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State/Territory Name: Louisiana

State Plan Amendments (SPA) #: LA-20-0005

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Children and Adults Health Programs Group

April 24, 2020

Ruth Johnson
Medicaid Executive Director
Louisiana Department of Health
P.O. Box 629
Baton Rouge, LA 70821-0629

Dear Ms. Johnson:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), LA-20-0005, submitted on April 7, 2020, has been approved. This SPA has a retroactive effective date of March 1, 2020.

In response to the COVID-19 public health emergency, Louisiana notified CMS on April 7, 2020 that it would invoke its existing CHIP state plan authority (LA-19-0022) on March 1, 2020, to waive premiums and prior authorization requirements, provide enrollees eligibility beyond the renewal period, and waive certain verification requirements at application and renewal, during a state or federally declared public health emergency or disaster.

In addition, the state requested to implement new flexibilities through this SPA (LA-20-0005) to:

- Conduct tribal consultation subsequent to the submission of this SPA, as permitted under section 1135 of the Social Security Act;
- Provide an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status as long as the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period; and
- Suspend the state's premium lock-out period, and continue coverage of CHIP eligible children regardless of whether there is an outstanding premium.

In the event of a future disaster, this SPA provides Louisiana with the authority to implement the aforementioned temporary policy adjustments by simply notifying CMS of its intent, the effective date and duration of the provision, and a list of applicable Governor or federally-declared disaster or emergency areas. While the state must provide notice to CMS, this option provides an administratively streamlined pathway for the state to effectively respond to an evolving disaster event.

Page 2 - Ms. Ruth Johnson

Your title XXI project officer is Ms. Sandra Phelps. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
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Baltimore, MD 21244-1850
Telephone: (410) 786-1968
E-mail: Sandra.Phelps@cms.hhs.gov

If you have any questions, please contact Meg Barry, Acting Division Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/signed Amy Lutzky/

Amy Lutzky
Acting Deputy Director

cc: Courtney Miller, Director, Medicaid and CHIP Operations Group
Jackie Glaze, Deputy Director, Medicaid and CHIP Operations Group

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

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

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

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

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

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

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

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

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

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

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

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment.

For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

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

Original Plan

LaCHIP Phase I

Medicaid Expansion SCHIP for children 6-18 between 101- 133 Percent of the Federal Poverty Level

Effective Date: November 1, 1998

Implementation Date: November 1, 1998

Amendment 1

LaCHIP Phase II

Medicaid Expansion SCHIP for Children 0-18 Between 134-150 Percent of the Federal Poverty Level

Effective Date: October 1, 1999

Amendment 2

LaCHIP Phase III

Medicaid Expansion SCHIP for Children 0-18 Between 151-200 Percent of the Federal Poverty Level

Effective Date: June 6, 2001

Amendment 3

Removal of Waiting Period in Medicaid Expansion SCHIP

Approval date: February 24, 2003

Amendment 4

LaCHIP Phase IV

Creation of Separate SCHIP – Unborn Child Option

Effective date: April 1, 2007

Amendment 5

LaCHIP Phase V

Separate SCHIP for Children 0-18 between 201-250 Percent of the Federal Poverty Level

Effective date: April 1, 2008

Implementation date: May 1, 2008

Amendment 6

Addition of Robert Wood Johnson Foundation Maximizing Enrollment for Children Grant Funds \$999,926.00 for grant period: February 15, 2009 through February 14, 2003

Effective date: February 15, 2009

Implementation date: February 15, 2009

Amendment 7

Addition of Prospective Payment Methodology for Federally Qualified Health Centers and Rural Health Centers LaCHIP Phase V

Effective date: July 1, 2010

Implementation date: July 1, 2010

Amendment 8

Addition of Dental Benefit for LaCHIP Phase V

Effective date: February 1, 2012

Implementation date: February 1, 2012

Amendment 9

Withdrawn

Amendment 10

Withdrawn

Amendment 11

Reduction of Dental Reimbursement Fees for EPSDT Dental Services for Phase V

Effective date: July 1, 2012

Implementation date: July 1, 2012

Amendment 12

LaCHIP Phase V Benefits Administration Changes

Effective date: January 1, 2013

Implementation date: January 1, 2013

Amendment 13

LA SPA TN 13-01 CH

Reimbursement Rate Reduction for LaCHIP Affordable Plan Dental Services

Effective date: August 1, 2013

Amendment 14

LA SPA TN 14-0002

Modified Adjusted Gross Income (MAGI) eligibility and methods to cover targeted low-income children from conception to birth to non- Medicaid eligible mothers.

Effective date: January 1, 2014

Implementation date: January 1, 2014

Amendment 15

LA SPA TN 14-0003

MAGI Eligibility for Children Covered Under Title XXI Funded Medicaid Program

Effective date: January 1, 2014

Implementation date: January 1, 2014

Amendment 16

LA SPA TN 14-0004

Establishment of 2101(f) Groups to cover children who lose Medicaid eligibility as a result of discontinuation of disregards.

Effective date: January 1, 2014

Implementation date: January 1, 2014

Amendment 17

LA SPA TN 14-0005

MAGI-based eligibility processing to utilize the model single streamline paper and online application.

Effective date: October 1, 2013

Implementation date: October 1, 2013

Amendment 18

LA SPA TN 14-0006

MAGI non-financial eligibility policy on residency, citizenship, social security numbers, substitution of coverage, non-payment of premiums, and continuous eligibility.

Effective date: January 1, 2014

Implementation date: January 1, 2014

Amendment 19

LA SPA TN 15-0001

MAGI Eligibility and Methods – Determination State to Assessment State

Effective date: November 1, 2015

Amendment 20

LA SPA TN 16-0001

MAGI Eligibility Processing – Assessment State to Determination State

Effective date: April 20, 2016

Amendment 21

LA SPA TN 18-0008

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Compliance

Effective date: October 2, 2017

Amendment 22

LA SPA TN 19-0013

CHIP Managed Care

Effective date: July 1, 2018

Amendment 23

LA SPA TN 19-0010

Children’s Health Insurance Program Reauthorization Act (CHIPRA)

Lawfully Resident Children

Effective date: February 1, 2019

Amendment 24

LA SPA TN 19-0022

CHIP Disaster Eligibility and Enrollment

Effective date: July 10, 2019

Provisions for implementing temporary adjustments to eligibility and enrollment policies for application and redetermination, cost sharing, and prior authorization requirements for children in families living in Federal Emergency Management Agency (FEMA) or governor-declared disaster areas at the time of the disaster event. In the event of a disaster, the State will notify the Centers for Medicare & Medicaid Services (CMS) of the intent to provide these temporary adjustments, the effective dates of such adjustments, and the parishes/areas impacted by the disaster.

Amendment 25

LA SPA TN 20-0005

CHIP Disaster Eligibility and Enrollment

Effective date: March 1, 2020

Implementation date: March 1, 2020

To implement provisions for temporary adjustments to eligibility and enrollment policies for tribal consultation, eligibility standards and methodology, and premiums lock-out period for children in families living in state or federally declared disaster or public health emergency areas at the time of the event. In the event of a disaster/public health emergency, the State will notify the Centers for Medicare & Medicaid Services (CMS) of the intent to provide these temporary adjustments, the effective dates of such adjustments, and the parishes/areas impacted by the disaster. The duration of the provisions may not exceed the duration of the state or federal disaster period.

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.

On July 16, 2019, a tribal notification with a summary of the State's intent to seek approval from CMS to implement temporary adjustments to eligibility and enrollment policies for application and redetermination, cost-sharing, and prior authorization requirements for children in families living in Federal Emergency Management Agency (FEMA) or governor-declared disaster areas at the time of the disaster event, was sent to the five federally recognized tribes. The seven-day comment period for the tribal notification ended July 23, 2019.

In the event of a state or federally declared disaster or public health emergency, the State may modify the tribal consultation process by shortening the number of days before submission of the SPA and/or conducting consultation after submission of the SPA. The duration of the provisions may not exceed the duration of the state or federal disaster period.

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))

Phase I:

- 1) **On July 31, 1998, Louisiana submitted a proposal to implement a State Children’s Health Insurance Program, which expanded Medicaid coverage to uninsured children who were at least six years of age but under 19 years of age in families with incomes at or below 133 percent of the federal poverty level (FPL).**

The expansion was to serve an estimated additional 28,350 children. Louisiana implemented this expansion on November 1, 1998.

Phase II:

- 2) **On June 30, 1999, Louisiana submitted a state plan amendment to expand Medicaid coverage to children between birth and up to 19 years of age in families with incomes above 133 percent and at or below 150 percent FPL. The expansion was to serve an estimated additional 10,725 children. Louisiana implemented this Phase II LaCHIP Medicaid expansion on October 1, 1999.**

Phase III:

- 3) **On December 18, 2000, Louisiana submitted a state plan amendment to further expand Medicaid eligibility to children from birth up to 19 years of age in families with incomes up to 200 percent FPL. A total enrollment of 22,575 was projected. Phase III implementation began January 1, 2001.**

Children Below 200 Percent FPL - See attached Exhibit 2.1.

Creditable Coverage

At initial implementation of SCHIP in 1998, privately provided creditable coverage was minimal, with only one private foundation, Blue Cross/Blue Shield’s Caring Program for Children, providing limited health services coverage to children in the state who were uninsured. This does not meet the definition of creditable coverage. Prior to implementation of Phase I of LaCHIP, participation was limited to children below 133 percent FPL and less than 1,000 children were covered. Upon implementation of LaCHIP Phase I, the Caring Program for Children then increased its threshold to 150 percent FPL and 187 children were covered with a limit of 200 enrollees. Upon implementation of LaCHIP Phase II, the Caring Program for Children was discontinued. The only creditable public coverage available is Medicaid. The State’s public hospital system continues to function as a “safety net” system and operates pediatric outpatient clinics

throughout the state.

As a direct result of SCHIP implementation in 1998, Louisiana experienced a significant increase in the percentage as well as number of children with creditable health coverage under its public health insurance programs. Administrative data shows that the number of children with public coverage has increased from 315,571 in October 1998 to 620,926 in August of 2007. This takes into consideration the decrease in publicly covered children in New Orleans by 61,188 as a result of Hurricane Katrina.

A state level, 10,000 household survey -- referred to as the Louisiana Health Insurance Survey (LHIS)—was conducted in the Summers of 2003, 2005, and 2007 [results pending for 2007] to determine health coverage status. We believe this survey provides the most accurate available information for Louisiana based on the survey size as well as adjustments for the state specific Medicaid undercount which was calculated through surveying a subset of individuals enrolled. The survey results provide information on health coverage of children by income level, race and ethnicity and geographic location and can be accessed on the “Reports” page of our website at www.lachip.org.

