
Table of Contents

State/Territory Name: Rhode Island

State Plan Amendment (SPA) #: RI-22-0006

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) State Plan Pages

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



Children and Adults Health Programs Group

June 23, 2022

Kristin Pono Sousa
Medicaid Program Director
Executive Office, Health and Human Services
3 West Road, Virks Building
Cranston, RI 02920

Dear Ms. Sousa:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number RI-22-0006 submitted on June 3, 2022, has been approved. Through this SPA, Rhode Island has demonstrated compliance with the American Rescue Plan Act of 2021 (ARP). This SPA has an effective date of March 11, 2021 and extends through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period, as described in section 1135(g)(1)(B) of the Social Security Act (the Act).

Section 9821 of the ARP amended sections 2103(c)(11)(B) and 2103(e)(2) of the Act to mandate coverage of COVID-19 testing, treatment, and vaccines and their administration without cost-sharing or amount, duration, or scope limitations. Sections 2103(c)(11)(B) and 2103(e)(2) of the Act also require states to cover, without cost sharing, the treatment of conditions that may seriously complicate COVID-19 treatment, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19. The state provided the necessary assurances to demonstrate compliance with the ARP in accordance with the requirements of sections 2103(c)(11)(B) and 2103(e)(2) of the Act.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 457.65 that the state submit SPAs that are related to the COVID-19 public health emergency by the end of the state fiscal year in which they take effect. CMS is allowing states that submit SPAs after the last day of the state fiscal year to have an effective date in the prior state fiscal year, but no earlier than the effective date of the public health emergency. Rhode Island requested a waiver to obtain an earlier effective date of March 11, 2021.

Pursuant to section 1135(b)(5) of the Act, CMS is also allowing states to modify the timeframes associated with tribal consultation required under section 2107(e)(1)(f) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA. Rhode Island requested a waiver to modify the tribal consultation timeline by

Page 2 – Ms. Sousa

completing the tribal consultation after the effective date of the SPA and after the SPA was submitted to CMS.

This letter approves Rhode Island request for a March 11, 2021 effective date and provides the state with the authority to modify the tribal consultation timeline.

Your Project Officer is Kathleen Connors de Laguna. She is available to answer your questions concerning this amendment and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: 410 786-2256
E-mail: Kathleen.Connorsdelaguna@cms.hhs.gov

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

Sincerely,

/Signed by Amy Lutzky/

Amy Lutzky
Deputy Director
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

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

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

Preamble

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

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

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

**SECTION 1. GENERAL DESCRIPTION AND PURPOSE OF THE
STATE CHILD HEALTH PLANS AND STATE CHILD HEALTH
PLAN REQUIREMENTS (SECTION 2101)**

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

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

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

1.1.3. A combination of both of the above.

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

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

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

Effective date: October 1, 1997, although the effective date for the Section 1115 waiver was January 18, 2001.

Effective date for Amendment #1 expansion of eligibility up to 300 percent FPL is January 5, 1999.

Effective/Approval date for Amendment #2, Rhode Island's compliance SPA is September 19, 2002.

Effective date for Amendment #3, Rhode Island's separate child health program is November 1, 2002.

Effective date for Amendment #4, adding a \$10,000 liquid asset limit for eligibility, is October 1, 2006.

Effective date for Amendment #5, removing a \$10,000 liquid asset limit for eligibility is July 1, 2007.

Effective date for Amendment #7, to an eligibility group of children who are otherwise eligible aliens lawfully residing in the United States as authorized by section 214 of the Children's Health Insurance Reauthorization Act of 2009 is July 1, 2009.

Effective date for Amendment #8, to eliminate CHIP premiums, is 1 July 2014.

Effective date for RI-20-002, to extend renewals for emergencies, is March 16, 2020

Effective date for RI-20-002, to temporarily delay acting on certain changes in circumstances affecting CHIP eligibility for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area, is March 16, 2020.

Effective date for RI-20-002, to provide for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, is March 16, 2020.

Effective date for RI-22-0006, to document compliance with the American Rescue Plan ACT COVID treatment, testing, and vaccination coverage, is March 11, 2021

Implementation date: October 1, 1997, although the various components of the program, including applicable amendment provisions, have been implemented since then.

Implementation date: Amendment #1 was not implemented.

Implementation date for Amendment #2, compliance SPA was per CMS regulation.

Implementation date for Amendment #3, Rhode Island's separate child health program is November 1, 2002.

Implementation date for Amendment #4, adding a \$10,000 liquid asset limit for eligibility is October 1, 2006. However, this amendment was not

implemented.

Implementation date for Amendment #5, removing a \$10,000 liquid asset limit for eligibility is July 1, 2007.

Implementation date for Amendment #7, to an eligibility group of children who are otherwise eligible aliens lawfully residing in the United States as authorized by section 214 of the Children's Health Insurance Reauthorization Act of 2009 is July 1, 2009.

Implementation date for Amendment #8, to eliminate CHIP premiums, is 1 July 2014.

Implementation date for RI-20-002, to extend renewals for emergencies, is for up to the duration of the emergency, or at state discretion, a shorter period of time.

Implementation date for RI-20-002, to temporarily delay acting on certain changes in circumstances affecting CHIP eligibility for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area, is for up to the duration of the emergency, or at state discretion, a shorter period of time.

Implementation date for RI-20-002, to provide for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, is for up to the duration of the emergency, or at state discretion, a shorter period of time.

Implementation date for RI-20-0009, updating to be compliant with the SUPPORT ACT, is October 1, 2019.

Implementation date for RI-22-0006, to document compliance with the American Rescue Plan ACT COVID treatment, testing, and vaccination coverage, is March 11, 2021

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.

RI-20-0002: To address the COVID19 public health emergency, the state seeks a waiver under section 1135 of the Act to 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.”

RI-20-0009 Tribal Notice May 26,2020

RI-22-0006- Under 1135 authority, Rhode Island contacted its tribal partners to notify them of this amendment via email at the time the amendment was submitted.

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
RI-13-023 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS15 CS8 CS9 CS13	MAGI-Based Income Methodologies Eligibility – Targeted Low Income Pregnant Women Eligibility – Coverage from Conception to Birth Eligibility – Deemed Newborns	Incorporate within a separate subsection under section 4.3 Supersedes the current sections Geographic Area 4.1.1-P; Age 4.1.2-P; and Income 4.1.3-P Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Supersedes the current section 4.1.9-P regarding deeming and incorporate within a separate subsection under section 4.3
RI-13-024 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
RI-13-025 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
RI-13-026 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
RI-13-027	Non-Financial	CS17	Non-Financial Eligibility –	Supersedes the current section 4.1.5

