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State/Territory Name: Delaware

State Plan Amendments (SPA) #: DE-18-0003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

JAN 17 2019

Stephen M. Groff, Director
Division of Medicaid and Medical Assistance
Delaware Health and Social Services
P.O. Box 906
New Castle, DE 19720-0906

Dear Mr. Groff:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), DE-18-0003, submitted on October 18, 2018, with additional information provided on December 21, 2018, has been approved. The SPA has an effective date of October 12, 2018.

This SPA updates the CHIP premium requirements by adding a $10 premium for children ages 6 through 18 years old with family income from 134 through 142 percent of the Federal Poverty Level (FPL), and reducing the current $15 premium to $10 for all children with family income from 143 through 159 percent of the FPL.

From July 1, 2014 to July 1, 2018, the state charged a $15 premium for children ages 6 to 18 years old with family income from 134 percent of the FPL to 142 percent of the FPL. Beginning July 1, 2018, the state reduced this premium to $10. Neither of these premiums were authorized by the CHIP state plan, which stated that this group of children was not subject to a premium. The state has agreed to reimburse impacted families the amounts collected from July 1, 2014 through October 12, 2018 by August 2019.

Following implementation of SPA DE-18-0003, the state's premiums will be as follows:

FPL		Previous Monthly Premium Amount, in approved CHIP state plan	Premium Amounts Actually Charged to Families	Monthly Premium Amount, approved in SPA DE-18-0003
134%	142%	$0 Per Family (ages 6-18)	$15 Per Family (ages 6-18)	$10 Per Family (ages 6-18)
143%	159%	$15 Per Family (ages 1-18)	$15 Per Family (ages 1-18)	$10 Per Family (ages 1-18)
160%	176%	$15 Per Family (ages 1-18)	$15 Per Family (ages 1-18)	$15 Per Family (ages 1-18)
177%	212%	$25 Per Family (ages 1-18)	$25 Per Family (ages 1-18)	$25 Per Family (ages 1-18)

Your title XXI project officer is Ms. Ticia Jones. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Jones' 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) 786-8145
E-mail: Ticia.Jones@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Jones and to Mr. Francis McCullough, Associate Regional Administrator (ARA) in our Philadelphia Regional Office. Mr. McCullough's address is:

Centers for Medicare & Medicaid Services
Philadelphia Regional Office
Division of Medicaid and Children's Health Operations
The Public Ledger Building, Suite 216
150 South Independence Mall West
Philadelphia, PA 19106

If you have questions or concerns regarding the matters raised in this letter, 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,

/signed Anne Marie Costello/

Anne Marie Costello
Director

cc:
Mr. Francis McCullough, ARA, CMS Region III, Philadelphia

DELAWARE HEALTHY CHILDREN PROGRAM

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

Preamble

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

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

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

DELAWARE HEALTHY CHILDREN PROGRAM

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

State/Territory: DELAWARE
(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))**

Thomas R. Carper, Governor June 30, 1998
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: Stephen M. Groff	Position/Title: Director, Division of Medicaid and Medical Assistance (DMMA)
Name: Lisa Zimmerman	Position/Title: Deputy Director, DMMA
Name: Beth Laucius	Position/Title: Chief of Administration, DMMA

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

Affairs, Office of Management and Budget, Washington, D.C. 20503.

DELAWARE HEALTHY CHILDREN PROGRAM

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

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

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

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

1.1.3. ☒ A Combination of both of the above.

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

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

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

Original Plan

Effective Date:	October 1, 1998
Implementation Date:	February 1, 1999

DELAWARE HEALTHY CHILDREN PROGRAM

Subsequent Plan Amendments

State Plan Amendment	Effective Date	Implementation Date
SPA #1	July 1, 1999	
SPA #2	October 1, 2001	August 1, 2001
SPA #3	June 12, 2003	Withdrawn – June 12, 2003
SPA #4	January 1, 2007	October 1, 2009
SPA #5	April 1, 2009	April 1, 2009
SPA #6	July 1, 2010	July 1, 2010
SPA #7	July 1, 2014	July 1, 2014
SPA # DE-CHIP-16-001	January 1, 2017	January 1, 2017
SPA # DE-CHIP-17-003	Pending approval	Pending approval

Summary of Approved CHIP MAGI SPAs:

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
DE-13-0012 Effective/ Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS15	Eligibility – Targeted Low Income Children MAGI-Based Income Methodologies	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Incorporate within a separate subsection under section 4.3
DE-13-0013 Effective/ Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
DE-13-0016 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
DE-13-0015 Effective/ Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19	Non-Financial Eligibility – Residency Non-Financial Eligibility – Citizenship Non-Financial Eligibility – Social Security Number Non-Financial	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR Supersedes the current section 4.1.9.1 Supersedes the current section 4.4.4

DELAWARE HEALTHY CHILDREN PROGRAM

		CS20 CS21 CS27	Eligibility – Substitution of Coverage Non-Payment of Premiums Continuous Eligibility	Supersedes the current section 8.7 Supersedes the current section 4.1.8
DE-13-0014 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4

Approved Plan Amendment – DE-CHIP-18-003

Purpose of SPA: To update CHIP Premiums to be compliant with MAGI requirements.
Proposed effective date: August 2, 2017
Proposed implementation date: August 2, 2017

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.

Delaware does not have any state or federally recognized Indian tribes. Any Delaware resident, including those who are American Indians or Alaska Natives, may participate in the review of amendments to state law or regulation and may offer comments on all program policies, including those relating to provision of child health assistance to American Indian or Alaskan Native children.

DELAWARE HEALTHY CHILDREN PROGRAM

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

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

The population of Delaware was estimated to be 724,773 in 1996. There were 183,895 children in the 0 - 18 age group or 25% of the State population. Based on the Center for Applied Demography and Survey Research, University of Delaware, approximately 23,432 children (or 13% of the children in Delaware) are uninsured. Of the 23,432 uninsured children in the 0 - 18 age group, 14,581 (or 2.0% of the State's population) are ≤ 200% FPL; 8,851 (4.8% of the State's population) are > 200% FPL. It is assumed that approximately 4,068 uninsured children age 0 - 18 ≤ 100% FPL are eligible for Medicaid/Title XIX. Therefore, DHCP will target approximately 10,513 children between 100% - 200% FPL.

Of the 183,895 children 0 - 18 in Delaware, 89.5% have some form of health insurance: 112,135 (or 61.0%) have private insurance; 48,328 (or 26.3%) currently have health care coverage through Title XIX Medicaid; 4,068 (or 2.2%) are eligible for, but not receiving Medicaid. In essence, Title XXI will increase the number of insured children in the 0 - 18 group by 10,513 (or 5.7%), thereby bringing the total of insured children in Delaware to 95.2%. The remaining 8,851 (or 4.8%) or the 0 - 18 population comprises uninsured children above 200% FPL.

According to a published report by the Center for Applied Demography and Survey Research, University of Delaware (U of D), Blacks are twice as likely to be without health insurance compared to Caucasians. Hispanics have a higher risk, almost 5% higher, than Blacks of being without insurance. 51% of the uninsured are male, 69% are White, 8% are Hispanic.

The major reason cited by the U of D report for lack of insurance among 0 -18 year olds are: poverty, lack of education, lack of work experience, and no

family responsibility (i.e., unmarried and without children). Parents of these children are likely to be single-parent households with low-income jobs.