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):

Louisiana currently outstations Medicaid eligibility workers at the State’s eleven public disproportionate share hospitals. In addition, Louisiana has more than 400 certified Medicaid Application Centers throughout the state that offer opportunities for assistance in applying for Medicaid for children at locations other than the “welfare office.” These include Community Action Agencies, Head Start, school-based health centers, churches and other faith-based organizations and health care providers, etc. (A complete current listing of Medicaid application centers is available for review.)

Eligibility for cash assistance (Temporary Assistance for Needy Families known in Louisiana as Family Income Temporary Assistance Program-FITAP) is determined by the Department of Social Services (DSS), Office of Family Security. The Louisiana Department of Health (LDH) has a memorandum of understanding with DSS to determine initial and ongoing Medicaid eligibility using July 16, 1996 eligibility criteria for applicants determined eligible for cash assistance. Applicants rejected because of income and resources are referred on-line to LDH for exploration of Medicaid

eligibility. Individuals who lose eligibility for cash assistance receive an additional month of Medicaid eligibility while they are referred to BHSF to determine continuing eligibility for Medicaid only. Possible eligibility in all Medicaid Programs is evaluated before Medicaid is terminated.

The Maternal and Child Health Section of the Office of Public Health also provides referrals to Medicaid via its Women, Infants and Children (WIC) and prenatal clinics as well as a toll-free hotline through which they try to link callers with available resources for medical and social services.

LaCHIP outreach activities have included:

- 1) Back to School Campaigns at locations statewide each August;**
- 2) Distributing LaCHIP flyers to all public school children and many parochial school children;**
- 3) Providing “Application Assistor” training for school-based health centers;**
- 4) Continuing interagency agreement with Department of Education that encompasses LaCHIP outreach and education about the benefits and processes;**
- 5) Contracting for “Walkers and Talkers Enrollment Initiative” in four parishes;**
- 6) Participating in fiscal intermediary provider training workshops to inform providers;**
- 7) Hiring Spanish-language in-house translator to translate materials and attend outreach opportunities;**
- 8) Awarded six-month grant to conduct outreach to Hispanic community in metropolitan New Orleans;**
- 9) Providing programs and materials for meetings with Annual 100 Black Men Conferences, Louisiana Chapter National Conference of Black Mayors, Inc., Native American tribal gatherings, and faith-based organizations; and**
- 10) Providing information packets to headquarters of American, United, U.S. Airways, and Delta airlines following the September 11 tragedies.**

Louisiana continues to be aggressive in identifying and enrolling all uncovered low-income children who are eligible to participate in Medicaid and SCHIP. In 2004, Governor Blanco identified enrolling all **eligible** children in LaCHIP and Medicaid as one of her immediately health policy goals and by August 2005, the number of low-income children with public coverage had increased by more than 50,000. In conjunction with expansion to moderate-income households, the administration and Legislature appropriated money to enroll an additional 24,000 children in Medicaid or LaCHIP in SFY 08, including

unprecedented funding for outreach.

- 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:

Louisiana’s Department of Health is not directly involved in a public-private partnership concerning health insurance for children but made referrals to the private “Caring Program for Children” as appropriate until program was discontinued. A denied Medicaid application was necessary to qualify for the program. Louisiana currently has a task force on the working uninsured that is examining potential options for future public-private partnerships to increase access to health coverage.

2007 legislation to expand health coverage [Act 407] included a provision that the Department work to develop a premium assistance program. With our Medicaid expansion SCHIP program we use Section 1906 authority to provide premium reimbursement for families who have employer sponsored insurance available when cost effectiveness can be established. The scale of our HIPP program has been greatly expanded with staff of 13 (7 added for SFY 08), an increase from just one staff person prior to 2004.

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

1. **Coordination with Medicaid**

The same one-page application form is used to apply for Medicaid and LaCHIP. Applicants are first evaluated for eligibility for Title XIX programs, then for Title XXI, but the process is transparent to applicants.

2. **Coordination with Private Insurance**

Given that the first two phases of Title XXI were expansions of Medicaid coverage up to 133 percent and 150 percent FPL respectively, problems with crowd out *were* not significant. In addition, provisions which required a three-month gap in insurance coverage previously incorporated into the Title XXI Medicaid expansion policy in 1998 were deleted in 2001 at the request of CMS to bring the state into compliance with current federal regulations at 42 CFR 435.914.

3. **Coordination with Title V**

Office of Public Health (OPH) administers the State’s Title V Block

Grant which includes outreach programs to pregnant women and children, and they have shared their expertise and successful methods in conducting outreach. OPH operates WIC clinics in 108 different locations throughout the state and oversees 32 school-based health centers. Each of these locations has been designated as a LaCHIP Application Assistance Site and formal training has been conducted for over 350 employees to enable them to assist applicants in completing the application form and in gathering necessary verifications. We will continue our collaboration with OPH in jointly developing outreach strategies involving WIC clinics, school-based health clinics, and Children's Special Health Services clinics. Title V clinics are enrolled as Medicaid providers and bill for services provided to the Title XIX and Title XXI children while Title V funds are reserved for patients with no health coverage.

The Office of Public Health, Section of Maternal and Child Health, received a grant of nearly \$1 million in 1999 from the Robert Wood Johnson Foundation (RWJF) for Louisiana's *Covering Kids* Initiative which assists in outreach to uninsured children. We closely coordinated with OPH to ensure that the *Covering Kids* initiative complemented and filled in the gaps in LaCHIP outreach initiatives. The OPH initiative included two pilots, the first targeting service industry employers in the Greater New Orleans area and a second through St. Francis Cabrini Hospital in Central Louisiana. Additional components included a statewide public relations campaign and development of outreach materials for limited English proficient populations, former TANF recipients and other specific target populations.

4. **Coordination with Other Medical Programs**

The State's charity hospital system has Medicaid eligibility outreach workers in all facilities who assist potential eligibles in applying for Medicaid or LaCHIP, as appropriate. Other public treatment programs such as mental health services also make these applications available. Many Medicaid providers and community agencies also make LaCHIP applications available.

Section 3. Methods of Delivery and Utilization Controls

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

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and

primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

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

3.1.1 Choice of Delivery System

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

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

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

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

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

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

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should

describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

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

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

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

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

- No
- Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others. **CHIP populations that are members of the Chisholm Class receive behavioral health services through a managed care delivery system; however, Chisholm Class members may opt out of managed care for physical health services. The State would then provide those physical health services through fee-for-service.**

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

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

- Managed care organization (MCO) (42 CFR 457.10)
 - Capitation payment
Describe population served: **All, with the exception of those in a Prepaid Inpatient Health Plan (PIHP)**
- Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
 - Capitation payment
 - Other (please explain)
Describe population served: **Children at risk of out of home placement who are in the Coordinated System of Care (CSoC).**

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

- Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
 - Capitation payment
 - Other (please explain)
Describe population served:
- Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
 - Case management fee
 - Other (please explain)
- Primary care case management entity (PCCM Entity) (42 CFR 457.10)
 - Case management fee
 - Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
 - Other (please explain)

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

- Provision of intensive telephonic case management
- Provision of face-to-face case management
- Operation of a nurse triage advice line
- Development of enrollee care plans

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

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

3.1.3 Nonemergency Medical Transportation PAHPs

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

- The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):
 - All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
 - The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
 - The provision against provider discrimination in 42 CFR 457.1208.
 - The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).

- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

- 3.2.1 The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))
- 3.2.2 The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))
- 3.2.3 The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.
- 3.2.4 The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

3.3 Rate Development Standards and Medical Loss Ratio

- 3.3.1 The State assures that its payment rates are:

- Based on public or private payment rates for comparable services for comparable populations; and
- Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

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

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

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

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

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

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

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

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

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

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

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

3.4 Enrollment

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

3.4.1 Enrollment Process

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

3.4.1.2 The State assures that its enrollment system gives beneficiaries already enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity priority to continue that enrollment if the MCO, PIHP, PAHP, PCCM, or PCCM entity does not have the capacity to accept all those seeking enrollment under the program. (42 CFR 457.1210(b))

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

Yes

No

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

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

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

3.4.2 Disenrollment

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

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

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

457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

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

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

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

3.4.2.5 Enrollee Requests for Disenrollment.

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

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

- Yes
- No

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

- The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))
- The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))
- The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:
 - During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
 - At least once every 12 months thereafter;
 - If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
 - When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

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

3.5 Information Requirements for Enrollees and Potential Enrollees

- 3.5.1** The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.
- 3.5.2** The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))
- 3.5.3** The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-

(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

- 3.5.4 The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:
- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
 - Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))
- 3.5.5 If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:
- The format is readily accessible;
 - The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
 - The information is provided in an electronic form which can be electronically retained and printed;
 - The information is consistent with the content and language requirements in 42 CFR 438.10; and
 - The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.
- 3.5.6 The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:
- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
 - Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
 - Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
 - Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
 - Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees:
 - That oral interpretation is available for any language and written translation is available in prevalent languages;
 - That auxiliary aids and services are available upon request and

- at no cost for enrollees with disabilities; and
- How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

3.5.7 ☒

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

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

3.5.8 ☒

The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees

of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.