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Effective/Implementation Date: January 1, 2014	Eligibility	CS18 CS19 CS20 CS21	Residency Non-Financial Eligibility – Citizenship Non-Financial Eligibility – Social Security Number Non-Financial Eligibility – Substitution of Coverage Non-Financial Eligibility – Non-Payment of Premiums	Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR Supersedes the current section 4.1.9.1 Supersedes the current section 4.4.4 Supersedes the current section 8.7
RI – 18-005 Effective/Implementation Date: October 2, 2017	MHPAEA Compliance		Document compliance with the MHPAEA of 2008	Supersedes the current section 6 Supersedes the current section 8
RI – 19-004 Effective/Implementation Date: July 1, 2018 Approval Date: August 9, 2019	Managed Care Final Rule Compliance		Document compliance with the Medicaid and CHIP Managed Care Final Rule	Supersedes the current section 3
RI-20-0009	SUPPORT ACT			
RI – 22-0006 Effective/Implementation Date: March 11, 2021 Approval Date: June 23, 2022	American Rescue Plan Act Compliance		Document compliance with the American Rescue Plan Act COVID treatment, testing, and vaccination coverage	New addition to section 6.2.31

**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))**

In November of 1993, the State of Rhode Island was granted a Section 1115 Waiver (11-W-00004/1) to develop and implement a mandatory Medicaid managed care demonstration program called Rlte Care. Rlte Care, implemented in August 1994, has the following general goals:

- To assure care as well as coverage to all eligible Medicaid families and children, all eligible pregnant women and all eligible uninsured children
- To control the rate of growth in the Medicaid budget for the eligible population

Rlte Care was designed for the following groups to be enrolled in licensed health maintenance organizations (HMOs, or Health Plans):

- Family Independence Program (FIP)¹ families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)
- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

Rlte Care has been expanded five times, with Federal approval, as follows:

- Effective March 1, 1996, to expand to children up to age 8 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective May 1, 1997, to expand to children up to age 18 in households with incomes up to 250 percent of the FPL who are uninsured

¹Originally Aid to Families with Dependent Children (AFDC)

- Effective November 1, 1998, to expand to families with children under age 18 including parents with incomes up to 185 to FPL (expansion under Section 1931)
- Effective July 1, 1999, to expand to children up to age 19 in households with incomes up to 250 percent of the FPL
- Effective December 1, 2000, to maximize children in foster care placements from fee for service Medicaid to Rlte Care

The May 1997 and July 1, 1999 expansions, because they were implemented after March 15, 1997, qualify as eligible Medicaid expansions under Title XXI of the Social Security Act. By Section 1115 waiver approval, effective January 18, 2001, Section 1931 parents and relative caretakers and pregnant women between 185 and 250 percent of the FPL were covered under Title XXI. On December 20, 2002, the State submitted a draft amendment to provide prenatal care to unborn children, if other applicable State eligibility requirements are met, as a separate child health program. Thus, everywhere else in this State Child Health Insurance Program (SCHIP) Plan (Plan) where a *separate child health program* is referenced, it is only for this population. Otherwise, all other aspects of the State's approved Plan are a Medicaid expansion. It should be noted that the State received approval on January 5, 1999 to expand to children under age 19 in households with income up to 300% of the FPL. The State has not yet implemented the approved amendment and has no immediate plans to do so due to budgetary constraints.

In addition to these covered populations, the Rlte Care Health Plans must make coverage available to certain State funded or "buy-in" groups who pay 100 percent of the applicable premium; the first group's premiums are supplemented by State-only funds:

- Pregnant women who are uninsured whose household income is between 250 and 350 percent of the FPL
- Children who are uninsured whose household income is in excess of 250 percent of the FPL
- Licensed family child-care providers and their children under age 18

Rlte Care has proved to be extremely successful as the following information indicates:

- Member Choice of Health Plan
 - Enrolled approximately 118,000 members into one of three Health

Plans

- Ninety-three percent of enrollees chose their own Health Plan in the first year
- Only 4 percent changed Health Plans when given the opportunity to do so during the first open enrollment period; only 1 percent during the second open enrollment period; and only 3 percent during the third open enrollment period. Plans changes have remained low.
- Covered Uninsured Families
 - Made comprehensive health coverage available to previously uninsured children up to age 19, up to 250 percent of the Federal poverty level and previously uninsured pregnant/postpartum women
 - Made coverage available to parents and adult caretakers up to 185 percent of the FPL
- Improved Access to Primary Care
 - Increased primary care physician participation from 350 to over 900 physicians
 - Increased average per enrollee physician visits from two per year pre-Rlte Care (1993) to five per year in Rlte Care
 - Decreased emergency room visits and hospital utilization each by more than one-third from 1993 to Rlte Care
- Positive Impact on Maternal Health
 - Increased the number of women on Medicaid waiting at least 18 months between births from 60 percent pre-Rlte Care (1993-94) to 79 percent in 1999 completely closing the gap between Medicaid and commercially-insured women
 - The percentage of pregnant women on Medicaid who smoked during pregnancy decreased significantly from 32 percent in 1993-94 to 24 percent in 2000
- Improved Prenatal Care

- The number of women on Medicaid who began prenatal care in the first trimester increased from 78 percent in 1993-94 to 84 percent in 2000
- The number of women on Medicaid receiving adequate prenatal care increased significantly from 57 percent in 1993-94 to 73 percent in 2000
- Improved Infant Health Outcomes
 - In inner city areas of the State:
 - The low birth weight infants born decreased from 10 percent in 1993 to 5 percent in 1995.
 - The percentage of infants who had their first physician visit before two weeks increased significantly from 54.4 percent in 1993 to 70 percent in 1995.
 - The percentage of infants who waited less than two weeks for specialty care increased significantly from 43.5 percent in 1993 to 71.4 percent in 1995.
- Improved Child Health
 - Children in Rlte Care have higher well-child visit rates than children enrolled in commercial insurance as well as children enrolled in Medicaid nationally
 - In a study of 2-year-olds in Rlte Care, 79 percent were screened for lead poisoning compared to only 19 percent in Medicaid nationally
- Excellent Member Satisfaction
 - Overall, 98 percent of the respondents to the 2001 Rlte Care Member Satisfaction Survey were "very satisfied" or "satisfied" with Rlte Care. This percentage has remained relatively constant since the State began enrolling individuals in Rlte Care
 - Survey responses stratified by Health Plans ranged from 96 to 98 percent who reported that overall they were "very satisfied" or "satisfied" with Rlte Care

The State has built upon these successes by making Rlte Care available to

expanded populations. Incrementally, as noted above and where permissible, including these expansion populations in the State Child Health Insurance Program (SCHIP).

According to the U.S. Bureau of the Census², the number of persons covered and not covered by health insurance in the State of Rhode Island in 1996 was 940,000. Of this total, 93,000 (with a standard error of 13,000), or 9.9 percent (with a standard error of 1.3 percent), were not covered by insurance. Preliminary estimates³, not adjusted for the uninsured or sample design, of the uninsured children in Rhode Island as if July 1, 1996, were as follows:

Percent with No Health Coverage, Ages 0 to 17, Rhode Island, 1996

Income Group	Percent Uninsured
<100% FPL	19.2%
100 to 199% FPL	13.1
200 to 299% FPL	7.5
300 to 399% FPL	1.6
>=400% FPL	1.0
Don't Know	19.1
Refused	<u>14.1</u>
Total	9.5%

With an estimate of 235,283 children in Rhode Island as of July 1, 1996, this means that there were an estimated 22,352 without health insurance coverage as of July 1, 1996.