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)

Pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act, Delaware with use administrative funds to offer health services initiatives under this plan with the goal of improving the health of children, defined as "individual(s) under the age of 19 including the period from conception to birth," per 42 CFR 457.10. Delaware assures that it will use no more than 10% of the total expenditures under this Plan, as specified in 42 CFR 457.618, to fund the State's health service initiatives.

Vision to Learn

Access to vision exams and glasses is critical for students' educational achievements and health outcomes, as 80% of all learning during a child's first 12 years is visual. It comes as no surprise that students with vision problems tend to have lower academic performance, as measured by test scores and grades, and that students' performance in school impacts future employment earnings, health behaviors, and life expectancy. As such, Delaware seeks to use the health services initiative option to improve the health of low-income children by increasing their access to needed vision services and glasses through a targeted, school-based initiative. Delaware intends to contract with a non-profit Medicaid participating provider to offer these services on-site at certain Delaware schools. (Delaware is currently engaged with Vision to Learn (VTL), which has been serving Delaware children since 2014 and is a certified Medicaid participating provider. VTL is a non-profit, philanthropically-funded entity that provides free eye exams and glasses to students at schools in low-income communities.)

The following describes how the CHIP HSI will be operationalized:

- The qualified provider will target Delaware's low-income children by identifying Title I schools in which at least 51% of the student body receives free or reduced price meals.

- These schools will provide the qualified provider with a list of children who have failed the school-supplied vision screening. The qualified provider will give these children parental consent forms to take home.
- For children who return with parental consent, the qualified provider will give one vision exam and, if needed, corrective lenses and frames (including replacements, as needed) on-site in a mobile eye clinic.
- The qualified provider will collect identifying information from all children it serves (for example, name and date of birth) and submit this information to the Delaware Division of Medicaid and Medical Assistance (DMMA). Based on this data, DMMA will identify children who are enrolled in Medicaid or CHIP and their managed care organization (MCO) and return this information to the qualified provider, who will then submit bills for Medicaid and CHIP enrollees directly to the MCOs. The MCOs will pay based on negotiated, standard fees.
- The qualified provider will submit information about services provided to DMMA for the children ages 18 or younger who DMMA has not identified as enrolled in Medicaid or CHIP. DMMA will remit payment for these services through CHIP HSI funding.
- DMMA will perform outreach by supplying the provider with brochures and information about the CHIP and Medicaid Programs to provide to children that are not currently enrolled in Medicaid or CHIP.

Delaware provides the following assurances regarding this Health Service Initiative (HSI), Vision to Learn (VTL) – Delaware:

- This HSI will only target children under the age of 19;
- This HSI will not supplant or match CHIP Federal funds with other Federal funds nor allow other Federal funds to supplant or match CHIP Federal funds; and
- HSI funds will not be used for children with private coverage and will only be used to cover VTL services provided to uninsured children

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.

Delaware does not have any state or federally recognized Indian tribes. Any Delaware resident, including those who are American Indians or Alaska Natives, may participate in the review of amendments to state law or regulation and may offer comments on all program policies, including those relating to provision of child health assistance to American Indian or Alaskan Native children.

2.2 Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

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

The State of Delaware expanded coverage for children to age 18 and to 100% of the Federal poverty level in 1992, in tandem with plans to develop an 1115 waiver. This waiver was in conjunction with the duPont Hospital for Children a.k.a. the Nemours Foundation. Nearly 7,000 newly eligible children were added in the first year of increased eligibility which constituted a 31.3% increase in the number of children served by Medicaid. When the State received approval for the 1115 waiver that authorized the Diamond State Health Plan, this population of children was rolled into the Diamond State Health Plan and duPont

became a provider with all MCOs.

Effective October 1, 2001, all children under the age of 1 enrolled in the Delaware Healthy Children Program were transferred to a Medicaid expansion with no interruption in coverage.

Pursuant to an initiative by the State, the Nemours Foundation also provides free primary health care services in physician clinics to uninsured children up to 175% of poverty and charges a fee on a sliding scale basis to those above 175% of poverty. Since its inception in 1993, the Nemours initiative has resulted in the creation of ten (10) new primary care facilities providing physician services to over 6,200 non-Medicaid children annually.

The Division of Social Services, Medical Assistance Program, the Division of Public Health and the Department of Education work closely together to identify uninsured children and route them to Medicaid for eligibility determination. We have developed an early identification program with the largest hospitals in the State to notify us immediately of the birth of a child to a Medicaid eligible mother. The State's Enrollment Broker (Health Benefits Manager) provides multiple outreach programs to bring the Diamond State Health Plan and Medicaid to the attention of possibly eligible persons. The State will amend the HBM contract to include these same services for the Title XXI population.

The enrollment process through the Health Benefits Manager worked very well and prevented direct marketing and adverse selection by managed care plans.

The WIC program also participates with the State and the MCOs to identify children in the WIC program who may also be eligible for Medicaid.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The State's relationship with its managed care companies and the Health Benefits Manager (Enrollment Broker) are public-private partnerships. The outreach and education programs are provided in a

public-private environment with the State working with each of these entities to identify and enroll eligible persons into the Medicaid program.

In addition, the Nemours Clinics provide services for the Medicaid Children, primarily through contracts with the Managed Care Organizations. They also provide services to uninsured children up to approximately 175% for no charge. These primary care clinics are supported primarily by the Nemours Foundation, a private philanthropical organization, whose trust requires investments in the health of Delaware's children.

2.3. Describe the procedures the state uses to accomplish coordination of CHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

The public and private entities, which provide health care to children in the State, are already in partnership with Delaware's Department of Health and Social Services, which will be administering this program. The State is entering discussions with the Nemours Foundation, which provides primary care services to low-income and underinsured children who are not eligible for Medicaid to obtain their agreement to alter their income cap to cover children above 200% of FPL on a more generous basis since the State will assume coverage for uninsured children below 200% of the FPL who meet eligibility criteria.

Additionally, in the State's Division of Public Health, Maternal and Child Health program activities are funded under the Maternal and Child Health Block Grant program, Title V of the Social Security Act. This funding is intended to improve the health of all mothers and children and must be equally divided on prevention and primary care services for children, pregnant women, mothers and infants, and children with special health care needs. Referral processes are in place with the DPH and FQHCs, which aid in the identification and referral of uninsured children in the appropriate program. Applicants who do not qualify for Medicaid or the DHCP are referred to FQHCs.

All applicants will be screened by staff employed by the State of Delaware Division of Social Services to assure that they are potentially eligible targeted low income children. The screening document will determine:

DELAWARE HEALTHY CHILDREN PROGRAM

1. If the child(ren) has Medicaid coverage or is potentially eligible. If the child has Medicaid, the Social Services staff will cease screening for The Delaware Healthy Children Program. If potentially eligible because family income appears to be less than the Medicaid limit, a Medicaid application will be processed.

2. If the child is not Medicaid eligible, the social worker will screen for family income, credible coverage within last six months, residency, citizenship, Social Security Numbers, and age.

3. If child appears to qualify based on passing those screens, an application will be mailed or handed to the family.

4. Other State and private agencies serving potentially eligible targeted low-income children will be encouraged to refer such children for screening.