3.5.9 ☒

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

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

3.5.10 ☒

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

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

- The extent to which, and how, after-hours and emergency coverage are provided, including:
 - What constitutes an emergency medical condition and emergency services;
 - The fact that prior authorization is not required for emergency services; and
 - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
 - The right to file grievances and appeals;
 - The requirements and timeframes for filing a grievance or appeal;
 - The availability of assistance in the filing process; and
 - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

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

3.5.12 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in

42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

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

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

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

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

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

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

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

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

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

3.5.18 The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in

accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

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

- 3.6.1 The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)
- 3.6.2 The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)
- 3.6.3 The State assures that it:
- Publishes the State’s network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
 - Makes available, upon request, the State’s network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

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

- 3.6.4 The State assures that each MCO, PAHP and PIHP meet the State’s network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)
- 3.6.5 The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:
- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
 - Women’s health specialists to provide direct access to covered care necessary to provide women’s routine and preventative health care services for female enrollees; and
 - Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to

42 CFR 438.206(b)

- 3.6.6** The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))
- 3.6.7** The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))
- 3.6.8** The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:
- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
 - Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
 - Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
 - Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
 - Establishing mechanisms to ensure compliance by network providers;
 - Monitoring network providers regularly to determine compliance;
 - Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))
- 3.6.9** The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)
- 3.6.10** The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has

been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

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

3.6.11 ☒

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

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

3.6.12 ☒

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

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

3.6.13 ☒

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

3.6.14 ☒

The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct

utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))

- 3.6.15** The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP implements the policy. (42 CFR 457.1216, cross-referencing to 42 CFR 438.62)
- 3.6.16** The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:
- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
 - Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
 - Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services;
 - Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
 - Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees;
 - Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;
 - Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
 - Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

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

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

- 3.6.17 The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.
- 3.6.18 The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))
- 3.6.19 The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:
- Is in accordance with applicable State quality assurance and utilization review standards;
 - Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))
- 3.6.20 The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

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

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

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

- Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));
- MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));
- MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));
- If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and
- MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3

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

- The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;
- All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations,

including applicable subregulatory guidance and contract provisions; and

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

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

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

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

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

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

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

3.8 **Beneficiary Protections**

3.8.1 The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42

CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))

- 3.8.2** The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))
- 3.8.3** The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:
- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))
 - Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
 - Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

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

- 3.9.1** The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))
- 3.9.2** The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))
- 3.9.3** The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))
- 3.9.4.** Does the state offer and arrange for an external medical review?

- Yes
 No

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

- 3.9.5** The State assures that the external medical review is:
- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
 - Independent of both the State and MCO, PIHP, or PAHP;
 - Offered without any cost to the enrollee; and
 - Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))
- 3.9.6** The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))
- 3.9.7** The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))
- 3.9.8** The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))
- 3.9.9** The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.
- 3.9.10** The State assures that the notice of an adverse benefit determination explains:
- The adverse benefit determination.
 - The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
 - The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
 - The procedures for exercising the rights specified above under this

assurance.

- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))

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

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

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

- Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
- Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:
 - An appeal of a denial that is based on lack of medical necessity.
 - A grievance regarding denial of expedited resolution of an appeal.
 - A grievance or appeal that involves clinical issues.
- All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
- Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

- The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))
- 3.9.14** The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))
- 3.9.15** The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))
- 3.9.16** The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))
- 3.9.17** The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))
- 3.9.18** The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:
- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
 - Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
 - Resolve the appeal as expeditiously as the enrollee's health

condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

- 3.9.19** The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))
- 3.9.20** The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross-referencing to 42 CFR 457.408(d)(1))
- 3.9.21** For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:
- The results of the resolution process and the date it was completed; and
 - For appeals not resolved wholly in favor of the enrollees:
 - The right to request a State review, and how to do so.
 - The right to request and receive benefits while the hearing is pending, and how to make the request.
 - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross-referencing to 42 CFR 457.408(d)(2)(i) and (e))
- 3.9.22** For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross-referencing to 42 CFR 457.408(d)(2)(ii))
- 3.9.23** The State assures that if it offers an external medical review:
- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
 - The review is independent of both the State and MCO, PIHP, or PAHP; and
 - The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))
- 3.9.24** The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support

an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))

- 3.9.25** ☒ The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:
- The right to file grievances and appeals;
 - The requirements and timeframes for filing a grievance or appeal;
 - The availability of assistance in the filing process;
 - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
 - The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

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

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

3.10 Program Integrity

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

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

- 3.10.1** The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:
- Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;
 - Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and
 - Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280)
- 3.10.2** The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)
- 3.10.3** The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))
- 3.10.4** The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:
- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
 - Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
 - Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
 - Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP;

- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least \$5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

- 3.10.5** The State assures that each MCO, PIHP, or PAHP requires and has a mechanism for a network provider to report to the MCO, PIHP or PAHP when it has received an overpayment, to return the overpayment to the MCO, PIHP or PAHP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCO, PIHP or PAHP in writing of the reason for the overpayment. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(2))
- 3.10.6** The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))
- 3.10.7** The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))
- 3.10.8** The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))
- 3.10.9** The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control

interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

- 3.10.10** The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))
- 3.10.11** The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)
- 3.10.12** The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:
- Encounter data in the form and manner described in 42 CFR 438.818.
 - Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.
 - Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.
 - Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.
 - Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.
 - The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

- 3.10.13** The State assures that:

- It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))
 - It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and
 - It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))
- 3.10.14** The State assures that each MCO, PIHP, PAHP, PCCM, PCCM entity, and any subcontractors provides: written disclosure of any prohibited affiliation under 42 CFR 438.610, written disclosure of and information on ownership and control required under 42 CFR 455.104, and reports to the State within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract. (42 CFR 457.1285, cross referencing 42 CFR 438.608(c))
- 3.10.15** The State assures that services are provided in an effective and efficient manner. (Section 2101(a))
- 3.10.16** The State assures that it operates a Web site that provides:
- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services;
 - Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
 - The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

3.11 Sanctions

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

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

beneficiaries.

- 3.11.1 The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)
- 3.11.2 The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))
- 3.11.3 The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

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

- 3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?
 Yes
 No

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

- 3.11.5 The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))
- 3.11.6 The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b))
- 3.11.7 The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review

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

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

3.12.1 Quality Strategy

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

- 3.12.1.1 The State assures that it will draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished CHIP enrollees as described in 42 CFR 438.340(a). The quality strategy must include the following items:
- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
 - A description of:
 - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
 - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
 - Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
 - A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
 - The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
 - For MCOs, appropriate use of intermediate sanctions that, at

a minimum, meet the requirements of subpart I of 42 CFR Part 438;

- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a "significant change" for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

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

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

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

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

3.12.1.6 The State assures that it will submit to CMS:

- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
- A copy of the revised strategy whenever significant changes

are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

3.12.1.7 Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:

- Make the strategy available for public comment; and
- If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))

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

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

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

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

- Standard performance measures specified by the State;
- Any measures and programs required by CMS (42 CFR 438.330(a)(2));
- Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);
- Mechanisms to detect both underutilization and overutilization of services; and

- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1))

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

- 3.12.2.1.2 The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:
- Measurement of performance using objective quality indicators;
 - Implementation of interventions to achieve improvement in the access to and quality of care;
 - Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
 - Planning and initiation of activities for increasing or sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

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

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

- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

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

3.12.2.2.1 The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))

3.12.2.2.2 The State assures that it annually requires each MCO, PIHP, and PAHP to:

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

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

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

3.12.3 Accreditation

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

3.12.3.1 The State assures that it requires each MCO, PIHP, and PAHP to inform the state whether it has been accredited by a private independent accrediting entity, and, if the MCO, PIHP, or

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

- 3.12.3.2 The State assures that it will make the accreditation status for each contracted MCO, PIHP, and PAHP available on the Web site required under 42 CFR 438.10(c)(3), including whether each MCO, PIHP, and PAHP has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level; and update this information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

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

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

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

3.12.5 Quality Review

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

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

3.12.5.1 External Quality Review Organization

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

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

3.12.5.2 External Quality Review-Related Activities

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

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

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

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

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

- 3.12.5.2.4** The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:
- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
 - A review, conducted within the previous 3-year period, to determine the PCCM entity’s compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

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

- 3.12.5.3.1** The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))
- 3.12.5.3.2** The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).
- 3.12.5.3.3** The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO,

PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:

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

3.12.5.3.4 ☒ The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));
- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
 - Objectives;
 - Technical methods of data collection and analysis;
 - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
 - Conclusions drawn from the data;
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care

services furnished to CHIP beneficiaries;

- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

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

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

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

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

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

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

Section 4. Eligibility Standards and Methodology (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: Statewide

4.1.2. Age: Children through the age of 18 years will be eligible for Medicaid Expansion SCHIP as well as the Separate SCHIP, except for those unborn children whose coverage is limited to Conception through Birth

4.1.3. Income:

LaCHIP Medicaid Expansion (Equal to or Less than 200 percent FPL) To be eligible for the Medicaid expansion, a child must live in a family whose income is at or below 200 percent FPL, after allowing the following Medicaid eligibility monthly deductions: \$90 per working individual, the first \$50 of voluntary or court- ordered child support received for the entire income unit, all court ordered child support paid by a member of the income unit to someone outside the home, up to \$200 paid child care per child under age 2 and up to \$175 paid child care for children over the age of 2.

For an unborn child enrolled in **LaCHIP Phase IV**, family income (counting the unborn in the family unit) must be at or below 200 percent of the Federal Poverty Level and the family otherwise ineligible for Title XIX Medicaid benefits.

The four income deductions mentioned above in the definition of how income is treated for the LaCHIP Medicaid Expansion

program (\$90 per working individual, the first \$50 of voluntary or court-ordered child support received for the entire income unit, all court-ordered child support paid by a member of the income unit to someone outside the home, up to \$200 paid child care per child under age 2 and up to \$175 paid child care for children over the age of 2) are the same that are utilized for the LaCHIP Phase IV eligibility groups in order to most efficiently comply with the screen and enroll requirement of this State Plan.

For LaCHIP Phase V, the state will disregard income amounts above 200 percent FPL up to 250 FPL. Thus the effective income eligibility level will be 250 FPL. No standard Medicaid income deductions will be applied to this group of eligibles above 200 percent FPL of gross income.

- 4.1.4. Resources (including any standards relating to spend downs and disposition of resources):
- 4.1.5. Residency (so long as residency requirement is not based on length of time in state): Applicants must be residents of Louisiana.
- 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: LaCHIP Medicaid expansion and Prenatal option enrollees cannot have other creditable health insurance. LaCHIP Phase V enrollees cannot have other creditable health insurance **or** have access to the state employee health benefits plan.
- 4.1.8. Duration of eligibility: The duration of 12 months without regard to changes in income or household composition. Coverage will end prior to 12 months of coverage if the child is found ineligible at random review or at audit, turns age 19, moves from the state or obtains creditable health insurance. For unborn children, the duration of eligibility is from the month of conception or the first month of eligibility following conception, whichever is later, through the month of birth.
- 4.1.9. Other standards (identify and describe): Children whose family’s income is greater than 200 percent FPL will be subject to a period of uninsurance defined as 12 months prior to enrollment, except as specified in 4.4.4.2

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

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

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
 - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
 - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
 - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
 - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
 - (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
 - (vi) Aliens currently in deferred action status; or
 - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;
- (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
- (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
- (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

- Elected for pregnant women.
 Elected for children under age 19

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

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

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

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

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

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

The methods of establishing eligibility and continuing enrollment will be the same as under Title XIX except for citizenship.