Although these estimates have not been adjusted, we believe that the number of uninsured children targeted under this Title XXI Program Plan would have been less than 14,000⁴ as of July 1, 1996.

The State's efforts have had a remarkable impact on the children uninsurance rate in the State. More recent CPS data show that in 2000, 6.2 percent of the overall population in Rhode Island lacked health insurance and 2.4 percent (this

²Bennefield, R.L. "Health Insurance Coverage: 1996", *Current Population Reports: Consumer Income*

³U.S. Bureau of the Census. "Estimates of the Population of the U.S., Region, and States by Selected Age Groups and Sex: Annual Time Series, July 1, 1990. to July 1, 1996," St-96-10

⁴22,352 x 61.4% = 13,724

is a three-year average) of children lacked health insurance – both the lowest in the nation.⁵

As described in Section 5 of this Plan, the State has undertaken a well-defined outreach effort to identify and enroll uninsured children in RIte Care Health Plans. The State also implemented activities made possible by other changes in the Balanced Budget Act of 1997, to simplify the application and enrollment process. This was done to remove barriers associated with applying and enrolling through a "welfare" environment. An example of some of the outreach strategies implemented include:

- Accessing the National Governor's Association sponsored "Insure Kids Now" hotline
- Providing funding for outreach workers to 32 community-based organizations to enroll new children each month
- Targeted mailings to community organizations and school-based personnel
- Distributing information to every school-aged child Kindergarten through 6th grade in the State
- Media coverage in professional newsletters and Rhode Island newspapers
- Using the Department of Human Services Web-site to disseminate information
- Providing public service announcements and radio and television interviews through the media
- Streamlining the mail-in application in both English and Spanish
- Supporting a bi-lingual information line.

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

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).

⁵ Griffin, J. *Profiles and Trends of the Uninsured in Rhode Island: Characteristics of Uninsured Working-Age Adults in Rhode Island 1996-2000*, MCH Evaluation, Inc. April 2002.

As noted earlier, the State has had an ongoing, active outreach program to enroll uninsured eligible children in Rlte Care. This outreach effort is described in Section 5 of the Plan.

The State's contracts with Rlte Care Health Plans require that the Health Plans work to identify uninsured children for potential enrollment. Specifically, Section 2.05.01 of the Health Plan contract requires: "The Contractor, through members of its provider network, is encouraged to identify uninsured patients who may be Rlte Care eligible and to make referrals to the State for eligibility determination." The contract also contains important coordination requirements. Specifically, Section 2.07 requires coordination with out-of-plan services and other health/social services available to members including:

- Special education
- Mental health services for seriously and persistently mentally ill adults (SPMI) and severely emotionally disturbed children (SED)—these are out-of-plan benefits
- Newborn Metabolic Screening Program
- Comprehensive Emergency Services Program
- Children's Intensive Services Program
- Early Start Program
- Lead Program
- Adolescent Pregnancy and Parenting Service Network
- Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

In addition, Health Plans are required under Section 2.08.10 of the contract, to contract with the currently operating school-based clinics in the State and to contract with future school-based clinics that might be developed. Health Plans are also encouraged to contract with Title X providers and Federally qualified health centers (FQHCs).

With respect to the FQHCs, it is important to understand that Rhode Island does not have a service delivery system within its public health structure. Thus, the FQHCs, primarily, and hospitals, secondarily, have served as the historical safety net for the uninsured in the State. When Rlte Care was being implemented, the FQHCs elected to form their own Health Plan—Neighborhood Health Plan of Rhode Island. However, all other Rlte Care participating Health Plans have elected to include some of the FQHCs in their provider networks. In addition, FQHCs operate the

existing school-based clinics in the State. Thus, FQHCs are an integral component of RItE Care, without a mandate for their inclusion within networks.

Another important coordination feature of RItE Care is that Health Plans are responsible for certain Early Intervention (EI) services, subject to a stop-loss provision. Section 2.07.04.01 of the Health Plan contract stipulates that the Health Plan is responsible for the first \$3,000 for medically necessary, appropriate speech, hearing, language, physical and occupational therapies under EI. The State covers any additional services on a fee-for-service basis, as billed by the Health Plans as stop-loss claims.

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:

RItE Share, Rhode Island's new Premium Assistance Program, helps low- and middle-income families obtain health insurance coverage through their employer by paying the employee's share of monthly premiums for family coverage.

Under RItE Share, individuals who are eligible for Medicaid/SCHIP and are employed by an employer that offers a "qualified" plan, enrolls in the ESI through their employer. In order for an applicant to be enrolled in RItE Share:

- The parents and/or their children are determined eligible for Medicaid/SCHIP (RItE Care), and
- One of the parents has access to ESI and works for an employer that offers an approved plan

The employer contribution to the cost of coverage remains unchanged. The State pays for the employee's share of the health insurance premium either by paying the employer or by paying the employee. RItE Share members are eligible for "wrap around" services, which are Medicaid-covered services not included in the employer's health plan, as well as for coverage of commercial insurance co-payments.

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))

The State has had an ongoing, active outreach program to identify and enroll uninsured eligibles in Rlte Care. This outreach effort is described in detail in Section 5 of this document.

The State's contracts with Rlte care Health Plans require that the Health Plans work to identify uninsured individuals for potential enrollment. Specifically, Section 2.05.01 of the Health Plan contract requires: "The Contractor, through members of its provider network, is encouraged to identify uninsured patients who may be Rlte Care eligible and to make referrals to the State for eligibility determination." The contract also contains important coordination requirements. Specifically, Section 2.07 requires coordination with out-of-plan services and other health/social services available to members:

- Special education
- Mental health services for seriously mentally ill adults and seriously emotionally disturbed children
- Newborn Metabolic Screening Program
- Comprehensive Emergency Services Program
- Children's Intensive Services Program
- Early Start Program
- Lead Program
- Adolescent Pregnancy and Parenting Service Network
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Family Outreach Program

In addition, Health Plans are required under Section 2.08.10 of the contract to contract with school-based health clinics. Health Plans are also encouraged to contract with Title X providers and Federally qualified health centers (FQHCs).

With respect to FQHCs, it is important to understand that Rhode Island does not have a service delivery system within its public health structure. Thus, the FQHCs, primarily, and hospitals, secondarily, have served as the historical safety

net for the uninsured in the State. When RItE Care was being implemented, the FQHCs elected to form their own Health Plan – Neighborhood Health Plan of Rhode Island (NHPRI). However, all other RItE Care participating Health Plans have elected to include some of the FQHCs in their provider networks. In addition, the FQHCs operate the existing school-based health clinics in the State. Thus, the FQHCs are an integral component of RItE Care.

Another important coordination feature of RItE Care is that Health Plans are responsible for certain Early Intervention (EI) services, subject to a stop-loss provision. Section 2.07.04.01 of the Health Plan contract stipulates that the

Health Plan is responsible for the first \$3,000 for medically necessary, appropriate speech, hearing, language, physical and occupational therapies under EI. The State covers any additional services on a fee-for-service basis, as billed by the Health Plan as stop-loss claims.