DELAWARE HEALTHY CHILDREN PROGRAM

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 Delaware Healthy Children Program (DHCP) is targeted to children under age 19 with income at or below 200% of the Federal Poverty Level (FPL). The service package will include all of those basic benefit services provided under the State's Medicaid Managed Care program as it was structured during 1998. Services will be provided by the same fully capitated managed care organizations (MCOs) participating with Medicaid. In addition, participants in the DHCP will receive pharmacy services comparable to the Medicaid population. They will also receive all medically necessary mental health and substance abuse treatment services (any treatment modality) which exceed the basic MCO benefit of 30 outpatient visits for mental health. The mental health/substance abuse services will be provided through the State's Department of Services for Children, Youth, and Families. For children actively case managed by the Department's Division of Child Mental Health Services (a JCAHO-certified public mental health managed care provider), a monthly encounter rate will be billed to the DHCP. Children receiving mental health or substance abuse services by the Department's Division of Family Services or the Division of Youth Rehabilitation Services will have their care paid on a fee-for-service basis. Beyond the 31 days of additional coverage of inpatient care, children will become eligible for Medicaid long-term care services. Thus the DHCP will provide very high quality mental health and substance abuse coverage - coverage which is better by far than most private sector coverage. Services will be provided statewide with no variations based on geography.

Children are eligible under Title XXI (DHCP) only after enrollment with a MCO. Delaware assures that it will spend no more than 10% of actual or estimated Federal expenditures for outreach and administrative costs in accordance with Section 2105(a)(2)). The plan does not currently include any initiative to provide services through any options other than through MCO capitated

arrangements with the two “wrap-around” services listed above.

Dental Benefits will be provided on a fee-for-service basis.

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

Delaware will use the same utilization control procedures as are used for the Diamond State Health Plan (also see Section 7). These are:

Utilization Management

The MCO must have written utilization management policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and retrospective review of claims. As part of its utilization management function the MCO must also have processes to identify utilization problems and undertake corrective action.

The MCO will develop and maintain a Utilization Management Committee to oversee utilization management decisions. The committee must include membership by individuals representative of the organization's provider network. The committee must also participate in the development of utilization management policies and procedures. The MCO must also ensure that it has sufficient/appropriate staff and resources to perform utilization management functions.

In addition, the State operates a Drug Utilization Review system that provides for prospective and retrospective reviews with oversight provided by a nine-member board. The prospective review generates alerts for medication problems at the time that the prescription is dispensed. The retrospective review monitors beneficiary compliance and overall prescribing/dispensing patterns.

DELAWARE HEALTHY CHILDREN PROGRAM

Section 4. Eligibility Standards and Methodology (Section 2102(b))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☒ Geographic area served by the Plan: All of Delaware.

4.1.2. ☒ Age: Children from ages 1 to 19. This amendment moves infants previously covered into a Medicaid expansion.

4.1.3. ☒ Income: Eligibility will be established using gross income of all immediate family* members living in the same household with a standard $90 disregard per earner, a disregard for the amount of actual child care expenses up to $175 for children age 2 and above and $200 for children under age two. In addition, there will be a disregard of the first $50 of child support for any potentially eligible children. The resultant countable income will be compared to 200% of the FPL for a family the size of those in the immediate family with one exception (a pregnant woman will count as two [2] people for determining the FPL level to use). Income less than or equal to 200% of the FPL will qualify the children for eligibility for The Delaware Healthy Children Program. (The State is considering allowing a buy-in for families with incomes between 200% and 300% of the FPL with payment of the full capitation amount as their premium as part of a State-supported initiative.) * "Immediate family" is defined a unit (living in the same household) comprised of various adults who are legally/financially responsible for each other, and various children (related or unrelated) for whom the adults have legal responsibility or for whom the adults have accepted parental-like responsibility. This is the same definition that is used for Medicaid eligibility.

All wages paid by the U. S. Census Bureau for temporary employment related to Decennial Census activities are excluded in years in which there is a federal census.

DELAWARE HEALTHY CHILDREN PROGRAM

4.1.4. ☐ Resources (including any standards relating to spenddowns and disposition of resources): _____

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): Must be current Delaware resident with intent to remain.

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

4.1.7. ☒ Access to or coverage under other health coverage: Must be uninsured for at least 6 previous months (see exceptions in section 4.4.4.1).

4.1.8. ☒ Duration of eligibility: 12 months of guaranteed eligibility.

4.1.9. ☒ Other standards (identify and describe): must be (1) ineligible for enrollment in any public group health plan; and, (2) a social security number is required for an applicant child, effective August 24, 2001.

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

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

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C.§§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) Aliens currently in deferred action status; or

(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

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

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

4.2. The State assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

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4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

Eligibility and redeterminations of eligibility will be conducted by staff under the administration of the Title XIX / Medicaid program consistent with those activities for Medicaid applicants / recipients.

Individuals will be enrolled with MCOs using the same Health Benefits Manager and the same process of enrollment as is used by Delaware's Diamond State Health Plan. Individuals will be given a time frame to choose an MCO, and then, in the absence of any indication of choice, will be automatically assigned to an MCO based on location and availability of providers.

The application form for Delaware's Title XXI program will be incorporated into the Medicaid application so that there is no need to apply separately after a determination of Medicaid eligibility is completed.

Eligibility will always be determined, as defined in the remainder of this section, by staff under the administration of the Title XIX/Medicaid program, using abbreviated, mail-in applications and outstationing eligibility staff at various sites. On a daily basis, the information on all Title XIX and Title XXI clients will be electronically transferred to the State's Health Benefits Manager and the State's Fiscal Agent. The Health Benefits Manager will mail information regarding all available MCO choices to the client. As with Title XIX, clients eligible under Title XXI will have an enrollment application that pre-selects an MCO for them. If written or verbal contact is not made by the client to the HBM within thirty (30) days of their eligibility start date, they will be assigned to the pre-assigned MCO. The HBM does a follow-up telephone contact 20 days after the first notice. All information from the HBM to the Title XXI eligible will carry the name of the Title XXI program and will be separate and distinct from Title XIX information.

Families who do not pay the premiums may re-enroll at any time without penalty, with the re-enrollment period starting with the first month for which the premium is paid.

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

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

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4.4. Describe the procedures that assure that:

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

The Delaware Client Information System (DCIS) and the Medicaid Management Information System (MMIS) will be used to monitor and control eligibility. The DCIS will contain edits that assure that income and age limitations are not exceeded and that action is taken when a child is about to turn age 19. Likewise, the MMIS will contain edits that assure that aid category codes for this population are limited to individuals under age 19.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

The eligibility for Title XXI, Delaware Healthy Children Program, will be done in conjunction with a Medicaid application. Policy will require that Medicaid / Title XIX be the primary program for coverage for children. Since the benefits for the Medicaid population with “wrap around” services is a slightly richer package than for Title XXI, staff will be assuring that the Medicaid package has priority. The State’s DCIS II system includes this population to assure that Medicaid is first in the priority level for establishment of eligibility. (See Section 2.3)

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

Delaware uses a joint application form for Medicaid and Title XXI. Our automated eligibility system, DCIS II, incorporates a set of eligibility rules that explore the most beneficial and comprehensive benefits for applicants and recipients. Applicant and recipient data is evaluated through a "cascade" of Medicaid programs. If the applicant or recipient

is found ineligible for Medicaid, the system automatically explores eligibility for Title XXI.

4.4.4 The insurance provided under the State Child Health Plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☒ Coverage provided to children in families at or below 200% of the FPL: describe the methods of monitoring substitution.