In the event of a FEMA or governor-declared disaster, the State will notify CMS of the intent to provide temporary adjustments to its eligibility and enrollment policies, the effective dates of such adjustments, and the parishes/areas impacted by the disaster.

In the event of a FEMA or governor-declared disaster and at the State's discretion, enrollees may be granted eligibility and receive services beyond their certification period.

In the event of a FEMA or governor-declared disaster and at the State's discretion, enrollees may be provided additional time to submit a renewal or verification.

In the event of a FEMA or governor-declared disaster and at the State's discretion, eligibility verification requirements may be waived at application and renewal. The State may allow self-attestation to complete the eligibility determination, in accordance with 42 CFR 457.380.

In the event of a FEMA or governor-declared disaster and at the State's

discretion, the State may waive or delay collection of premiums in accordance with Section 8.2.1.

In the event of a state or federally declared disaster or public health emergency, the State may provide for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the state or federally declared disaster or public health emergency. The duration of the provisions may not exceed the duration of the state or federal disaster period.

Such measures will be recorded in the case notes of the eligibility record.

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.

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))

At eligibility determination and redetermination, applications are reviewed for coverage under a group health plan or health insurance coverage, for access to a state employee health benefits plan, and for Medicaid eligibility prior to enrollment in the Title XXI separate child health program.

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))

Screening procedures identify any applicant or enrollee who would be potentially eligible for Medicaid prior to enrollment in the Title XXI separate child health program.

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

Any applicant who is ineligible for Medicaid and appears eligible for the separate child health program is automatically reviewed for separate child health program eligibility.

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

Applications and renewals request information about coverage under a group health plan or private health insurance policy. For the prenatal option, we have no waiting period as our intent is to provide and expedite prenatal care for the unborn child.

- 4.4.4.2. Coverage provided to children in families over 200 percent and up to 250 percent FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

In addition to using employer-based coverage information provided on applications, Louisiana is implementing a cross match with group health insurance providers through our third-party liability contractor to determine current and recent health insurance status. This match will assist in verifying that the applicant is uninsured and has met the required period of uninsurance. This match will also provide an independent source of data for the number of individuals who applied for LaCHIP and had private insurance within the previous 12 months prior to application. With this data, we will be able to more accurately determine the extent to which substitution is occurring. Applicants who lose coverage involuntarily are not subjected to the 12-month waiting period. The following reasons are considered involuntary loss of coverage:

- › loss of eligibility for the coverage resulting from divorce or death of a parent
- › the child reaches maximum lifetime coverage amount
- › expiration of coverage under a COBRA continuation provision within the meaning given in 42 U.S.C. 300gg-91
- › **involuntary** termination of health benefits due to (a) a long-term disability or other medical condition; or (b) termination of employment (including layoff or business closure) or reduction in number of hours of employment
- › changing to a new employer who does not provide an option for dependent coverage; or
- › the family terminated health benefits plan coverage for the child because private insurance is not cost effective (the cost to the child's family for the coverage

exceeded 10 percent of the family's income). Another disincentive to dropping private coverage is the addition of cost sharing (premiums and copayments) in the LaCHIP benefit package for families with net incomes greater than 200 percent FPL.

4.4.4.3. Coverage provided to children in families above 250 percent 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.

Superseding Pages of MAGI CHIP State Plan Material
State: Louisiana

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
LA-14-0002 Effective/Implementation Date: January 1, 2014	MAGI Eligibility	CS7	Coverage of targeted low-income children	Supersedes the current sections 4.1.1, 4.1.2, and 4.1.3
		CS9	Coverage of children from conception to birth when mother is not eligible for Medicaid	Supersedes the current sections 4.1.1, 4.1.2, and 4.1.3
		CS13	Cover as deemed newborns children covered by section 1115 demonstration	Supersedes the current section 4.1.3
		CS15	Oklahoma SoonerCare Assurance that state will apply MAGI based income methodologies for all separate CHIP covered groups	Supersedes the current section 4.1.3
LA-14-0003 Effective/Implementation Date: January 1, 2014	MAGI Eligibility for children covered under title XXI funded Medicaid program	CS3	Converts state's existing income eligibility standards to MAGI-equivalent standards, by age group	Section 4.0 of the current CHIP state plan
LA-14-0004 Effective/Implementation Date: January 1, 2014	Establish 2101 (f) Groups	CS14	Eligibility – Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
LA-14-0005 Effective/Implementation Date: Oct 1, 2013 3c	MAGI-based Eligibility Processing	CS24	An alternative single, streamlined application, screening and enrollment process, renewals	Supersedes the current sections 4.3 and 4.4
LA-14-0006 Effective/Implementation Date: January 1, 2014	MAGI Eligibility	CS17 CS18 CS19 CS20 CS21 CS27	Non-financial eligibility policies on: Residency Citizenship Social Security Number Substitution of Coverage Non-Payment of Premiums Continuous Eligibility	Section 4.1.5 Section 4.1.0; 4.1-LR; 4.1.1-LR Section 4.1.9.1 Section 4.4.4 Section 8.7 Section 4.1.8
LA 15-0001 Effective November 1, 2015	MAGI Eligibility & Methods	CS24	FFM Determination to Assessment State	Section 4.4.2

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
LA 16-0001 Effective April 20, 2016	Eligibility Processing	CS24	Assessment to FFM Determination State	Section 4.4.2
LA SPA TN 19-0010 Effective date: February 1, 2019	Eligibility Processing	CS18	Eliminates the Five-Year Waiting Period and Provides Coverage to Lawfully Residing Children Under the Age of 19.	4.1-LR and 4.1.1-LR

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)

As designed, our outreach plan is constructed to identify, inform, and help enroll both Title XIX (Medicaid) and Title XXI (SCHIP) eligible children. The application form, verification requirements and documentation requirements for Title XIX and Title XXI are exactly the same, and the difference in the programs is transparent to the applicant. We are using the name LaCHIP in our marketing and outreach for all children under age 19 in order to minimize confusion between LaCHIP and CHAMP (Title XIX poverty related) and make the enrollment process seamless for the applicant.

OUTREACH PLAN DEVELOPMENT

Phase III outreach was based on the following:

- **analysis of outreach efforts in prior years of LaCHIP implementation**
- **initial recommendations of the LaCHIP Task Force and the LaCHIP Task Force's Outreach Subcommittee**
- **continuing review of research, studies and reports related to outreach and enrollment**
- **collaboration with the Office of Public Health (OPH)**
- **outreach plans from Bureau of Health Services Financing (BHSF) Regional Outreach Workgroups consisting of Medicaid eligibility field staff**

COORDINATION OF OUTREACH EFFORTS WITH TITLE V

LDH's Office of Public Health administers the State's Title V Block Grant which includes outreach programs to pregnant women and children, and they have shared their expertise and successful methods in conducting outreach. OPH operates WIC clinics in 108 different locations throughout the state and oversees 32 school-based health centers. Each of these locations has been designated as a LaCHIP Application Assistance Site and formal training has been conducted for over 350 employees to enable them to assist applicants in completing the application form and gather necessary verifications. We will continue our collaboration with OPH in jointly developing outreach strategies involving WIC clinics, school-based health clinics, and Children's Special Health Services clinics.

FIELD STAFF INVOLVEMENT

As a Medicaid expansion, our 800+ Medicaid eligibility employees located throughout the state have proven themselves to be an invaluable resource in outreach efforts. We provided extensive training to Medicaid eligibility field staff regarding the importance of outreach and the role of each employee in achieving our enrollment goals. Continued internal marketing of our objective to increase Medicaid enrollment is an integral part of our outreach plan. BHSF eligibility field staff is divided into nine geographical regions within the state. Each region has a regional outreach workgroup consisting of caseworkers, supervisors and managers who have developed and implemented outreach plans tailored to the demographics and unique needs within each region.

This "bubble up" (rather than "trickle down") strategy has resulted in field staff at the local level having a greater commitment to reaching the current unenrolled eligible children as well as the new eligibles resulting from LaCHIP. Field staff has "ownership" in the process, as they have developed and recommended their own outreach strategies. Giving regional field staff the opportunity for significant input and active involvement has resulted in enthusiasm and participation in initial outreach efforts, as well as many innovative and creative ideas.

The Regional Outreach Workgroups completed much background work in identifying stakeholders and compiling comprehensive data/ mailing lists in their geographic areas. Contacts have been made and agreements reached with merchants, employers, libraries, post offices, district Social Security offices, banks, discount stores, fast food restaurants, physician's offices, pharmacies, schools, churches, and other community organizations to distribute applications, display posters, and promote LaCHIP enrollment. Outreach reports are submitted by each region, summarizing the previous month's outreach activities.

MAJOR ADMINISTRATIVE CHANGES

As a prerequisite to outreach efforts, the Agency exercised federal options to streamline and simplify the enrollment process, making it more user friendly, and removing existing barriers. These modifications represent the foundation of our

outreach strategy and were intended to minimize the “welfare” stigma and facilitate enrollment while maintaining the integrity of the programs. We have taken major steps to create an environment in which one can enroll in LaCHIP while maintaining privacy and dignity.

Simplified Application Form

A simple application form which requires only information deemed essential was designed for both Title XIX and Title XXI enrollment. The form is intended to be completed by the applicant rather than the interviewer. The application has been revised several times, with the most recent revision dated March 2007. The application form can be mailed or faxed to the Central LaCHIP Processing Office, as well as submitted at any of our local BHSF offices and more than 400 out-stationed Medicaid Application Centers. Application forms can be requested by telephone, and the design of the application as a tri-fold brochure makes widespread distribution of the application form itself practical. In conjunction with the launch of Phase III of LaCHIP, we updated the cover and included additional graphics and information and continue to refine it. Copies of the Application Form in Adobe Acrobat format can be downloaded and/or printed from the Louisiana LDH LaCHIP Internet web site noted below: (<http://www.lachip.org>).

No Application Interview Required

Neither a face-to-face interview nor telephone interview is required to apply for Title XIX and Title XXI for children. While Louisiana currently has a network of more than 400 out-stationed Medicaid Application Centers at which application can be made for children, the application process prior to LaCHIP implementation was designed to have the application form completed by the interviewer. We removed this potential barrier and feature in our marketing that the enrollment process is “new,” “easy,” and that an interview is not required.