SECTION 3. METHODS OF DELIVERY AND UTILIZATION CONTROLS (SECTION 2102)(A)(4))

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

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

Neonatal Intensive Care Unit (NICU) Services are provided in Fee-For Service, as are Special Education services as defined in a child's Individual Education Plan (IEP) and Lead Program Home Assessment and Non-Medical Case Management provided by the Department of Health or Lead Centers for lead poisoned children.

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

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

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

- Managed care organization (MCO) (42 CFR 457.10)
 Capitation payment
Describe population served: Children and families under 136% Federal Poverty Level (FPL), children under nineteen (19) years of age under 250% FPL, pregnant women under 250% FPL, Extended Family Planning population, Children with Special Health Care Needs, children in Foster Care, and Former Foster Care youth.
- Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
 Capitation payment
 Other (please explain)
Describe population served:

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following

box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

- Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
- Capitation payment
 - Other (please explain)
- Describe population served: Dental services for Medicaid and CHIP eligible children and young adults born after May 1, 2000.

- 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(i) (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.

The Medical MCO is required to pay remittances, the Dental PAHP is not required 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 a remittances but not a dental PAHP, please include this information. The Dental PAHP is not required to pay remittances, however this will be included as a requirement in the contract amendment effective July 1, 2019.

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))

The State will come into compliance with this provision by July 1, 2019.

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 enrollee's 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)) The State will come into compliance with this provision by January 1, 2020.
- 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: Conception to 19, except for covered adults; conception to birth is the separate child health program
- 4.1.3. Income: Up to 250% of the FPL
- 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 living in the State with the intent to stay; this includes children under 19 as provided for in Section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) who are otherwise eligible aliens lawfully residing in the United States: such aliens consist of qualified aliens subject to the 5-year bar, aliens described in 8CFR 103.12(a)(4), and legal non-immigrants whose admission to the U.S. is not conditioned on having a permanent residence in a foreign country (such non-immigrants include citizens of the Compact of Free Association States who are considered permanent non-immigrants but does not include visitors for business or pleasure or students). The State assures that it will continue to verify the immigration status of this group of children to ensure they meet the eligibility requirements.
- 4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility): Not applicable
- 4.1.7. Access to or coverage under other health coverage: Effective January 1, 2002, enrollment in Rlte Share, the State’s premium assistance program, became mandatory for Medicaid-eligible individuals whose employers offered an approved health plan. For the separate child health program, applicants cannot be enrolled under a group health

plan or health insurance coverage (including access to a State health benefits plan).

4.1.8.

Duration of eligibility: Same as Medicaid.

4.1.9.

Other standards (identify and describe): A Social Security Number (SSN) is required for Medicaid-eligible individuals. This does not apply to the separate child health program. At redetermination, proof of current immigration status will be required just as it is required for the initial eligibility determination.

4.1.10

Check if the State is electing the option under section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible individuals lawfully residing in the United States:

- (1) “Qualified aliens” otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;
- (2) Citizens of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who have been admitted to the United States (U.S.) as non-immigrants and are permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;
- (3) Individuals described in 8 CFR 103.12(a)(4) who do not have a permanent residence in the country of their nationality and are in statuses that permit them to remain in the U.S. for an indefinite period of time pending adjustment of status. These individuals include:
 - (a) Individuals currently in temporary resident status as Amnesty beneficiaries pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);
 - (b) Individuals currently under Temporary Protected Status pursuant to section 244 of the INA;
 - (c) Family Unity beneficiaries pursuant to section 301 of Public Law 101-649 as amended, as well as pursuant to section 1504 of Pub. L. 106-554;
 - (d) Individuals currently under Deferred Enforced Departure pursuant to a decision made by the President; and

- (e) Individuals who are the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and
- (4) Individuals in non-immigrant classifications under the INA who are permitted to remain in the U.S. for an indefinite period, including the following who are specified in section 101(a)(15) of the INA:
 - Parents or children of individuals with special immigrant status under section 101(a)(27) of the INA as permitted under section 101(a)(15)(N) of the INA;
 - Fiancées of a citizen as permitted under section 101(a)(15)(K) of the INA;
 - Religious workers under section 101(a)(15)(R);
 - Individuals assisting the Department of Justice in a criminal investigation as permitted under section 101(a)(15)(U) of the INA;
 - Battered aliens; and
 - Individuals with a petition pending for 3 years or more as permitted under section 101(a)(15)(V) of the INA.

The State elects the CHIPRA section 214 option for children up to age 19

The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period

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

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

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

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

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

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

Any person may request information about either Rlte Care or Rlte Share, either by telephone, mail, or in person. A request for information may be followed by an application for Rlte Care, Rlte Share, or another form of assistance. Authorized DHS staff must furnish information to the inquiring person in accordance with DHS policy and procedures. The DHS InfoLine staff also furnishes information upon request regarding Rlte Care and Rlte Share, and how to apply.

A formal application procedure is required to ensure a person's right to apply without delay. It affords an opportunity to state her/his needs and to learn what DHS can do to assist her/him. It also affords DHS the opportunity to apprise the person of her/his responsibilities in relation to DHS and the programs, both as an applicant, and, should eligibility be established, as a recipient.

An applicant may be assisted in the application process, including completion of the application form, by one or more individuals of her/his choice, and when accompanied by such individual(s), may be represented by them.

DHS streamlined the Rlte Care application process effective November 1, 1998 by introducing a shortened, mail-in application and by eliminating most verification requirements. This application is in English/Spanish and is widely available at community agencies or by contacting DHS.

Family Assistance Program (formerly AFDC) cash recipients access Rlte Care by virtue of their cash eligibility as determined through the Family Independence Program application process. Medical Assistance Only (MAO) cases and non-MA unborn children access Rlte Care and Rlte

Share through the mail-in application. No separate screening or application process is required.

Applicants for RIte Care and RIte Share may mail in applications to DHS or submit applications at any DHS district office or any site designated by DHS. Under Medicaid law, DHS is required to outstation eligibility workers in community settings. DHS, along with the Department of Health, provides funding to the RI Health Center Association (RIHCA) to meet this requirement. Each health center employs a Family Resource Counselor on its premises. These FRCs are of the culture and/or speak the language of the community in which they serve. The FRCs are trained to screen families/pregnant women for RIte Care/RIte Share; assist potentially eligible families in the completion and filing of the mail-in application; provide follow-up to applicants as appropriate; check the Recipient Eligibility Verification System (REVS) to determine the outcome of the application; and assist recipients with the annual renewal process. They are also responsible for screening and referring families for the cash assistance, Food Stamps, WIC and childcare services. DHS is an active participant in the regular training sessions in which all FRCs are mandated to participate. This ensures that the FRCs are aware of any changes to the State's assistance programs.

Applications are acted upon promptly. A decision on eligibility or ineligibility must be made within 30 days of an application filing date. This standard is not used as a waiting period nor as a basis for denial of an application. The applicant must be informed of the reason for any delay in a decision and her/his right to a hearing, if delay is beyond 30 days.