The Delaware Title XXI program is targeted to uninsured children and is not expected to supplant any health insurance currently provided to any applicant. Delaware's approach to crowd out is:

The joint application asks whether the applicant has had health insurance within the last six months. Children are not eligible for the Delaware Title XXI program unless they have been without health coverage for at least the six preceding months. Exceptions to this would be made if coverage is lost due to:

- death of parent,
- disability of parent,
- termination of employment,
- change to a new employer who does not cover dependents,
- change of address so that no employer-sponsored coverage is available,
- expiration of the coverage periods established by COBRA
- employer terminating health coverage as a benefit for all employees.

The recommendation for enforcement of this provision is:

Simple declaration at the time of application and during each redetermination.

The joint application asks whether the applicant currently has health insurance. The Third Party Liability Unit verifies this information.

Delaware will monitor the data collected from the application on private coverage, looking for trends on substitution of coverage

over time.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% of the FPL. Describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% of the FPL. Describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the State provides coverage under a Premium Assistance Program, describe:

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

The minimum employer contribution.

The cost-effectiveness determination.

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

American Indian and Alaska Native children are eligible for the Delaware Healthy Children Program on the same basis as any other children in Delaware. All children in Delaware who may be eligible will be targeted through outreach efforts specifically outlined in Section 5.

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Section 5. Outreach (Section 2102(c)

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

The State plans a multi-pronged approach to finding, notifying and assisting eligible children to enroll in DHCP such as:

- The State plans to replicate the simplified application process in place for Medicaid and continue to outstation staff to complete Medicaid and DHCP applications. Staff will coordinate the application so families can be screened and apply for both programs with a single application by mail without a face to face interview.

- During the Public Hearing process we will elicit partners who can help outreach to children in their communities, service area, client base etc. We will ask for their suggestions for outreach strategies. Delaware will supplement this process by considering the schools as an outreach point, because the Title XXI program targets children.

- Non-traditional outreach strategies, which have been used successfully in other States, such as adding a check off box to the reduced/free lunch application in schools, will be considered. The sentence will ask parents if they would like their child's name referred to Medicaid for an application for benefits. Other non-traditional strategies may include fliers on pizza boxes and fast food trays, temporary agency employees paycheck inserts, article in the American Association of Retire Persons newsletter to reach grandparents raising their grandchildren.

- Delaware plans to search out other states' initiatives that have been successful and replicate those in Delaware if feasible.

- The State will use all media types, which are cost effective, such as traditional mailings, newspaper, buses, and Public Service Announcements on radio and television for different ethnic/racial/demographic/age markets.

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- The State will target children within the State programs who are known to be potentially eligible like children receiving food stamps, WIC, subsidized child care, etc. for a special “invitation” to join with a simplified application process since income/technical requirements are stored in common shared computer eligibility file.

- The State will periodically reevaluate and revise outreach strategies so enrollment is successful.

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

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid Plan and continue on to Section 7.

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

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

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

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

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

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

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

6.1.4. ☒ Secretary-Approved Coverage (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☐ Coverage the same as Medicaid State Plan
6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 Demonstration Project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
6.1.4.4. ☒ Coverage that includes benchmark coverage plus additional coverage
6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive State-based coverage
6.1.4.6. ☐ Coverage under a Group Health Plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison. (Please provide a sample of how the comparison will be done.)
6.1.4.7. ☐ Other (Describe)

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

6.2.1. ☒ Inpatient Services (Section 2110(a)(1))
6.2.2. ☒ Outpatient Services (Section 2110(a)(2))
6.2.3. ☒ Physician Services (Section 2110(a)(3))
6.2.4. ☒ Surgical Services (Section 2110(a)(4))
6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
6.2.6. ☒ Prescription drugs (Section 2110(a)(6)) – included as a "wrap-around" service with the same limitations as the Title XIX program.
6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7)) - included as a "wrap-around" and limited to drug categories where the over-the-counter product may be less toxic, have fewer side effects, and be less costly than an equivalent legend product.
6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))
6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a State-operated mental hospital and including residential or other 24-hour

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therapeutically planned structural services (Section 2110(a)(10)) - inpatient mental health and/or substance abuse treatment services will be provided as "wrap-around" services by the DSCYF. Inpatient services will be provided with limits based on medical necessity. Children who need inpatient services beyond this will convert to Medicaid Long-Term Care.

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) - 30 days of outpatient care included in the basic MCO benefit. Additional days of outpatient mental health and/or substance abuse treatment services, with limitations based on medical necessity, will be provided by the DSCYF. See note in 6.2.10.

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

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

6.2.14. ☒ Home and community-based health care services (See instructions) (Section 2110(a)(14)) - limited to medically necessary home health services provided by the MCOs as part of the basic benefit. Does NOT include personal care, chore services, day care, respite care, or home modifications. Home health aide services are covered as medically necessary according to the State's published definition.

6.2.15. ☒ Nursing care services (See instructions) (Section 2110(a)(15)) - there is a limit of 28 hours of Private Duty Nursing Services per week in the basic benefit; no additional hours available.

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

6.2.17. ☒ Dental services (Section 2110(a)(17)) – included as "wrap-around" services with the same limitations as the EPSDT dental program. The SCHIP dental benefit is comprehensive in nature and consists of the following services: Diagnostic, Preventive, Restorative, Endodontics, Periodontics, Prosthodontics, Oral Surgery, and adjunctive services (such as, anesthesia, behavior management, occlusal guard, and treatment of dental pain). Orthodontic services are covered for diagnosed conditions considered to be handicapping malocclusions.

6.2.18. ☒ Inpatient substance abuse treatment services and residential

substance abuse treatment services (Section 2110(a)(18)) – see note in 6.2.10.

6.2.19. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19)) – see note in 6.2.10.

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

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

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

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

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

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

6.2.26. ☒ Medical transportation (Section 2110(a)(26)) Emergency transportation only as provided in the basic benefit package.

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (see instructions) (Section 2110(a)(27))

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

6.2- 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 42 CFR 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. (42 CFR 457.496(f)(1)(i))

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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 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)

For the purpose of the MHPAEA analysis, Delaware defined mental health and substance use disorder (MH/SUD) benefits as benefits for the conditions listed in ICD-10-CM, Chapter 5 "Mental, Behavioral, and Neurodevelopmental Disorders" with the exception of:

- The conditions listed in subchapter 1, "Mental disorders due to known physiological conditions" (F01 to F09);
- The conditions listed in subchapter 8, "Intellectual disabilities" (F70 to F79); and
- The conditions listed in subchapter 9, "Pervasive and specific developmental disorders" (F80 to F89).

Delaware defined medical/surgical (M/S) benefits as benefits for the conditions listed in ICD-10-CM Chapters 1-4, subchapters 1, 8 and 9 of Chapter 5, and Chapters 6-20.

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☐ 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 ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

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6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (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 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

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.

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Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as 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 (42 CFR 457.496(b)). 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 42 CFR 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.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

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. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

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

Inpatient: All covered services or items (including medications) provided to a member while in a setting (other than a home and community-based setting as defined in 42 CFR Part 441) that requires an overnight stay.

Outpatient: All covered services or items (including medications) provided to a member that do not otherwise meet the definition of inpatient, emergency care, or prescription drugs.

Emergency Care: All covered services or items (including medications) delivered in an emergency department (ED) setting or free standing emergency room.

Prescription Drugs: Covered medications, drugs and associated supplies and services that require a prescription to be dispensed. These products are claimed using the National Council for Prescription Drug Programs (NCPDP) format.

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 (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, 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 (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar 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. (42 CFR 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: A monetary coverage limit that applies to *all* CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits 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. (42 CFR 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 (42 CFR 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. (42 CFR 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.