Fewer Verification Requirements

Verification requirements for poverty-level children were reconsidered, and we discontinued requesting verifications that are not mandatory, such as copies of Social Security cards and verification of assets. Effective July 1, 2000, verification for the eligibility factors of residence, age, relationship, citizenship, and household composition was not required, unless determined by the eligibility examiner to be questionable. Beginning July 1, 2006, citizenship and identity are verified prior to enrollment, with citizenship primarily being established by the caseworker through Vital Records. While Louisiana had no assets test for poverty-level children and pregnant women, verification of assets had been routinely requested for all applications so that the information was available for consideration in the Medically Needy Program (which has an assets test), in the event the applicant was ineligible for a poverty level program. Such verification requests were eliminated in 1998. Procedures for processing applications incorporate follow up by telephone and/or mail when essential verification (income) is not received. Eligibility examiners have

been trained to be pro-active in obtaining verifications and to deny applications for non-receipt of verification only if eligibility cannot otherwise be established.

Central LaCHIP Processing Office

We have established a Central Processing Office in Baton Rouge to process mail-in applications for poverty-level children. Application forms and other marketing materials are printed with a single address and fax number. Our goal is for caseworkers to produce decisions in fewer than the 45-day processing standard, with a minimum number of denials for procedural reasons, while maintaining the integrity of the program. Average statewide processing time for LaCHIP applications is less than ten days.

Central Processing Office staff has been trained to regard excellent customer service as a vital part of their job performance. Employees assist callers who have not yet filed an official application in determining whether they are income eligible, suggest possible methods of verifying income, answer questions regarding LaCHIP covered services and make appropriate referrals.

12-Month Continuous Eligibility

Children are certified for 12-months continuous eligibility regardless of increases in income and/or changes in household size. This reduces “churning” and provides continuity of care.

OVERALL MARKETING STRATEGY

The key messages used in social marketing to all segments of the primary target audience are simple:

- Applying for LaCHIP is easy;
- Preventive health care is important;
- Health insurance is available to thousands of currently unenrolled children under age 19 in Louisiana;
- Children in working families and two parent households can be eligible for LaCHIP; and
- Help with the enrollment process is readily available.

We are maintaining a single “look” (logo, slogan, color) throughout all our marketing materials, using the primary colors in our logo of red, blue, and green, and the symbol of an apple. We used focus groups as well as pre-testing and post-testing in the development of Phase III printed materials (brochures, leaflets, posters, direct mailings) to identify the most effective messages and to assure that the materials are culturally and linguistically appropriate for our target audiences. We maintain a single logo throughout all our marketing materials.

We launched the LaCHIP Phase III Outreach Campaign with a mass mailing to organizations and agencies which provide services to families with household incomes between 150 percent and 200 percent FPL (our secondary target audience). The

mailing consisted of a presentation-type portfolio announcing LaCHIP Phase III expansion to 200 percent FPL and the simplified procedure for applying for children's health insurance coverage. The packet included an introductory letter soliciting support, a poster, brochures, applications, a Rolodex card (with toll-free hotline and fax numbers, e-mail address, mailing address for applications), a promotional item to be determined, and a postcard for ordering additional materials.

SPECIAL MARKETING TO SEGMENTS OF THE PRIMARY TARGET AUDIENCE

For marketing purposes, we have segmented the primary target audience and are emphasizing specific messages for each segment. Special strategies and initiatives have been implemented or are planned for each of these segments of the primary target audience.

1. Adolescents, Teens & Their Parents

The 15- through 18-year old age group presented special challenges, as Louisiana did not cover children born before October 1, 1983 in its pre-SCHIP Medicaid Program at 100 percent of the FPL. We developed additional age appropriate posters and brochures to reach this group and marketed to them directly as well as to key individuals who influence them: middle-school and high-school personnel (principals, teachers, counselors, coaches, school nurses), family planning clinics, providers of services to homeless and runaway youth and substance abuse programs, and mentors. One version of the 834,000 LaCHIP flyers which was included with School Free Lunch applications was designed with graphics to appeal specifically to teens and adolescents rather than younger children. Recognizing the high drop-out rate in Louisiana schools, we are pursuing ways to reach school drop-outs, including local recreation centers, which serve as a meeting place for this group in many towns.

2. Low-Income Working Parents

We anticipated that for children eligible under Phase III (income from 150 percent to 200 percent of the FPL) low-income working parents would be the primary target audience. Marketing materials clearly stress that many children with a working parent or parents are eligible for LaCHIP. We continue to direct marketing efforts toward employers in small firms and the service industry who frequently do not offer health insurance coverage for dependents and work with their human resource personnel to distribute applications with paychecks, display posters and applications in employee lounges and otherwise educate employees regarding LaCHIP. Marketing materials for our existing Medicaid Pregnant Women program named LaMOMS are being edited to address changes associated with SCHIP Unborn option. Outreach initiatives are targeted to the growing number of uninsured working mothers in need of pre-natal care to ensure a healthy start for their unborn child.

3. Current and Former TANF Recipients

The special marketing message for current and former TANF recipients is that the time limits on cash assistance are not applicable to LaCHIP. Assurances need to be given that receipt of LaCHIP does not count against the TANF 60-month lifetime maximum. The key secondary target audience for this group is TANF Case Managers and organizations active in training TANF recipients and placing them in the workforce. Because TANF and Medicaid functions are handled by different Departments and usually not located in the same office, outreach to this population requires close collaboration with the Department of Social Services and both the Central Office and local level. Colorful posters targeting current and former TANF recipients have been printed and are currently displayed in TANF Offices throughout the state.

4. Immigrants & Limited English Proficient Individuals

The LaCHIP application form has been available in both Spanish and Vietnamese since January 2001. The Agency has arranged for contracted translation services for all our application processing offices, and the availability of this service will be featured in marketing materials and on our Internet web page. Culturally appropriate posters and leaflets have been designed for the Spanish speaking and Vietnamese communities. Additional out-stationed Application Centers within the Spanish speaking and Vietnamese communities have been and continue to be actively recruited. The identified secondary target audience for this segment includes Associated Catholic Charities, the Asian American Society and other social service organizations.

LaCHIP Prenatal Option outreach efforts include the deployment of bilingual workers in the department's Strategic Enrollment Unit. Initiatives seek the assistance of community leaders to help to dispel the prevailing knowledge that pre-natal coverage is denied by our agency due to the mother's immigration status. Additional outreach by our bilingual workers takes place in locations where the emerging new immigrant population, who have moved to the Metropolitan New Orleans area seeking job opportunities in the construction boom, congregate for work, social or faith-based activities.

5. Grandparents & Other Kin Caregivers

This segment consists of children who are being cared for by grandparents or other relatives because of incarceration of the mother, substance abuse, neglect or abandonment. Many of these grandparents/non-parent relatives are not aware that their income is not considered in determining eligibility for the child.

We have worked closely with Councils on Aging and Social Security offices throughout the State to assist in informing kin caregivers of the differences in eligibility for Medicaid compared to other need-based programs (Food Stamps, TANF): 1) it is not necessary to have legal custody of a child to apply for coverage; 2) income of kin caregiver is not counted in determining eligibility, and

3) if the caregiver does not choose to cooperate with Support Enforcement Services, the child's Medicaid eligibility is not affected. We continue to work with CBO's and the faith community to assist with outreach to kin.

6. **Homeless or At Risk of Homelessness**

We have identified those organizations and groups who already work with homeless families and runaway youth, including Healthcare for the Homeless, UNITY for the Homeless, Society of St. Vincent de Paul, Multi Service Center for the Homeless, YWCA, and Legacy Project. Also included in this secondary target audience are the homeless liaisons for parish school systems and participants in the Emergency Shelter Grant Program.

7. **Children With Special Needs**

We have contracted with Families Helping Families Resource Centers to assist with outreach and enrollment of children under age 19 on the MR/DD Medicaid Waiver Waiting List who were not receiving Medicaid. We have arranged with the Office for Citizens with Developmental Disabilities (OCDD) to provide LaCHIP applications to parents applying for services for children with developmental disabilities and with the Office of Public Health to provide applications in their Special Health Services clinics for medically fragile children.

8. **"Healthy" Children**

We recognize that parents may fail to apply for coverage for children who are not sick. Marketing messages for this target audience emphasize the importance of preventive care and the merit of enrolling children before a health crisis occurs. Our outreach includes not only health related community events, but the different other fairs and festivals which families attend such as the Catfish Festival, Oyster Festival, and Parish Sheriffs' Annual Fun Day. We are actively seeking to establish public-private partnerships with hospitals and professional medical associations to market LaCHIP in their wellness campaigns.

9. **Native Americans**

We coordinate enrollment for Native Americans through the tribal liaison workers for Medicaid Services. In addition to Louisiana's four federally recognized Native American tribes □ Biloxi-Tunica, Coushatta, Jena Band of Choctaw, and Chitimacha □ we have identified additional groups of Native Americans. These include the United Houmas Nation and the Biloxi Chitimacha Confederation of Muskogees who have agreed to distribute brochures and applications to their members. We continue to assure through this coordinated effort that every Native American family with children is mailed or given an application form and provided assistance in applying.

10. **Migrant Children**

We make special efforts to identify those children whose parents are mobile and employed in the agricultural and fishing industries. Most Louisiana parish

school systems have migrant advocates who assist in informing these families about LaCHIP. Also, the Department of Agriculture can provide the names of employers who hire migrant workers. Marketing to this segment emphasizes the confidentiality of the enrollment process, addresses recent “public charge” clarifications, and allay fears that undocumented immigrant status of the parents will be reported.

11. Lower Mississippi Delta Region and Other Rural Residents

Special marketing considerations are required for residents of the Lower Mississippi Delta Region. Much of this region is rural and there is a disproportionately high level of poverty in this as well as other rural areas of Louisiana. Transportation barriers are of even greater significance to this population and the mail-in application process is stressed.

The remaining unenrolled eligibles will require different methods. Churches are highly trusted in towns and communities within the Delta Region. In addition, the high school drop-out rate is very high, and for many, school-based outreach is not an option. We are contracted with the Louisiana Chapter of the National Conference of Black Mayors to conduct specialized outreach involving the faith-based community recreation centers frequented by dropouts.

SECONDARY TARGET AUDIENCE IDENTIFIED

We will continue to concentrate marketing efforts on our secondary target audience as well as those individuals who have contact with and who are influencers of our primary target audience. This secondary target audience includes agencies, organizations, and individuals who already receive federal and/or state funds to provide health and social services to children and families.

Public, Parochial and Charter Schools

Through collaboration with the Department of Education, a LaCHIP flyer has been attached to free-lunch applications distributed to all students at the beginning of the school year. The flyer features the toll-free telephone number and is intended to create awareness of LaCHIP and advise the caregiver how to request an application/apply for LaCHIP. This has been very effective. Plans are to continue statewide distribution of the LaCHIP flyer annually.