When the applicant is found to be eligible, the acceptance date for medical coverage is the first day of the month of application. When the applicant is found ineligible or the applicant makes the decision after signing the application the she/he does not want assistance, DHS notifies the applicant in writing of the rejection. This letter informs the applicant at the same time of her/his right to appeal the decision and the method by which the applicant can request a hearing.

The program provides for 12 months continuous coverage for infants, regardless of income changes, except for death, voluntary withdrawal from the program, removal from the State, or failure to pay the applicable premium share. For an unborn child, upon birth the child will be automatically eligible as a Medicaid expansion case until the child's first birthday. At that point, the child's continuing eligibility will be re-determined just like any other Medicaid expansion case. For other than infants, eligibility is re-determined every 12 months. If there is a change of income in the interim and DHS becomes aware of it, re-determination will occur at

that time.

In the event of a federal or state declared emergency or disaster, the state will notify CMS of the intent to provide additional time for beneficiaries living and/or working in Governor or federally declared disaster or emergency areas to complete the renewal process, and additional time for the state to process renewals.

In the event of a federal or state declared emergency or disaster, the state will notify CMS of the intent to temporarily delay acting on certain changes in circumstances affecting CHIP eligibility for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area. The state will continue to act on changes in circumstance related to residency, death, voluntary termination of coverage, erroneous eligibility determinations, and becoming eligible for Medicaid.

In the event of a federal or state declared emergency or disaster, the state will notify CMS of the intent to 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.

These standards assure that the State shall verify that eligible children under 19 as provided for in Section 214 of CHIPRA who are otherwise eligible aliens lawfully residing in the United States continue to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing in the United States. (Section 1903(v)(a)(4)(c) of the Act).

The State assures that by choosing to provide for the optional coverage of children under 19 as provided for by Section 214 of CHIPRA who are otherwise eligible aliens lawfully residing in the United State: The State has elected the option to apply such coverage with respect to such category of children under Title XIX (Section 2107(e)(1)(E))

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 access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)); (42 CFR 457.310(b), 42CFR 457.350(a)(1), 457.80(c)(3))

At eligibility determination and redetermination, all applications are reviewed for coverage under a group health plan, or health insurance coverage, for access to a State health benefits plan, and for Medicaid eligibility prior to enrollment in a 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 eligibility based on his or her mother under one of the poverty level groups described in Section 1902(1) of the Social Security Act, Section 1931 of the Act, or Medicaid demonstration project under Section 1115 of the Act.

- 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 found ineligible for Medicaid and appears to be eligible for the separate child health program is automatically reviewed for separate child health program eligibility.

- 4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102(b)(3)(C)); (42CFR 457.805, 42 CFR 457.810(a)-(c))

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

The principal method is to monitor the availability of

private health insurance at the time of initial application (and at re-determination). This ties to RItE Share now being mandatory. In addition, the State established a Business Advisory Committee. Finally, the two commercial Health Plans participating in RItE Care monitor their commercial enrollment levels carefully.

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

See Section 4.4.4.1.

- 4.4.4.3. Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution. The State has not yet implemented its approved amendment to cover targeted low-income children up to 300% of the FPL.

- 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. Qualification does not require that a family be without coverage for a defined waiting period. This is because families cannot drop coverage to enroll in RItE Care due to Rhode Island's requirement that any applicant or enrollee with access to qualifying coverage must maintain or enroll in that coverage, and the State will reimburse the family for their monthly premium share, as a condition of Medicaid (separate child health program) eligibility.

The minimum employer contribution. There is no minimum employer contribution.

The cost-effectiveness determination. Cost-effectiveness is determined on an employer plan-specific basis, as opposed to an individual- or family-specific basis. This method ensures that the cost to

the State for those enrolled in the premium assistance program (RIte Share) is less than enrolling those same individuals or families in RIte Care.

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

RIte Care and RIte Share are available to targeted low-income individuals in the State who are American Indians and Alaskan Natives, except as noted in Section 8.6, cost-sharing does not apply to American Indians and Alaskan natives. Otherwise, the programs are identical in all respects. Also see Section 9.9.1 for involvement of the Narragansett Tribe, the only Federally recognized tribe in the State of Rhode Island.

SECTION 5. OUTREACH (SECTION 2102(C))

Describe the procedures used by the state to accomplish:

5.1 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)

When RIte Care expanded eligibility to include uninsured children aged 8 to 18 up to 250 percent of the FPL, the State embarked on a multifaceted outreach plan to enroll these children. The purpose of this outreach plan was to build upon prior efforts to enroll the targeted low-income child populations in RIte Care. To effectively reach target populations, multiple outreach methods took place with a total investment of \$1.8M by the Department of Human Services (DHS), a considerable investment given the size of the State. Outreach was coordinated very closely with Rhode Island's Covering Kids grant. The first phase of the outreach campaign began early in 1999, when DHS established performance-based contracts with 32 community-based agencies and community health centers to fund outreach workers to find and enroll eligible children. These contracts were in place until June 2000. The second major phase of the outreach campaign was a comprehensive school-based initiative over the 1999-2000 academic year.

TYPES OF OUTREACH

The following outreach activities have occurred as part of the public information campaign.

Targeted mailings

Print material, such as brochures, flyers, and inserts, have been developed and mailed or distributed to the groups that have contact with the targeted low-income child population. RIte Care Info Line telephone numbers are included on all print materials.

The targeted mailings included:

- Community Organizations
 - State/government agencies and programs
 - Non-profit community organizations
 - Hospitals, health center organizations, Health Plans
- School superintendents, principals, parent teacher organizations

- School nurses, school social workers, school psychologists, special education directors
- Head Start Directors, licensed preschools and nursery schools

Distribution of Materials to Every School-Age Child in Rhode Island

Similar to South Carolina's efforts for Partners for Health Children program, a RIte Care brochure was distributed to every (K through 6th grade) child in the State. This was undertaken in cooperation with the 347 schools in the State, with the schools actually handling the distribution of materials to each child.

Print Media

Media coverage on this expanded eligibility was promoted in professional newsletters and Rhode Island newspapers during the public information campaign.

Internet

Information on the eligibility expansion of RIte Care was added to the Department of Human Services (DHS) Website.

Piggyback mailings

When possible, information on the eligibility expansion has been inserted and mailed with other State or local mailings when appropriate, e.g., unemployment checks.

Public Service Announcements

Announcements for radio that were developed by HCFA have been used for this public information campaign. Airtime was purchased rather than relying on PSAs.

Press Conference

A kick-off press conference has announced the beginning of each eligibility expansion and initiation of the Covering Kids Project in Rhode Island.

Television and Radio Interviews

Interviews on television and radio shows were set up for DHS and Center for Child and Family Health (CCFH) staff.