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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 and the results 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 (42 CFR 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 least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 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 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results 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 (42 CFR 457.496(c)(2)(i)); (42 CFR 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 QTLs 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 portion of medical and surgical benefits in the classification 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 of 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. (42 CFR 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. (42 CFR 457.496(d)(3)(i)(E))

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Guidance: Please include the state's methodology and results 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? (42 CFR 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. (42 CFR 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 42 CFR 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 42 CFR 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. (42 CFR 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 predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 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 predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 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. (42 CFR 457.496(d)(4)); (42 CFR 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 and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

See Attachment 1 for a list of NQTLs and MH/SUD benefits by classification and benefit package for each for Highmark Health Options and Attachment 2 for UnitedHealthCare Community Plan. Attachment 3 provides the NQTL analysis by classification and benefit package for each for UnitedHealthCare

Community Plan and Attachment 4 for Highmark Health Options. Note that this same information was submitted to CMS as documentation of parity compliance for MCO enrollees (42 CFR Part 438).

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 medical or surgical benefits provided by out-of-network providers?

☐ Yes

☒ No However, Attachment 1 through 4 include information on Standards for Out-of-Network Coverage since information on that NQTL was provided to CMS as part of the Part 438 documentation for MCO enrollees.

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. 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 (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

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 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

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

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

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

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

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

community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

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

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

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

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

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Section 7. Quality and Appropriateness of Care

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

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

Quality Assurance Structure

The MCO's utilization management and quality assurance program will consist of internal monitoring by the MCOs, oversight by DSS and the federal government, and evaluation by an independent, external review organization (EQRO). These programs are in place for the MCOs currently contracting for Title XIX clients and the same programs will be used for Title XXI. Future RFPs for Managed Care Organizations will include the need to provide services for both the Title XIX and the Title XXI programs. All MCOs must have a quality assurance structure composed of:

(a) An internal system of monitoring services;

(b) Designated staff with expertise in quality assurance; and

(c) Written policies and procedures for quality assurance and utilization management.

Quality Assurance System

As with Title XIX, MCOs are required to establish, implement, and adhere to the Quality Assurance and Utilization Management review systems approved by the Department and based on the current HCFA guidelines (A Health Care Quality Improvement System for Medicaid Managed Care issued July 6, 1993) or subsequent revisions thereof, and shall:

(a) Ensure that health care is provided as medically necessary in an effective and efficient manner;

(b) Assess the appropriateness and timeliness of care provided;

(c) Evaluate and improve, as necessary, access to care and quality of care with a focus on improving patient outcomes;

(d) Focus on the clinical quality of medical care rendered to enrollees; and

(e) Incorporate all the "Minimum Quality Assurance and Utilization Management Requirements."

MCOs will be held accountable for monitoring, evaluating, and taking action as necessary to improve the health of its members under contract with DSS. MCOs will also be held accountable for the quality of care delivered by sub-contractors, which must comply with all quality management procedures and requirements of this RFP.

Quality Assurance Policy and Procedures

NOTE: These policies and procedures are already in place for Title XIX. MCOs must distinguish between Title XIX and Title XXI for reporting.

Internal policies and procedures must:

(a) Assure that the utilization management and quality assurance committee has established parameters for operating and meets on a regular schedule which is at least quarterly; committee members must be clearly identified and representative of the MCO's providers, accountable to the medical director and governing body, and must maintain appropriate documentation of the committee's activities, findings, recommendations, and actions;

(b) Provide for regular utilization management and quality assurance reporting to the MCO management and MCO providers, including profiling of provider utilization patterns;

(c) Be developed and implemented by professionals with adequate and appropriate experience in quality assurance;

(d) Provide for systematic data collection and analysis of performance and patient results;

(e) Provide for interpretation of this data to practitioners;

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(f) Provide for making appropriate changes when problems in quality of care are found; and

(g) Clearly define the roles, functions, and responsibilities of the quality assurance committee and medical director.

Internal Quality Assurance Program

The MCO must have an internal written quality assurance plan (QAP) that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas. Emphasis must be placed on, but need not be limited to, clinical areas relating to well baby care, well child care, pediatric and adolescent development, as well as on key access or other priority issues for [Title XXI] patients such as teen age pregnancy and immunizations.

All MCOs are to structure their internal QAPs in a manner consistent with the standards as outlined in the Federal Government's "Quality Assurance Reform Initiative Guide for States" (QARI) or subsequent revisions thereof, for internal and external quality assurance reviews.

Provider Profiling

The MCO must have written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State and qualified to perform their services according to CMS's "A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for the States", or subsequent revisions thereof. The MCO also must have written policies and procedures for monitoring its providers and for disciplining providers who are found to be out-of-compliance with the MCO's medical management standards.

Quality Assurance Report

As with the existing Title XIX program, plans will also be required to submit periodically to DSS reports regarding results of their internal monitoring. This will include the reporting of The Health Plan Employer Data and Information Set (HEDIS), version 3.0 or subsequent revisions, and other targeted health indicators that shall be monitored by DSS as well as other specific quality data periodically requested by the federal government. The MCO must agree to

submit a quality assurance report six (6) months after the contract effective date and semi-annually thereafter. These reports will distinguish clearly between the Title XIX and the Title XXI programs.

Outcomes Objectives

The State, in conjunction with the MCOs, will develop a system of incentives for reaching outcome objectives in certain key areas to be defined by the State and MCOs. These outcome objectives will include, at a minimum, childhood immunizations, well baby and well child care pediatric asthma, and behavioral health care. MCOs will be required to submit on a periodic basis objective numerical data and/or narrative reports describing clinical and related information on health services and outcomes of health care for the Title XXI and Title XIX enrolled populations. Each program will be handled as separate programs for reporting.

Internal Staff

The State's enrolled populations for the Title XIX and the Title XXI programs are too small to require separate internal programs for the MCOs. Therefore, internal staff and internal committees may serve both populations. A clear definition will be made during reporting.

The MCO must designate a quality assurance and utilization management coordinator, who is either the MCO's medical director or a person who directly reports to the medical director. This individual is responsible for the development and implementation of the quality assurance program. The coordinator must have adequate and appropriate experience in successful utilization management and quality assurance programs and be given sufficient time and support staff to carry out the MCO's utilization management and quality assurance functions. This person, or persons, will also be responsible for assuring the interface and support of the EQRO and State quality assurance functions as necessary.

Quality Assurance Committee

MCOs must have a quality assurance committee that assists the coordinator in carrying out all quality assurance functions. This committee must satisfy the DSS's requirements and, at a minimum:

(a) Demonstrate that the Committee will have oversight responsibility and input on all quality assurance and utilization management activities;

(b) Demonstrate that the committee has accountability to the MCOs governing board;

(c) Ensure membership on the committee and active participation by individuals representative of the MCOs provider community; and

(d) Demonstrate that the contractor will secure adequate insurance for members of the committee and subcommittees.

Quality Assurance and Utilization Management Coordinator

The coordinator and the quality assurance committee must be accountable to the MCO's governing body.