Applications are distributed through school nurses, guidance counselors, coaches, school based-health centers and periodically sent home with all students in selected parishes or schools. Presentations are given at school board meetings, PTA meetings and other school events. In addition, each parish school system has a migrant education coordinator and homeless coordinator with whom we are working.

Louisiana State Departments & Agencies:

LDH Office of Public Health and its clinics (Pre-Natal, WIC, Family Planning, Children's Special Health Services)

LDH Office for Citizens with Developmental Disabilities

LDH Office of Mental Health

LDH Office for Addictive Disorders

DSS Office of Family Support (*TANF*, Child Support Enforcement, Food Stamps, Subsidized Child Care)

DSS Office of Community Services (Protective Services, Subsidized Adoption)

DSS Office of Rehabilitative Services

Department of Employment and Training (Job Corps, JTPA)

Department of Agriculture

Department of Corrections

Department of Insurance

Governor's Office of Community Programs

Providers of Health & Social Services

Providers of health and social services include rural health clinics, federally qualified health centers, physician offices, hospitals, disproportionate share hospitals, community action agencies, and Head Start. A LaCHIP training segment and materials were developed, and be included in the 2000 Medicaid Provider Workshops which will be held in ten different cities across the state in September 2000 and October 2000.

Community-Based Recipients of Federal Grants

We have identified recipients of federal grants who provide services in local communities to segments of the primary target population. Such grants are given by the Department of Housing & Urban Development, Department of Labor, Department of Education, Department of Health and Human Services (including the Social Security Administration), Department of the Interior, Department of the Treasury, Small Business Administration and Department of Agriculture. These projects are frequently announced by news releases to local newspapers and include programs such as Upward Bound, summer feeding programs for children, Cooperative Extension Service initiatives and university-sponsored summer workshops for high school health instructors. As these are identified, we provide LaCHIP introductory packets and request their assistance in helping to enroll eligible children.

APPLICATION FORM DISTRIBUTION

The shortened application form along with its design as a tri-fold brochure makes wide distribution of the application itself highly practical. The holder is "refillable" and includes the message "If empty, call [toll-free number] for an application." Application form displays have been placed in a wide variety of non-traditional locations including child support enforcement offices, unemployment offices, grocery

stores, pharmacies (locally owned as well as major chains Rite Aid, CMS, Walgreen's, and Winn Dixie), health clinics, housing authority offices, day care centers, financial aid offices at vocational schools, colleges, and universities, state and federal legislators' offices, libraries, school health clinics, employee lounges, credit counseling offices, laundromats, driver's license offices, U.S. Post Offices, McDonald's, and Wal-Mart.

TOLL-FREE TELEPHONE AND FAX LINES

We have established a toll-free hotline (1-877-2LaCHIP/252-2447) where callers can receive additional information, assistance in completing the application and determine application status. In addition, applications/ verifications can be faxed to a toll-free number (1-877-LAFAXUS/523-2987). The toll-free fax number is also given to employers when we request that income verification be faxed, in an effort to lessen employer resistance to providing verification by fax.

A voice messaging feature gives callers the option to leave a message requesting an application be mailed the next business day. This feature is available 24 hours/7 days a week; callers still have the option to speak with an agency representative during normal business hours. All calls to the toll-free number are categorized and identified by parish/region of origin for purposes of analysis.

MEDIA

We have made and will continue to make use of free media, with our objectives being: 1) to announce expanded eligibility, 2) to advise target and secondary populations of the *simple* application process and, 3) to dispel common myths regarding LaCHIP and Medicaid such as children must be receiving "welfare" in order to qualify. We have worked in conjunction with the LDH Bureau of Communications and Inquiry to issue press releases to daily and weekly newspapers throughout the state, submit articles to the Louisiana Medicaid Provider Newsletter and other periodicals, and arrange for appearances on radio and television talk shows. Local cable stations and local newspapers have run public service announcements. Local outreach staff has been very effective in arranging LaCHIP coverage on television news, talk, and special interest shows and radio talk shows.

To launch Phase III, we used paid media, with paid spots on television and radio, billboards.

OUT-STATIONED APPLICATION CENTERS

The state Medicaid program currently has contract Application Centers with out-stationed workers where applications can be made for children at more than 400 locations throughout the state.

With the redesign of the application form and elimination of the interview requirement, the role of contract out-stationed workers in completing applications for coverage for children changed significantly. The focus is disseminating the

application form, encouraging potential eligibles to apply and providing assistance to families in the process. The Application Centers continue to provide one-on-one assistance to applicants who need help in completing the application form. Application Centers receive partial reimbursement of administrative costs (\$14) only if all verification necessary to establish eligibility accompanies the simplified application.

INTERNET WEB SITE

We have created an initial Internet Web Page for LaCHIP on the LDH Website (www.lachip.org) which contains a “down-loadable” application and brochure as well as frequently asked questions on LaCHIP.

SPEAKERS BUREAUS

Outreach Coordinators have been designated in each of the nine geographic regions who coordinate speaking appearances within the region to promote LaCHIP to both primary and secondary target audiences. Each region has an LCD projector and laptop PC to enable them to do presentations with Microsoft PowerPoint, and staff has received training in PowerPoint presentations. Local staffs have been trained and provided with talking points and audience handouts. We continue to actively seek opportunities to give presentations to professional organizations such as social workers, school nurses, educators and PTA’s, tenant meetings, ministerial alliance meetings, and service and civic organizations including Big Brother/Big Sisters, Kiwanis Club, Knights of Columbus, Lions Club and Jaycees.

COMMUNITY EVENTS

Portable displays promoting LaCHIP are displayed at health fairs, kindergarten registrations, festivals, and other community events such as back-to-school expos which are frequented by the target audience. The displays are colorful and visually appealing and designed to increase awareness of the programs. Application forms and business-reply envelopes are distributed and assistance offered in completing the application form. Promotional items containing the LaCHIP logo and toll-free number are distributed at these events, including coloring books, crayons, pencils with apple shaped eraser tops, rulers, frisbees, stadium cups, pens, and water bottles.

OUTREACH MONITORING

The application form includes an optional question “Where did you get this application form?” A second optional question was added in the April 2000 revision of the application: “How did you hear about LaCHIP?” We have used this information to determine geographical areas for which additional resources and outreach efforts are required. Since we did not have a breakdown by parish of the number of uninsured children, we established a pro-rata share of the enrollment goal for each parish, based on their pre-LaCHIP enrollment of poverty level children. This “goal” has helped us to compare performance of regions and of parishes within regions, as well as given the local staffs concrete goals to work toward in their

outreach efforts. A healthy competitiveness has developed in which regions want to keep pace with the frontrunners.

Each region submits a monthly summary of outreach activity for the previous month. The reports include locations where applications were distributed and the number distributed, speaking engagements, copies of newspaper articles from within the region, and other outreach related activities.

We will continue to actively research successful outreach strategies and “best practices” in other states and make adjustments to achieve our goal of enrolling eligible children in the LaCHIP Program.

Section 6. Coverage Requirements for Children's Health Insurance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

limitations on cost sharing under such coverage. (Section 2103(a)(2))

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

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

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

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

- 6.1.4. Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)
Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under

the EPSDT benefit.

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

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

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

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

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

6.1.4.4. Coverage that includes benchmark coverage plus additional coverage.

6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage applicable only in New York, Pennsylvania or Florida. (under 42 CFR 457.440)

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

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

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

6.1.4.7. Other. (Describe)

The state will use the Medicaid network of providers but offer the limited benefit package outlined in the separate program and offer the same benefits package except for LaCHIP Phase IV children. LaCHIP Phase IV for unborn child coverage mirrors the benefit package offered through Title XIX program in Louisiana.

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

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

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

For the unborn child, the State covers pregnancy related services and services that if not treated could complicate the pregnancy, i.e., the State covers the same services that it covers for the SOBRA pregnant women category in the Medicaid State Plan.

Exception: Sterilization procedures are not covered for the SCHIP unborn child group. The services checked below are generally covered for Medicaid categorically needy eligibles and are potentially covered for the SCHIP unborn child group, depending on the need of the recipient. Louisiana Medicaid program rules apply; examples include benefit limits, extension of benefit limit procedures, prior authorization requirements, age limits, etc.

The State may waive the prior authorization requirements for services for children in families living in FEMA or governor-declared disaster areas at the time of the disaster event.

6.2.1. Inpatient services (Section 2110(a)(1))

6.2.1.1 Unborn - Louisiana Medicaid program rules apply; examples include benefit limits, extension of benefit limit procedures, prior authorization requirements, age limits, etc.

6.2.2. Outpatient services (Section 2110(a)(2))

6.2.2.1 Unborn - Louisiana Medicaid program rules apply; examples include benefit limits, extension of benefit limit procedures, prior

- authorization requirements, age limits, etc.**
- 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))
- 6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))
Limited to unborn children covered in LaCHIP Phase IV.
- 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 therapeutically planned structural services (Section 2110(a)(10))
6.2.10.1 Unborn - Louisiana Medicaid program rules apply; examples include benefit limits, extension of benefit limit procedures, prior authorization requirements, age limits, etc.
- 6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
6.2.11.1 Unborn - Louisiana Medicaid program rules apply; examples include benefit limits, extension of benefit limit procedures, prior authorization requirements, age limits, etc.
- 6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. ☒ Disposable medical supplies (Section 2110(a)(13))

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

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

Guidance: Nursing services may include nurse practitioner services, nurse midwife

services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

- 6.2.15. Nursing care services (Section 2110(a)(15))
- 6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. Dental services Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
LaCHIP Phases IV and LaCHIP Phase V has the same benefit as outlined in the Medicaid State Plan. Please reference Appendix A: EPSDT Dental Program Fee Schedule for full list of services.
- 6.2.18. Vision screenings and services (Section 2110(a)(24))
- 6.2.19. Hearing screenings and services (Section 2110(a)(24))
- 6.2.20. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
6.2.18.1 Unborn - Louisiana Medicaid program rules apply; examples include benefit limits, extension of benefit limit procedures, prior authorization requirements, age limits, etc.
- 6.2.21. Outpatient substance abuse treatment services (Section 2110(a)(19))
6.2.19.1 Unborn - Louisiana Medicaid program rules apply; examples include benefit limits, extension of benefit limit procedures, prior authorization requirements, age limits, etc.
- 6.2.22. Case management services (Section 2110(a)(20))
- 6.2.23. Care coordination services (Section 2110(a)(21))
- 6.2.24. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.25. Hospice care (Section 2110(a)(23))

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

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

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or

registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

- 6.2.27. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))
These services are limited to unborn children covered through LaCHIP Phase IV, who would obtain those services through the Medicaid State Plan.
- 6.2.28. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.29. Medical transportation (Section 2110(a)(26))

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

- 6.2.30. Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))
- 6.2.31. Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

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

- 6.2.1-DC State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:
1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
 2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
 3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
 4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
 5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
 6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
 7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)

8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
 9. Emergency Dental Services

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

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

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

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

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

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

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

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a

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

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

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)
- 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.

