telephone toll charges.

Case Services
Estimated monthly premium is ~~$214.13~~ $223.50 based on the programs most recent contract that was issued in ~~2009~~ 2010.

Contractual Services

The services listed below will be contracted services:

☐ Consultant services to conduct research and assist in the design and implementation of the eligibility system for Kid Care CHIP.

☐ Legal fees for the development of administrative rules

Sources of Non-Federal Share of Expenditures
In addition to federal funds, Kid Care CHIP State general fund appropriations will be used. Enrollment projections are based on current estimates of funds which will be appropriated for Kid Care CHIP. If enrollment expectations exceed those projected for funding, new enrollment may be suspended.