The qualifications and responsibilities must include but need not be limited to what follows below. Specifically, the coordinator must:

(a) Be licensed to practice medicine in the United States and be board-certified or board-eligible in his or her field of specialty;

(b) Be responsible for developing the MCO's annual written quality assurance description including areas and objectives, scope, specific activities, and methodologies for continuous tracking, provide review and focus on health outcomes;

(c) Be responsible for the MCO's utilization management and quality assurance committee, direct the development and implementation of the MCO's internal quality assurance plan and utilization management activities, and monitor the quality of care that MCO members receive;

(d) Oversee the development of clinical care standards and practice guidelines and protocols for the MCO;

(e) Review all potential quality of care problems and oversee development and implementation of continuous assessment and improvement of the quality of care provided to members;

(f) Assure that adequate staff and resources are available for the provision of proper medical care and health education to members;

(g) Specify clinical or health service areas to be monitored;

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(h) Specify the use of quality indicators that are objective, measurable, and based on current knowledge and clinical experience for priority areas selected by DSS as well as for areas the MCO selects; current Health Plan Employer Data and Information Set standards must be used;

(i) Oversee the MCO's referral process for specialty and out-of-plan services; all denied services must be reviewed by a physician, physician assistant, or advanced nurse practitioner; the reason for the denial must be documented and logged; all denials must identify appeal rights of the member;

(j) Be involved in the MCO's recruiting and credentialing activities;

(k) Be involved in the MCO's process for prior authorization and denying services;

(l) Be involved in the MCO's process for ensuring the confidentiality of medical records and member information;

(m) Be involved in the MCO's process for ensuring the confidentiality of the appointments, treatments, and required State reporting of adolescent sexually transmitted diseases;

(n) Work with the special programs coordinator to assure that reports of disease and conditions are made to DSS in accordance with all applicable State statutes, rules, guidelines, and policies and with all metropolitan ordinances and policies;

(o) Assure that control measures for tuberculosis, sexually transmitted diseases, and communicable disease are carried out in accordance with applicable laws and guidelines and contained in each provider manual;

(p) Serve as a liaison between the MCO and its providers and communicate regularly with the MCO's providers, including oversight of provider education, in-service training, and orientation;

(q) Be available to the MCO's medical staff for consultation on referrals, denials, complaints, and problems;

(r) Attend State medical director's meetings;

(s) Maintain current medical information pertaining to clinical practice and guidelines; and

(t) Attend grievance committee meetings when necessary.

External Quality Assurance Reviews

DSS will contract with independent, external evaluators to examine the quality of care provided by MCOs. The State will amend the existing contract with its EQRO for the Title XIX program. The amendment will clearly define the need to keep the populations and associated reporting separate.

The MCO will be required to cooperate with any external quality, independent assessment of its performance, which has been duly authorized by DSS. Independent assessments shall include, but not be limited to, the federally required reviews of (1) access to care, quality of care, cost effectiveness, and the effect of case management; (2) the contractor's quality assurance procedures, implementation of the procedures, and the quality of care provided; and (3) consumer satisfaction surveys.

The MCO agrees to assist in the identification and collection of any data or medical records to be reviewed by the independent assessors and/or DSS. The contractor shall ensure that the data, medical records, and workspace are available to the independent assessors or DSS at the contractor's work site.

DSS will monitor each MCO's adherence to QARI standards through one or more of the following mechanisms:

(a) Review of each MCO's written QAP prior to contract execution;

(b) Periodic review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes of health care for the enrolled population;

(c) On-site monitoring by DSS of QAP implementation to ensure compliance with all standards; such monitoring will take place at least once every six (6) months;

(d) Independent, external review of the quality of services furnished by each MCO, conducted by an entity under contract to DSS; such reviews will be conducted at least once each year; the MCO must

agree to make available to DSS's external evaluator medical and other records (subject to confidentiality constraints) for review as requested;

(e) On-site visits and inspections of facilities;

(f) Staff and enrollee interviews;

(g) Review of appointment scheduling logs, emergency room logs, denial of services, and other areas that will indicate quality of care delivered to enrollees;

(h) Medical records reviews;

(i) All quality assurance procedures, reports, committee activities and recommendations, and corrective actions;

(j) Review of staff and provider qualifications;

(k) Review of grievance procedures and resolutions; and

(l) Review of requests for transfers between primary care providers within each MCO.

The MCO shall submit a corrective action plan to resolve any performance or quality of care deficiencies identified by the independent assessors and DSS as determined necessary by DSS.

Fraud and Abuse Protections

The MCO may not knowingly:

(a) have a person who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non procurement activities under regulations issued pursuant to Executive Order 12549 or under guidelines implementing such order, as a Director, officer, partner, or person with beneficial ownership of more than 5% of the entity's equity, or

(b) have an employment, consulting, or other agreement with a person described above for the provision of items and services that are

significant and material to the entity's obligations under its contract with the State.

The MCO may not distribute directly or indirectly or through any agent or independent contractor marketing materials within the state:

(a) without prior approval of the State, and,

(b) that contains false and materially misleading information.

The MCO shall develop marketing materials specially for the Title XXI program. These materials will be provided to the State's HBM. The HBM will include these materials in all mailings to the eligible population.

The MCO shall distribute marketing materials to entire service areas covered under this contract.

The MCO or its subcontractors may not seek to influence an individual's enrollment with the MCO in conjunction with the sale of any other insurance.

The MCO shall comply with such procedures and conditions as the State prescribes in order to ensure that before a member is enrolled with the MCO, the individual is provided accurate oral and written information sufficient to make an informed decision.

The MCO shall not directly or indirectly, conduct door-to-door, telephonic or other "cold-call" marketing of enrollment.

The MCO shall require each professional providing services to members eligible for the program to have a unique provider identifier, the method of which will be approved by the State.

The MCO shall report any fraudulent or abusive practices by subcontractors or providers to DSS for investigation or referral to other appropriate authorities and must cooperate with any subsequent investigation. The MCO and its providers are subject to review or investigation by DSS and other State agencies for quality of care, fraud or abuse, and must cooperate fully in the provision of requested information to offices, including but not limited to, DHSS, the Department of Justice, the State Auditor, the Insurance Department, and the appropriate licensing agencies within the Department of Administrative Services.

Member Satisfaction Report

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MCOs must survey their members on at least an annual basis to determine satisfaction with MCO's services.

The MCO must agree to collect and assist DSS in collecting annual member satisfaction data through application of a uniform instrument to a randomly selected sample of its members The State will design a questionnaire to measure satisfaction and include measures of out-of-plan use, to include use of emergency rooms; average waiting time for appointments, including physician office visits; average time and distance to reach providers; access to special providers; and the number and causes of disenrollment; and coordination with other health programs. This member satisfaction survey will be based on the Consumer Assessment of Health Plan Survey (CAHPS). To ensure comparability of results, all members will receive the same survey. DSS will consider suggestions from the MCO for questions to be included in this survey. DSS will tally the results of these surveys, which will be published.

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
7.1.3. ☒ Information strategies
7.1.4. ☒ Quality improvement strategies

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

NOTE: These policies and procedures are already in place for Title XIX. MCOs must distinguish between Title XIX and Title XXI for reporting.

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

MCO's must have an internal written quality assurance plan (QAP) that monitors, assures, and approves the quality of care delivered over a wide range of clinical and health service delivery areas to include, but are not limited to:

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- Well baby care;
- Well child care;
- Pediatric and adolescent development; and,
- Immunizations.

Plans are also required to report semi-annually results of their internal monitoring. This will include the reporting of the above-referenced HEDIS indicators.