OUTREACH TO NON-ENGLISH SPEAKING POPULATIONS

Hispanic Outreach

All print materials for the general public have been translated into Spanish and distributed to known Hispanic organizations throughout the State. Newspaper advertisements (in Spanish) were developed and placed in Hispanic

newspapers. A Hispanic outreach subcommittee was formed and provided recommendations to DHS. This group has also been working closely with one of the Covering Kids' groups on immigrants. The RIte Care Application has been translated into Spanish.

Other Non-English Speaking Outreach

Contact has been made with community leaders in minority groups other than Spanish. Information was be distributed in English and then translated by community representatives into their language.

OUTREACH TO THE NARRAGANSETT TRIBE

DHS staff has met with tribal leaders as well as representatives of the Narragansett Indian Health Center.

COMMUNITY-BASED OUTREACH

In addition to the above activities, the State contracted with 32 community-based organizations (CBOs) to help find and enroll eligible children and families. These contracts combined base staffing of outreach workers plus incentive funds for successfully enrolled children. In addition, DHS contracted with the Rhode Island community health centers to also help enroll children. These activities were **not**, however, funded with Title XXI funds.

SIMPLIFICATION OF ELIGIBILITY/ENROLLMENT PROCEDURES

Efforts were made to simplify the eligibility and enrollment process for RIte Care, in order to de-stigmatize the program. Under these revised processes, potential enrollees sign up for RIte Care by mail and do not need to make a visit to the local welfare offices. The 32 contracted CBOs also served as sites where potential enrollees can receive an application and also receive help in completing it. In addition, 14 community-based health centers and 3 hospitals are helping to enroll potential members.

**SECTION 6. COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE
(SECTION 2103)**

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

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

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

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

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

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1))
(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. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. **See instructions.**

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) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please

provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

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 (Please provide a sample of how the comparison will be done)

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

- 6.1.4.7. Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked.

The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (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)); (42CFR 457.490) -- Most services are covered without limits, except as medically necessary. See the enclosed Attachments A and B from the *Rite Care Health Plan Contract*, for a delineation of the amount, duration and scope of in- and out-of-plan benefits for the Secretary-approved coverage.

- 6.2.1. Inpatient services (Section 2110(a)(1))
Provided as medically necessary
- 6.2.2. Outpatient services (Section 2110(a)(2))
Provided as medically necessary
- 6.2.3. Physician services (Section 2110(a)(3))
Provided as medically necessary
- 6.2.4. Surgical services (Section 2110(a)(4))
Provided as medically necessary
- 6.2.5. Clinic services (including health center services) and other ambulatory health care services (Section 2110(a)(5))
Provided as medically necessary
- 6.2.6. Prescription drugs (Section 2110(a)(6))
Covered when prescribed by a participating

physician/provider

- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
Covered when prescribed by a participating physician/provider.
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
Covered when ordered by a participating physician/provider.
- 6.2.9. Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
Enrolled female members have freedom of choice of provider
- 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))
Covered as needed
- 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))
Covered as needed
- 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))
Covered as ordered by a participating physician/provider as medically necessary.
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))
Covered as authorized by a physician/provider and under a written plan of care.

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 (See instructions) (Section 2110(a)(14))
Covered as authorized by a physician/provider and under a written plan of care.
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 (See instructions) (Section 2110(a)(15))
Covered as authorized by a physician/provider and under a written plan of care.
- 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))
Covered as needed
- 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)
Covered as needed
- 6.2.18. Vision screenings and services (Section 2110(a)(24))
Provided to all children and young adults up to age 21.
- 6.2.19. Hearing screenings and services (Section 2110(a)(24))
Provided to all children and young adults up to age 21.
- 6.2.20. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
Covered as needed
- 6.2.21. Outpatient substance abuse treatment services (Section 2110(a)(19))
Covered as needed
- 6.2.22. Case management services (Section 2110(a)(20))
Covered as needed
- 6.2.23. Care coordination services (Section 2110(a)(21))
Covered as needed
- 6.2.24. Physical therapy, occupational therapy, and services for

individuals with speech, hearing, and language disorders
(Section 2110(a)(22))
Covered as needed, based on medical necessity

- 6.2.25.** Hospice care (Section 2110(a)(23))
Covered as ordered by a participating physician/provider.
Services limited to those covered by Medicare.

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
Provided to all children and young adults up to age 21.

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))
Covered if referred by a participating physician.
Practitioners certified and licensed by the State of Rhode Island.

- 6.2.28. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28)) Premiums for private health care insurance coverage (Section 2110(a)(25))
Covered if determined cost effective and the individual is enrolled in the RIte Share premium assistance program.

- 6.2.29.** Medical transportation (Section 2110(a)(26))
Covered as needed

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))
Covered as needed

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

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

COVID-19 Vaccine:

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

COVID-19 Testing:

- The state provides coverage of COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act.
- The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.
- The state assures that coverage includes all types of FDA authorized COVID-19 tests.

COVID-19 Treatment:

- The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
 - The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);

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

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

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

6.2-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 (CDT⁶) 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 CDT⁷ 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.

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

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

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

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family

coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and(3)); (42 CFR 457.1005 and 457.1010)

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

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

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

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

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

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

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

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

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the

cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

6.4.2.2. 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)) (42 CFR 457.1010(b))

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

6.4.3-PA: Additional State Options for Providing Premium Assistance

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

- Yes
 No

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

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

The State assures that the qualified employer-sponsored insurance meets the definition as defined in Section 2105(c)(10)(B).

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

The subsidy payment is equal to the employee's share of the monthly premium and is generally paid directly to the member. Employers may elect to receive the subsidy payment directly, in which case the state will pay the employer directly.

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

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

The state ensures that individuals receiving premium assistance have access to all Medicaid covered services by directly paying Medicaid enrolled providers for services and cost sharing requirements up to the Medicaid allowable amount not covered in the commercial plans, as well as services that exceed the coverage of commercial plans.

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

The state provides wrap around benefits by directly paying Medicaid enrolled providers for services and cost sharing requirements up to the Medicaid allowable amount not covered in the commercial plans, as well as services that exceed the coverage of commercial plans.

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

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

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

The state does not impose a waiting period

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

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

If a child enrolled in the employer-sponsored coverage program (RlTe Share) experiences significant barriers in access to care, parents may submit a request to disenroll their child from the program. EOHHS will review each request to determine if the situation necessitates disenrollment from RlTe Share and enrollment in RlTe Care, the state's Medicaid managed care program.

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

Individuals who may be eligible for the state's premium assistance program (known as RlTe Share) are identified through the Medicaid application process. Potentially eligible individuals will receive a notice informing them of the option to enroll in the

premium assistance program. Additionally, the State operates a Rlte Share phone line to assist individuals with applications, and to answer questions regarding enrollment and eligibility. Information is also available on the State's website.

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

Yes
 No

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

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

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

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

Individuals who may be eligible for the state's premium assistance program (known as Rlte Share) are identified through the Medicaid application process. Potentially eligible individuals will receive a notice informing them of the option to enroll in the premium assistance program. Additionally, the State operates a Rlte Share phone line to assist individuals with applications, and to answer questions regarding enrollment and eligibility. Information is also available on the State's website.

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

The state assures that information is provided regarding premium assistance on the CHIP application form.