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.

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))

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

6.2.3.1.1 MHPAEA The State assures that:

- The State has classified all benefits covered under the State plan into one of the four classifications.
- The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

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

- Yes
- No

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

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

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

6.2.3.2 MHPAEA The State assures that:

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

Guidance: States are not required to cover mental health or substance use disorder benefits (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.

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))

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.

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

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.

6.2.-E Effective for dates of service on or after July 1, 2012, the reimbursement fees for EPSDT dental services are reduced to the following percentages of the

2009 National Dental Advisory Service Comprehensive Fee Report 70th percentile, unless otherwise stated.

- 6.2.1.-E** 65 percent for the following oral evaluation services:
- a) periodic oral examination;
 - b) oral examination- patients under three years of age; and
 - c) comprehensive oral examination- new patients;
- 6.2.2.-E** 62 percent for the following annual and periodic, diagnostic and preventive services:
- a) radiographs – periapical, first film;
 - b) radiographs- periapical, each additional film;
 - c) radiographs- panoramic film;
 - d) diagnostic casts;
 - e) prophylaxis- adult and child;
 - f) topical application of fluoride, adult and child (prophylaxis not included); and
 - g) topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age);
- 6.2.3.-E** 45 percent for the following diagnostic and adjunctive general services:
- a) oral/facial image
 - b) non-intravenous conscious sedation; and
 - c) hospital call; and
- 6.2.4.-E** 56 percent for the remainder of the dental services.

Removable prosthodontics and orthodontic services are excluded from the July 1, 2012 rate reduction.

6.2.-F Effective for dates of service on or after August 1, 2013, the reimbursement fees for LaCHIP Affordable Plan dental services shall be reduced by 1.5 percent of the Louisiana Medicaid rate on file July 31, 2013.

- 6.2.1.-F** The following services shall be excluded from the August 1, 2013 rate reduction:
- a) Removable prosthodontics; and
 - b) Orthodontic services.

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

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

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

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

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

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

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

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

Section 7. Quality and Appropriateness of Care

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

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

The contracted health plans participating in the Healthy Louisiana Program will provide data for children covered in LaCHIP Phase V in order for LDH to track the appropriateness of care provided at the same level as that of children covered under Title XIX or Medicaid expansion SCHIP.

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

The following HEDIS measures will be tracked on a quarterly basis:

- Well child visits for children in the first 15 months of life
- Well child visits in the 3rd, 4th, 5th and 6th years of life
- Use of appropriate medications for children with asthma
- Children and adolescents' access to primary care practitioners
- Childhood immunization status
- Adolescent well-care visits

7.1.3. Information strategies – parent surveys and claims data will be used

7.1.4. Quality improvement strategies – Disease Management program is

available for children with asthma and diabetes.

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

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

The methods used to assure access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations, as appropriate, are the same as under Title XIX for unborn children in LaCHIP Phase IV.

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

The methods used to assure access to covered services, including emergency services as defined in 42 CFR are the same as under Title XIX for unborn children in LaCHIP Phase IV.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

The methods used to assure access to 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 are the same as under Title XIX for unborn children covered in LaCHIP Phase IV.

Children between 200-300 percent FPL with chronic, complex or serious medical conditions will also be eligible for the optional Family Opportunity Act program being implemented concurrently with LaCHIP Phase V. This program will have the same methods to assure access as Medicaid, as it is a Title XIX program.

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

Decisions related to the prior authorization of health services are completed within 14 days after the receipt of a request for services, in accordance with Title XIX for unborn children covered in LaCHIP Phase IV.

The State may waive the prior authorization requirements for services for

children in families living in FEMA or governor-declared disaster areas at the time of the disaster event.

Section 8. Cost-Sharing and Payment

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

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

8.1.1. Yes

In the event of a FEMA or governor-declared disaster and at the State's discretion, the State may waive cost sharing for families living in FEMA or governor-declared disaster areas at the time of a disaster event.

8.1.2. No, skip to question 8.8. **Unborn children covered in LaCHIP Phase IV**

8.1.1-PW Yes

8.1.2-PW No, skip to question 8.8.

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

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

8.2.1. Premiums:
\$50 per month per family where family income is from 201 up to and including, 250 percent of the federal poverty level (FPL)

In the event of a FEMA or governor-declared disaster and at the State's discretion, the State may waive or delay collection of premiums at initial application or renewal for families living in FEMA or governor-declared

disaster areas at the time of a disaster event. If the State elects to delay collection of premiums, eligible individuals will be enrolled prior to payment of the premium.

In the event of a state or federally declared disaster or public health emergency, at the State's discretion, the premium lock-out policy is temporarily suspended and coverage is available regardless of whether the family has paid their outstanding premium for existing beneficiaries who reside and/or work in a state or federally declared disaster or public health emergency area. The duration of the provisions may not exceed the duration of the state or federal disaster period.

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other:

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

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

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

The cost sharing information is explained to potential enrollees through the application, which includes a chart of income eligibility and premium payment amounts. This information is also prominently displayed on the LaCHIP website. If changes are necessary to the cost sharing requirements, all current enrollees are notified by letter of the changes and the effective dates. Public hearings are held to allow the public to comment on any proposed changes to cost

sharing.

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

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

- 8.4.1.** Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)
- 8.4.2.** No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 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)) (42 CFR 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: Pharmacy co-payments)
- 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.

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))

- 8.5. Describe how the state will ensure that the annual aggregate cost sharing for a family does not exceed five 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))

Because there will no longer be co-pays, the maximum amount that a family would pay for coverage is \$600 per year for premiums. This will never exceed the five percent cost sharing required for 200 percent FPL.

- 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)

All Louisiana Medicaid and SCHIP applications request ethnicity information on each applicant. No cost sharing is imposed on those children who are verified to be a member of a federally recognized tribe. The applicant's statement on the application form is sufficient to exempt the child from any cost-sharing obligations.

- 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))

Applicants will not be enrolled in LaCHIP Phase V until they pay for the first month's premium. They will not receive access to benefits and will subsequently be notified that their eligibility is ending due to failure to pay. Premiums are due by the tenth of each month. If payment is not received by the tenth of the month a notice is generated notifying the responsible party that coverage will be

terminated if payment is not received by the twenty-first of the month. Non-payment of premium results in disenrollment effective 60 days after the due date.

In the event of a FEMA or governor-declared disaster and at the State's discretion, the State may waive or delay collection of premiums in accordance with Sections 8.1.1 and 8.2.1.

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))

See Section 9.2

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

Louisiana's strategic objectives are outlined below. For the sake of clarity and flow, performance goals, measures and data/information sources are included under the objective they support rather than in their own separate sections. Our strategic objectives address the issues which the State Children's Health Insurance Program legislation was passed to address. While they have been formulated for our Medicaid expansion, they also would be applicable to additional phases for children's health insurance under Title XXI which the State may undertake in the future, dependent upon legislative approval and funding.

STRATEGIC OBJECTIVE I:

Through an outreach effort begun in November 1998 to identify 72,512 uninsured children eligible for Medicaid coverage under either Title XIX or Title XXI by October 31, 1999, an additional 10,725 by September 30, 2000; and an additional 22,575 by December 31, 2001; and thereby reduce the number and proportion of uninsured children in the state

Performance Goal I.1.

Outreach and market to the families of uninsured children eligible under either Medicaid provisions in effect prior to April 1, 1997, or LaCHIP-Phase I (<133 percent FPL). This goal has been met.

Performance Measures:

X Number of LaCHIP applications distributed and those returned for processing by October 31, 1999

X Number of calls to the toll-free LaCHIP Helpline by October 31, 1999

Performance Goal I.2.

Outreach and market to the families of uninsured children covered by LaCHIP- Phase II (>133 percent FPL but <150 percent FPL). This goal has been met.

Performance Measures:

- X Number of LaCHIP applications distributed and those returned for processing from October 1, 1999 through September 30, 2000
- X Number of calls to the toll-free LaCHIP Helpline from October 1, 1999 through September 30, 2000
- X Number of LaCHIP applications distributed and those returned for processing from October 1, 2000 through September 30, 2001
- X Number of calls to the toll-free LaCHIP Helpline from October 1, 2000 through September 30, 2001

Performance Goal I.3.

Conduct a minimum of five specific outreach initiatives in the first year of LaCHIP. This goal has been met.

Performance Measures:

- X Number of targeted public information campaigns for LaCHIP Phase III eligibles and unenrolled Medicaid eligibles in Federal fiscal year 2001.

STRATEGIC OBJECTIVE II:

To determine eligibility and, by December 31, 2001, enroll 80 percent of all eligible children as Medicaid recipients under either Title XIX or Title XXI Medicaid expansion.

Performance Goal II.1.

Outreach and determine eligibility for 80 percent of all uninsured children potentially eligible for Medicaid or Title XXI Medicaid expansion.

Performance Measures

- X Percentage of uninsured children enrolled in Title XIX and Title XXI Medicaid expansion (71.6 percent by 10/31/99 and 75 percent by 9/30/2000 and 80 percent by 9/30/2001). This goal has been met.
- X Number of children enrolled as Title XIX (29,412) and Title XXI LaCHIP Phase I Medicaid expansion (28,350) eligibles by 10/31/99. This goal has been met.
- X Number of children enrolled as Title XIX (359,457) and Title XXI LaCHIP (Phases I-III) Medicaid expansion (61,650) eligibles by 12/31/2001. This goal has been met.

- X Average processing time
- X Percent of applications approved
- X Increase in percentage of Medicaid-eligible children enrolled
- X Reduction in percentage of uninsured children

STRATEGIC OBJECTIVE III:

To improve access to medical care in the most appropriate setting for children.

Performance Goal III.1.

To reduce inappropriate access to health care for children via emergency room visits for treatment of non-emergent conditions.