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))

Delaware will expect its contracting Medicaid MCOs to use existing provider panels to provide services to the DHCP. The State requires a 1:2500 patient to primary care provider ratio for DSHP and expects the MCOs to maintain that ratio for the DHCP. The MMIS provides weekly reports on MCO capacity. These reports are monitored by DSHP staff. The MCOs are notified of access issues and the need to add providers. Delaware Medicaid's contracting MCOs have contracts with all of the State's hospitals for outpatient and emergency care. A majority of Delaware's physician providers also contract with the Medicaid MCOs. The State's contracting MCOs report percentage of primary providers with open panels on a quarterly basis to DSHP.

The state requires the "prudent layperson" language for emergency services as defined by the BBA of 1997. This regulation also restricts the use of prior authorizations for emergency care and the denial of emergency care provided by non-network providers.

The State will perform consumer satisfaction surveys and will require the MCOs to perform consumer satisfaction surveys. Issues related to access are an integral part of these surveys. The State uses a modified CAHPs survey for the DSHP and will use the same methodology for the DHCP. The State also uses grievance and complaint records for DSHP to identify MCO panels that may be reaching capacity. These methods have worked well for DSHP and we would expect the same results for the DHCP.

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))

Benefit procedures exist for members with chronic, complex, or serious conditions. All of the managed care organizations must comply with regulations regarding access to and adequacy of specialists.

During enrollment, the Health Benefits Manager screens enrollees with chronic, complex, or serious medical conditions and refers this information to the MCOs. The MCOs utilize case managers to assure appropriate access to care for children with serious health care needs.

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))

The state complies with SCHIP requirement of decisions related to the prior authorization of health services within 14 days after receipt of request.

DELAWARE HEALTHY CHILDREN PROGRAM

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

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

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

8.1.1. ☒ YES
8.1.2. ☐ NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge 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)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. ☒ Premiums:

- $10 PFPM for families with children ages one (1) through five (5) with family incomes ranging from 143% FPL through 159% of FPL,
- $10 PFPM for families with children ages six (6) through eighteen (18) with family incomes ranging from 134% FPL through 159% of FPL,
- $15 PFPM for families with children ages one (1) through eighteen (18) with family incomes ranging from 160 % through 176% of the FPL, and
- $25 PFPM for families with children ages one (1) through eighteen (18) with family incomes ranging from 177% to 212% of the FPL.

(refer to CHIP MAGI State Plan Page CS21 for information on the effect of non-payment of premiums).

Incentives for pre-payment of premiums include the following: Pay three (3) months get one (1) premium free month; pay six (6) months get two (2) premium free months; pay nine (9) months get three (3) premium free months.

8.2.2. ☐ Deductibles:

8.2.3. ☐ Coinsurance or copayments:
~~Ten dollars ($10) per emergency room (ER) visit (waived if results in~~

~~immediate inpatient hospitalization or if a prudent layperson would interpret the need for the visit to the ER to be an emergency).~~

8.2.4. ☐ 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)(B))(42CFR 457.505(b))

The public will be notified of cost sharing requirements and any other aspects of the DHCP through the State's Administrative Procedures Act which requires publishing everything that has an impact on State citizens and provides an opportunity for public comment. Information is published in the Delaware Register of Regulations monthly as changes or new initiatives occur (www.state.de.us/research/dor/register.htm). Information will also be initially provided at public meetings and through outreach and educational efforts. Delaware will also use the Health Benefits Manager to educate and continue to do outreach similar to the DSHP.

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

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

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

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

8.4.1- MHPAEA ☒ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 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. (42 CFR 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 by 42 CFR 457.560 (42 CFR 457.496(d)(3)(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: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. 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.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

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.

DELAWARE HEALTHY CHILDREN PROGRAM

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 portion 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-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis 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? (42 CFR 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. (42 CFR 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 42 CFR 457.496(d)(3)(i)(B)) 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. (42 CFR 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 predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 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 predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

DELAWARE HEALTHY CHILDREN PROGRAM

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))

Since cost sharing is per family per month (PFPM), rather than per member per month, each family will pay the same amount no matter the number of children in the household. The premium rates are significantly less than those allowed by the Balance Budget Act of 1997 for premiums (see chart below). ~~There is a minimal copayment of $10 per inappropriate use of the emergency room that will be waived if a prudent layperson would deem the visit an emergency or if it results in an inpatient admission.~~ Delaware believes these levels of cost sharing are affordable but, at the same time, provide an incentive for clients to responsibly use health care services and avoid unnecessary emergency room visits.

An analysis of the State's fee schedule suggests that cumulative cost-sharing will rarely exceed 1% of the family's adjusted gross income. However, should families submit evidence that they have reached the aggregate limit on cost-sharing, the State will work with the MCOs on an individual basis to exempt the family from future cost-sharing.

Premiums as a Percentage of Income									
Premium Amount Per Month	Age	Family Size	134% FPL lower limit	143% FPL lower limit	159% FPL upper limit	160% FPL lower limit	176%FPL upper limit	177% FPL lower limit	212% FPL upper limit
$10 Monthly Premium	1 through 5	1		0.69%	0.62%				
	1 through 5	2		0.51%	0.46%				
	1 through 5	3		0.40%	0.36%				
	6 through 18	1	0.74%		0.62%				
	6 through 18	2	0.54%		0.46%				
	6 through 18	3	0.43%		0.36%				
$15 Monthly Premium	1 through 18	1				0.93%	0.84%		
	1 through 18	2				0.68%	0.62%		
	1 through 18	3				0.54%	0.49%		
$25 Monthly Premium	1 through 18	1						1.40%	1.17%
	1 through 18	2						1.03%	0.86%
	1 through 18	3						0.82%	0.68%

*Based on the 2018 Poverty Limit of $12,140 for 1 person, $16,460 for 2, and $20,780 for 3.

DELAWARE HEALTHY CHILDREN PROGRAM

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)

Delaware's application form asks for race group including American Indian/Alaskan Native and we accept self-declaration. This information is included in the automated record, which enables us to exclude these families from premium requirements. We will add a statement to the approval notices indicating that American Indian/Alaskan Native families are exempt from premium requirements. The approval notices include a toll free contact number. To exclude American Indian/Alaska Native enrollees from any copayments on non-emergent use of emergency room services, the premium and approval notices will include a statement advising families the AI/AN families are exempt. The notices will advise AI/AN families to call the Health Benefits Manager (HBM) at a toll-free number to identify themselves and request an exemption. MMIS has an exemption code that must be manually entered by the HBM.

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

Coverage will be cancelled when the family is in arrears for two premium payments. The coverage will end the last day of the month when the second payment is due. A notice of cancellation will be sent to the family advising the family to report any change in circumstances, such as a decrease in income that may result in eligibility for Medicaid. If one premium payment is received by the last day of the cancellation month, coverage will be reinstated (refer to CHIP MAGI State Plan Page CS21 for information on the effect of non-payment of premiums).

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

- ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

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

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

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

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this Title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this Title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

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

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

1) to decrease the number of uninsured children and thereby improve their health and chances for life success;
2) to mainstream uninsured children in the health care industry so they receive the same quality of care as insured children; and
3) to go from a clinical base system (fee-for-service/sick care) to a community-base system (managed care/preventive care) which provides genuine access to high quality care.

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

1) show-rate of uninsured children;
2) percentage increase in wellness visits; and
3) percentage decline in unnecessary emergency room visits.

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

The State will use the first year of the DHCP to develop base line information to monitor future years of the program. In addition, the State will expect the same utilization reporting for the DHCP that we currently receive for the DSHP. We will also monitor the experience of the DHCP against the experience for the same age cohorts under the DSHP to look for possible outliers.