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. (Section 2102(a)(7)(A));(42CFR 457.495(a))

The methods used for quality and appropriateness of care are the same as RItE Care. From the very beginning of RItE Care, the State has taken to heart the fact that it is a *demonstration* initiative. DHS developed a plan for monitoring⁸ RItE Care Health Plans early on. The plan included the following mechanisms for monitoring 12 areas of Health Plan operations:

- Annual Site Visit Protocol
- Disenrollment Grievance Log
- Informal Complaints and Grievance and Appeals Log
- Primary Care Provider (PCP) Survey
- Enhanced Services Report
- MMIS Special "Runs"
- Member Satisfaction Survey
- Self-Assessment Tool For Health Plan Internal Quality Assurance Plan Compliance With HCQIS
- Access Study Format
- PCP Open Practice Report
- Other Provider Report
- Financial Reporting Requirements
- Third-Party Liability Report

The State also crafted and has implemented an extensive research and evaluation program to determine how well RItE Care has done in accomplishing its goals. In fact, research began before RItE Care was actually implemented in order to have some baseline data for comparison with *demonstration* results.

The Components of the State's Quality Strategy

The following constitute the various components of the State's strategy for quality

⁸ The latest version is: Birch & Davis Health Management Corporation. *Plan For Monitoring RItE Care Health Plans*, August 1996.

assessment and performance improvement.

1 Performance Incentive Program

In the RIte Care Health Plan Contracts effective July 1, 1998, the State established a performance incentive program, under which Health Plans can earn payments over and above capitation and SOBRA payments for the attainment of certain administrative, access, and clinical goals. The State did so “to improve care by using available health plan data on access and outcomes” and “to improve the quality of health plan performance data.”⁹ This was part of an ongoing strategy of partnership with the Health Plans, with both the State and the Health Plans committed to continuous quality improvement for RIte Care. The “approach leverages a comparatively small amount of money in spotlight areas that DHS considers important.”¹⁰

The program began with 21 measures in three areas of focus: 9 for the administrative area, 5 for the access to care area, and 7 for the clinical care area. Five “pilot measures” were added in 2000 and include the following areas:

- Postpartum visit after delivery
- First outpatient pediatric visit for infants born into RIte Care
- Emergency room visits by child enrollees with asthma
- Outpatient visit after discharge for a mental health diagnosis
- Translation assistance

Each measure is clearly defined, has a numeric “standard” to be achieved, and has “scoring guidelines.”

Data on the *administrative* measures are collected during on-site reviews of each Health Plan. The Encounter Data System provides the information for the *access* and *clinical* measures. Data from 1998 established the baseline against which later performance is compared. DHS offers each Health Plan monetary incentives¹¹ as a reward for improvements in performance, information accuracy, and the completeness of data submitted.

In 2001, DHS received a Purchaser Award from the National Health Care Purchasing Institute for the program to recognize DHS’ “value purchasing” management philosophy.

2 Encounter Data System

9 Dyer, M.B., M. Bailit, and C. Kokenyesi. *Working Paper: Are Incentives Effective in Improving the Performance of Managed Care Plans?*, Center for Health Care Strategies, March 2002.

10 Rhode Island Department of Human Services. *Rhode Island Medicaid Program: Annual Report Fiscal Year 2001*, 42.

11 The total incentive pool equals approximately one percent of total capitation payments made to the Health Plans.

The Rlte Care Health Plans have worked diligently to implement an encounter data reporting system. Such a reporting system is one of the Special Terms and Conditions imposed by the Federal Government in granting the State the waivers necessary to implement Rlte Care. An encounter data system is designed to identify services provided to an individual and track utilization over time and across service categories, provider types, and treatment facilities. Unique features and functional components of encounter data include:

- **Episode-specific:** services associated with a particular episode of care are grouped together
- **Person-level:** able to track individuals through the system
- **Standardized:** all Health Plans are reporting using the same definition
- **Longitudinal:** able to track people across reporting period
- **Comprehensive:** able to track people across service and treatment categories

Tracking medical encounters from a point of service (e.g., a physician's office) through claim processing by the Health Plans to a data processing component to functional analytical files presents many operational challenges. As the Federal Government, Rhode Island, and the other waiver States have learned, it takes at least three years to achieve a level of consistency in reporting by Health Plans in order to have usable encounter data.

Information from the Rhode Island Encounter Data System has been reported since 1998, when a level of reporting consistency was reached and data were verified. Besides supporting the performance incentive program, the Encounter data System is also used to monitor utilization. Monitoring utilization is important in assuring that enrollees have access to needed services. Since June 2001, encounter data have been used to prepare *Rlte Stats* – a bimonthly publication of the DHS Center for Child and Family Health (which administers Rlte Care and Rlte Share) to provide information to the public on the health care provided under Rlte Care.

Whenever possible, encounter data analyses are compared to comparable national benchmarks such as from:

- National Ambulatory Medical Survey
- National Health Interview Survey
- National Hospital Ambulatory Medical Care Survey
- National Medicaid HEDIS Database/Benchmark Project
- Treatment Episode Data Set

3 Risk-Share Reporting

As noted in Section 3.1, DHS has entered into risk-share arrangements with two Health Plans – CHP and NHPRI. The purpose of these arrangements is to assure Rlte Care-eligible individuals have a choice of Health Plans in which to enroll¹². Under the risk-sharing methodology, risk is shared according to whether the actual Medical Loss Ratio¹³ in any quarter is within agreed-upon ranges or “risk corridors.”

The risk-share arrangements require that the Health Plans report monthly to DHS on the following:

- Utilization data, including hospital admissions, length of stay, days per 1,000 enrollees, and maternity stays
- Claims payable and claims statistics, including claims received, claims processed, and average processing time in days
- Financial information

These reporting requirements are currently being renegotiated with the Health Plans to partition the utilization data into the following categories: (1) institutional services (behavioral health and medical services by admissions, total days, and length of stay, emergency visits, ambulatory surgery, and other outpatient services reported as visits); (2) professional services (primary care, specialty services, emergency room physician visits, and behavioral health visits); (3) pharmacy (number of prescriptions); and (4) all other services used.

4 Rlte Care Annual Member Satisfaction Survey

Each year, since 1996, ACS/Birch & Davis, under contract to DHS, has conducted an Annual Member Satisfaction Survey. Satisfaction data provide a commentary by enrollees on the services they receive. Each annual survey is comprised of a random sample of Rlte Care members, who are selected as representative of the Rlte Care enrolled population. The samples are designed to be effective at a 25 percent response rate (plus or minus 5 percent) in measuring member satisfaction at the Rlte Care program level at a 95 percent confidence.

Each survey sample is mailed a survey questionnaire. The questionnaire is developed, in collaboration with the Rlte Care Consumer Advisory Council, for this survey to reflect Rlte care-specific program concerns. Questionnaires are pre-tested and modified accordingly. There are adult and child versions of the questionnaire. Adults answer on

¹² Federal regulations require that enrollees have a choice of plans in which to enroll.