Performance Measure:

Frequency of top ten non-emergent conditions seen in emergency rooms and billed to Medicaid as compared to a baseline.

STRATEGIC OBJECTIVE IV:

To establish “health homes” for children under the Medicaid/LaCHIP programs.

Performance Goal IV.1.

To recruit and orient physicians for participation as primary care physicians in managed care programs such as CommunityCARE or other managed care pilot programs.

Performance Measure:

- X Number and percent of Medicaid primary care physicians participating in “health home” programs such as CommunityCARE or other managed care pilot.
- X Number and percent of Medicaid children enrolled in CommunityCARE or other managed care pilot, thereby having a usual source of care available to them.

STRATEGIC OBJECTIVE V:

Increase access to preventive care for LaCHIP enrolled children.

Performance Goal V.1.

Achieve immunization levels for children enrolled in LaCHIP equal to those for an age-comparable group(s) of children enrolled in non-expansion Medicaid.

Performance Measure:

Percent of non-expansion Medicaid children versus LaCHIP Medicaid children, for specified age groups, receiving all recommended immunizations.

STRATEGIC OBJECTIVE VI:

Improve management of chronic health conditions among LaCHIP enrolled children.

Performance Goal VI.1.

Decrease instances of hospital-based crisis care for asthma among LaCHIP enrolled children through dissemination of effective patient education and disease management strategies to physicians.

Performance Measure:

X Number of emergency room visits for asthma

X Number of inpatient admissions for asthma

- 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))

Louisiana has measured performance by establishing a baseline for each performance goal through various methods including: conducting a baseline population-based survey; using State vital records, hospital discharge and claims information; and using other Medicaid and non-Medicaid databases that provide relevant information. For each performance goal, the method(s) of measurement has been established and reports generated to monitor on an ongoing basis Louisiana's progress toward meeting the goal.

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-child care
- 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: See attached EXHIBIT 9.3.7.7
- 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)

The state assures it will collect all data, maintain all records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires.

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

Louisiana has established the baseline levels for all performance measures established in Section 9 of the Plan. Most performance measures selected by the State are related to established data reporting systems. The data for establishing baseline levels was drawn from existing data sources such as vital records, Medicaid claims data, hospital discharge data and other such sources. Where necessary, Louisiana may supplement existing data sources by conducting a population-based survey.

The first year's annual assessment reported the results of efforts made to establish baseline levels for all measures and will report the State's progress in providing health benefits coverage to both "Medicaid eligible but unenrolled" children and "expanded LaCHIP Medicaid eligibles." In subsequent years, the annual assessment provides updated information on the performance of all measures. State staff will complete each year's annual assessment and will monitor ongoing progress toward meeting all

performance goals.

Through analysis of the patterns of utilization of services under the plan and the effectiveness of the plan as demonstrated through the performance measures established in Section 9, the evaluation assesses the overall quality and outcome of health benefits coverage provided under the plan. The provision of services, as an expansion of Medicaid will be fully encompassed by all quality control mechanisms in place in Louisiana's Medicaid managed care programs (PCCM).

The State's plan will be considered effective if it achieves the performance goals established in Sections 9.2.1. and 9.2.2.

- 9.6. The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)
- 9.7. The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))
- 9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)
- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1132 (relating to periods within which claims must be filed)
- 9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))
- On-going public involvement is assured by the interaction of the eligibility field staff in their communities as well as executive management's presentations to various legislative committees, providers and community groups. Executive management is also participating with the newly established legislative Task Force on the Working Uninsured and the Louisiana Health Care Commission's Subcommittee on the Uninsured. Eligibility regional staffs also keep "notebooks" on contacts with the public which are forwarded to headquarters. Any proposed expansion of coverage for the uninsured or amendment of program policy would require the promulgation of administrative rules in compliance with the Administrative Procedures Act, which includes public hearings as part of the**

normal rulemaking process. The program also responds to correspondence and calls regarding the LaCHIP program.

BACKGROUND ON DEVELOPMENT OF LaCHIP PROGRAM:

Congress in 1997 passed Public Law 105-33 to establish a new Title XXI under the Social Security Act called the States' Children's Health Insurance Program (SCHIP). Louisiana's Governor Foster then issued Executive Order No. 97-37 which created a 15-member Task Force to make recommendations regarding all the available options to Louisiana in order to implement a Louisiana Children's Health Insurance Program (LaCHIP). The LaCHIP Task Force was composed of eight legislators, the Commissioner of Insurance, the Commissioner of Administration, the Secretary and the Medical Director of the Louisiana Department of Health, the Chancellor of LSU Medical Center, the Executive Director of the Children's Cabinet, and the Governor's Chief of Staff. This Task Force is the designated forum for input from the public and other interested groups regarding the development and implementation of the LaCHIP program in Louisiana. As such, the LaCHIP Task Force held six meetings to receive information and recommendations from over 25 presenters which included children's advocates such as Family Voices, Louisiana Health Care Campaign, Mental Health Parity, Mental Health Association; health care providers such as Louisiana State Medical Society, Louisiana Primary Care Association, Louisiana Chapter of American Academy of Pediatrics, Louisiana Dental Association, Louisiana School Nurses' Organization and Office of Public Health; and academic centers such as Louisiana State University Medical Center, Tulane Medical School and Ochsner School of Medicine as well as HCFA and Dr. Kenneth Thorpe, Institute for Health Services Research, Tulane University School of Public Health. Task Force members were also encouraged to present their conceptual design(s) from their respective organization or department.

The LaCHIP Task Force reviewed the three options available for a SCHIP under Title XXI:

- A Title XXI Medicaid (expansion) model
- A State-designed private insurance program model
- A combination program

After examining the various options, the LaCHIP Task Force recommended the following actions be taken:

1. **Program Design**
That the Louisiana Department of Health pursue a phased-in Title XXI combination program over three years:
 - First Year - a Medicaid expansion model for children (six years³ to 19

³ Children birth to six years whose family income is below 133 percent FPL are currently Medicaid eligible.

- years) up to 133 percent of the Federal Poverty Level; and
- Second Year - a Medicaid expansion model for children (birth to 19 years) up to 150 percent of the Federal Poverty Level; and
- Third Year - a private insurance model for children (birth to 19 years from 150 percent to 200 percent of the Federal Poverty Level.

In May 1998 the Louisiana Legislature in its First Extraordinary Session of 1998, passed Senate Bill 78, designated as Act 128, which authorizes implementation of LaCHIP up to the 133 percent FPL. The Louisiana Department of Health is the designated agency to administer the LaCHIP program.

2. Outreach Efforts

That the Louisiana Department of Health implement enrollment outreach initiatives for both the currently unenrolled Medicaid eligibles (birth to 19 years) as well as the “new“ LaCHIP Medicaid eligibles. Such outreach initiatives are to include media notices of where and how to apply for LaCHIP, printed posters and flyers for distribution at public hospitals and clinics as well as community and rural health centers and recruitment of all FQHCs and Head Start Application Centers to become Medicaid Application Centers.

In June 1998 a workgroup was formed to develop the Outreach Plan. This workgroup included representatives from the LaCHIP Task Force and many advocacy and provider groups as well as representatives from all four federally recognized Indian tribes in Louisiana -- Biloxi-Tunica, Coushatta, Jena Band of Choctaw, and Chitimacha.

3. Enrollment

Innovative methods instituted to address existing barriers to applying for medical assistance include:

- a. That the Louisiana Department of Health enhance and streamline the Medicaid enrollment process by developing a shortened application form as well as permit mail-in of applications and relaxation of some of the verification requirements.
- b. That the possibilities of one-year guaranteed Medicaid eligibility and three months presumptive eligibility be further explored.

4. Access

That the Louisiana Department of Health explore the feasibility of primary care physicians' (PCPs) reimbursement rates being increased to ensure health care access to a “health home” for Medicaid eligibles, including Title XXI eligibles.

- 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))
Representatives from all four federally recognized Indian tribes in Louisiana were included on the workgroup that developed the Outreach plan. In addition, outreach coordinators worked with and continue to maintain contact with the various tribes by making presentations as requested. Application centers have been set up in areas where tribe members receive medical services. Four tribal liaisons also maintain contact with tribal leaders on an on-going basis.
- 9.9.2** For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).
The state has not amended policies relating to eligibility or benefits as described in 42 CFR 457.65(b) through (d) that eliminate or restrict eligibility or benefits. Any future changes meeting these criteria will be promulgated under the state’s rulemaking process as described in the Administrative Procedures Act.
- 9.10.** Provide a 1-year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)
- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
 - Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees

SCHIP Budget Plan Template

	Federal Fiscal Year 2013 Costs
Enhanced FMAP rate	
Benefit Costs	
Insurance payments	
Managed care	
per member/per month rate @ # of eligibles	
Fee for Service*	\$222,902,669
Total Benefit Costs	\$222,902,669
(Offsetting beneficiary cost sharing payments)**	\$379,756
Net Benefit Costs	\$222,522,913
Administration Costs	
Personnel	\$2,384,905
General administration	\$9,781,619
Contractors/Brokers (e.g., enrollment contractors)	\$166,315
Claims Processing***	\$1,056,456
Outreach/marketing costs	\$1,702,939
Other (e.g., indirect costs)	\$0
Health Services Initiatives	\$0
Total Administration Costs	\$15,092,234
10 percent Administrative Cost Ceiling	\$24,724,768
Federal Title XXI Share	\$177,094,569
State Share	\$60,520,578
TOTAL PROGRAM COSTS	\$237,615,147

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

*Based on 119,678 total eligible children at per member per month cost of \$155 for 0-250 percent FPL group

**Projected source of non-Federal plan expenditures; based on 4,019 eligibles at \$50 per family per month premium cost

***Based on claims processing contracts costing approximately \$1M

Section 10. Annual Reports and Evaluations (Section 2108)

- 10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)
 - 10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and
- 10.2. The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))
- 10.3. The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.
- 10.3-D Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the state to the Human Resources and Services Administration for posting on the Insure Kids Now! website.

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.**

Eligibility and Enrollment Matters

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

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

Health Services Matters

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

The State assures that the state laws or regulations are consistent with the intent of 42 CFR 457.1130(b). This grievance process for health service matters is provided by the insurance vendor and is in compliance with state laws, the Employee Retirement Income Security Act of 1974 (ERISA), and all other applicable regulations of the Department of Labor Procedures.

The review process for eligibility and enrollment matters is the same as the Medicaid Fair Hearing process for unborn children covered in LaCHIP Phase IV.

Premium Assistance Programs

12.3 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.