The State will require encounter data submission for the DHCP.The State can also identify specific reporting categories and require the MCOs to report that information from their database. The State will be able to report all of the CMS required information identified in section 9.3.

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

9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

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

9.3.8. ☐ Performance measures for special targeted populations.

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

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

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

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

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

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment) - State general funds for mental health services covered under the SCHIP State Plan are appropriated annually to the Delaware Department of Services for Children, Youth and Their Families (DSCYF). Claims for covered

behavioral health services are submitted to DMMA by DSCYF during the year as services are provided, and as the claims are processed and paid by DMMA. The State draws down the appropriate federal share and provides it to DSCYF.

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

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

A Legislative hearing was held on 3/18/98 related to Senate Bill 246, which would authorize the DHCP for Delaware. There were thirty (30) advocates present with testimony from
eleven (11) and written testimony from three (3).

The Delaware Health Care Commission (DHCC) hosted public hearings to obtain input on the Title XXI Plan in Kent County (Milford Library) on 3/31/98 and New Castle County (Stanton Middle School) on April 1, 1998.

The major issues raised at all hearings were the imposition of premiums, the six-month waiting period after loss of other insurance, the proposed $25 copay on ER services, and the exclusion of dental benefits for these children. In addition, advocates expressed concern that the State was not pursuing presumptive eligibility.

The DHCC, after deliberating the testimony, supported the Plan as written with modifications/exceptions to the six-month waiting period and the $25 copay on ER services. The recommended changes are reflected in this submission.

Delaware will publish, concurrent with this Plan submission, notice in the State's Register of Regulations under the requirements of the Administrative Procedures Act (APA). Any changes proposed after the Plan is implemented will be published in accordance with the APA with appropriate periods for comment and review/consideration of comments.

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))

Delaware has no federally or State-recognized Indian tribes. Any Delaware resident, including those who are American Indians or Alaska natives, may participate in the review of amendments to State law or

regulation and may offer comments on all Program policies, including those relating to provision of child health assistance to American Indian or Alaska native children. The process for review and comment is outlined in 9.9.2 below.

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 Section 457.65(b) through (d).

Delaware will publish, concurrent with Plan submission, notice in the State's Register of Regulations under the requirements of the Administrative Procedures Act (APA). Any changes proposed after the Plan is implemented will be published in accordance with the APA with appropriate periods for comment and review/consideration of comments.

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: Delaware	CHIP Health Service Initiative	Cost Projection of Approved CHIP Plan	Total
Federal Fiscal Year	FFY 2019	FFY 2019	FFY 2019
State's enhanced FMAP rate	93.29%	93.29%	93.29%
Benefit Cost			
Insurance Payments			
Managed care		$29,781,503	$29,781,503
per member/per month rate		8,732 / $284.22	
Fee for Service		$6,763,666	$6,763,666
Total Benefit Costs		$36,545,169	$36,545,169
(Offsetting beneficiary cost sharing payments)		($900,000)	($900,000)
Net Benefit Costs		$35,645,169	$35,645,169
Cost of Proposed SPA Changes - Benefit	$49,500	$49,500	$49,500
Administrative Costs			
Personnel		$100,000	$100,000
General Administration		$369,298	$369,298
Contractors/Brokers		$267,115	$267,115
Claims Processing		$756,508	$756,508
Outreach/marketing costs			
Health Services Initiatives		$98,880	$98,880
Other			
Total Administrative Costs		$1,591,801	$1,591,801
10% Administrative Cap		$3,723,697	$3,723,697
Cost of Proposed SPA Changes	$49,500	$49,500	$49,500
Federal Share	$46,179	$34,738,369	$34,738,369
State Share	$3,321	$2,498,601	$2,498,601
Total Program Costs	$49,500	$37,236,970	$37,236,970

Budget Assumptions

- Rate of client growth will increase an average of 2% in FY 2019;
- Capitation rates paid to commercial managed care organizations will increase an average of 8.3% based on new contracts;
- Enhanced federal FMAP will be 93.29% effective October 1, 2018;
- Sources of non-federal funds are General Funds, transfers from the Dept. of Children, Youth & Families and client premiums.

Section 10. Annual Reports and Evaluations (Section 2108)

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

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

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

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

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

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

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

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX. (Section 2107(e)) (42CFR 457.935(b))

The items below were moved from section 9.8. (Previously items 9.8.6-9.8.9)

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

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

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

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

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

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

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

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

12.1. Eligibility and Enrollment Matters

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

Note: Delaware is using Medicaid Fair Hearing Practices and Procedures for review of eligibility and enrollment, as follows:

Timely written notices of agency actions are provided to applicants and recipients that include a statement of the right to a fair hearing, how to request a hearing, and a statement that he or she may represent him or herself or may be represented by counsel or by another person. An opportunity for a fair hearing will be provided to any individual requesting a hearing who is dissatisfied with a decision of the Division of Social Services, (i.e., denial, suspension, reduction, delays, termination, disenrollment for failure to meet premium payment requirements). If the recipient requests a hearing within the timely notice period, enrollment will not be suspended, reduced, discontinued, or terminated until a decision is reached after a fair hearing.

The hearing officer will be an impartial official and may not have been previously involved with the matters raised at the hearing outside his duties as hearing officer. The notice of the hearing informs the applicant or recipient of the hearing procedures and of the opportunity to examine the record prior to the hearing.

The decision of the hearing officer shall be in writing and shall be sent to the appellant as soon as it is made but not more than 90 days after the date the appeal is filed.

12.2. Health Services Matters

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

Note: Delaware is using Medicaid Fair Hearing Practices and Procedures for review of health service matters, as follows:

MCOs must give clients due process rights when it denies, reduces, or terminates a client's health service; it must notify the client or his/her authorized representative in writing of the right to file a complaint/grievance. The notice shall explain: 1) how to file a complaint/grievance with the MCO; 2) how to file a complaint grievance with the State; 3) that filing a complaint/grievance through the MCO's complaint grievance process is not a

prerequisite to filing for a State hearing; 4) the circumstances under which health services will be continued pending a complaint/grievance; 5) any right to request an expedited complaint/grievance; 6) the right to advised or represented by an ombudsman, lay advocate, or attorney; and, 7) the right to request that a disinterested third party who works for the MCO assist in the writing of the complaint/grievance.

The MCO will notify the client of complaint/grievance resolution or schedule a date for the Grievance Committee non-expedited formal hearing within ten (10) calendar days of receipt of the request for the formal hearing. The complaint/grievance formal hearing must take place within thirty (30) calendar days of receipt of the written complaint/grievance (nonexpedited formal hearing). The MCO must render a decision to the client within thirty (30) calendar days of receipt of the written complaint/grievance (nonexpedited). If the decision affirms denial, reduction, or termination of a client's health service or in any way denies the resolution sought, the client will be informed of the right to apply for a fair hearing.

The MCO must ensure that the MCO's complaint/grievance system cannot be prerequisite to, nor a replacement for, the client's right to appeal to the Division of Social Services and request a fair hearing in accordance with 42 CFR 431, Subpart E.

The MCO must comply with DSS hearing rules and final hearing decisions.

The MCO will provide for an expedited formal complaint/grievance hearing (twenty-four (24) to forty-eight (48) hours) for any action, which seriously jeopardizes the client's health or well-being.

12.3. Premium Assistance Programs

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

N/A for Delaware