¹³ Medical Loss Ratio means Medical Expenses divided by Premium.

behalf of child members. Both versions are in English and Spanish. Sample members who did not respond to the initial mailing are sent a replacement mailing of the questionnaire. Responses received after a specified date each year are not included in the data analysis.

Each Annual Member Satisfaction Survey collects information on the following dimensions¹⁴:

- Regular doctor – other than whether the member has a regular doctor, information about:
 - Doctor’s location
 - How long it has been since last seen
 - Ability to talk to or see when sick
 - Waiting time for appointment when sick
 - Waiting time for appointment to begin
 - Ability to reach after hours and on holidays and weekends
 - Overall satisfaction
- Prevention services – information about areas discussed by regular doctor, such as the following for adults:
 - Tobacco, alcohol, or drug use
 - Diet, exercise, or seat belt use
 - Stress, depression, or anxiety
 - Family planning
- Pharmacy services – problems getting prescriptions filled
- Specialty services
 - Satisfaction with getting a referral
 - Problems experienced if dissatisfied
- Emergency services
 - Satisfaction, if ER services were used
 - Problems experienced, if dissatisfied
- Member services – helpfulness of plan staff, if a problem arose
- Member rights

¹⁴ It should be noted that dimensions, or questions, may change somewhat from year to year

- Been denied services
- Know how to appeal coverage decisions
- Know about Rlte Care Consumer Advisory Committee
- Transportation services
 - Satisfaction with Rlte Care transportation benefits, if used
 - Availability of car seat for child under 3, if taxi or van used
- Interpreter services – needed one for a visit, but one not offered
- Overall satisfaction

Data from the survey are item-analyzed separately for adult and child versions of the questionnaire. Responses are analyzed by Health Plan and for English-speaking versus Spanish-speaking respondents. Where possible, responses are compared over time to examine trends.

5 Complaint, Grievance, and Appeals Reporting by the Health Plans

Enrollees may file a complaint, grievance, or appeal with their Health Plan¹⁵ at any time. Health Plans have, since Rlte Care enrollment began, submitted quarterly reports to DHS summarizing the types of complaints made and whether or not they were resolved. Health Plans have also submitted a Grievance and Appeal Log quarterly from the beginning that itemizes, by enrollee, the nature of the grievance or appeal, how long it took to resolve, how it was resolved, and how long it took to notify the enrollee of the resolution. Data are summarized periodically.

In addition to reporting by the Health Plans, complaints from enrollees (or their representatives, providers, advocates, other State agencies, and others) can come to DHS directly through the bilingual DHS InfoLine or to DHS staff. Complaints may also go to the Rlte Care Consumer Advisory Committee. In addition, enrollees may avail themselves of the DHS Fair Hearing process at any time.

6. Provider Network Data

Access to care has multiple dimensions. One dimension, for example, is providing access to care for individuals who had no or limited access due to being uninsured. Another dimension, for example, is improving access for those who had coverage but nonetheless had difficulty obtaining the services they needed.

¹⁵ Enrollees may also register complaints with the State at any time including availing themselves of the DHS Fair Hearing process.

The State monitors the adequacy of the service delivery system on a continuous basis. Provider network listings are updated monthly, from information submitted by the Health Plans. Among the items of information submitted is whether or not a provider's practice is open to new members. Another item, for example, is language(s) spoken. The listings are matched, as necessary, with enrollee/ applicant listings to assess any network gaps in primary care provider (PCP) availability, for example. Geo-access analyses have also been performed periodically.

Provider network data analysis is also considered in light Annual Member Satisfaction Survey and complaint, grievance, and appeals analyses, to present a broader picture of the adequacy and appropriateness of the provider networks.

6. NCQA Information

As noted in Section 3.1, RIte Care-participating Health Plans must be State-licensed HMOs and must be, by State law, accredited by NCQA. Accreditation information is provided to the State by the Health Plans. Health Plan Employer Data and Information Set (HEDIS) are also provided to the State by the Health Plans. HEDIS data encompasses the following domains:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care¹⁶
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choice
- Health Plan Descriptive Information

The Effectiveness of Care domain includes, for example:

- Childhood immunization status
- Adolescent immunization status
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening in women
- Prenatal care in the first trimester
- Check-ups after delivery
- Controlling high blood pressure
- Comprehensive diabetes care
- Use of appropriate medications for people with asthma

¹⁶ This is actually the Consumer Assessment of Health Plans Survey (CAHPS).

The Access/Availability of Care domain includes:

- Adult's access to preventive/ambulatory health services
- Children's access to primary care practitioners

It should be noted that NCQA may rotate some of the measures from one year to the next, to reduce the burden on the Health Plans. NCQA requires an audit of HEDIS results by an independent agency (certified by NCQA) to ensure that HEDIS specifications have been met.

The similarity between some of the HEDIS measures and the Rlte Care performance incentive program is not coincidental. Where possible, the performance incentive program used HEDIS specifications for a given measure since the Health Plans were already collecting information in this manner. It is important to note, however, that except for NHPRI, the HEDIS data reported by the Health Plans are not Rlte Care-, or more precisely, Medicaid-specific.

The HEDIS results reported back to the Health Plans by NCQA (and, in turn, submitted to the State) show the results not for the Health Plan itself, but in comparison to "HEDIS national percentiles" at the 90th, 75th, 50th, and 25th levels, where available. The results are also shown for the Health Plan for prior years and in comparison to pre-set Health Plan goals, where applicable.

8. External Quality Review Organization (EQRO) Studies

One of the Special Terms and Conditions for the Rlte Care waiver is that the State must contract with an EQRO. The State has used its EQRO to validate encounter data as well as to perform clinical focused studies. The clinical focused studies, which are based on detailed review of a sample of medical and other records, have included the following clinical areas:

- Neonatal intensive care unit (NICU) utilization
- Emergency room (ER) utilization
- Behavioral health care

The State is in the process of procuring a new EQRO contract. In addition to the conduct of clinical focused studies, the State expects the EQRO will be used to perform analytical studies using already available data.

9. Medicaid Management Information System (MMIS) Data

Because Rlte Care enrollees are covered by the Medicaid fee-for-service system (FFS) for out-of-plan services (i.e., services not covered by the capitation payments to the Health Plans), *ad hoc* reports from the MMIS are prepared to analyze utilization of these

services. In addition, the MMIS provides the basic demographic information on enrollees (e.g., age, gender, and race). This latter information is actually imported into the MMIS from the State's eligibility system.

10. Transportation Data

As noted in Section 3.1, DHS has had an agreement with the Rhode Island Public Transportation Authority (RIPTA) since the beginning of RlTe Care for RIPTA to provide bus passes and non-emergency paratransit services (e.g., taxis) to RlTe Care-eligible individuals. DHS has had this arrangement with RIPTA because of the importance of transportation in assuring access to needed health care services by low-income individuals. RIPTA submits reports to DHS quarterly on the number of bus passes issued and on the utilization of paratransit services. These data are analyzed periodically.

11. Special Studies

As noted above, the State has implemented an extensive research and evaluation (R&E) program for RlTe Care. This program has included a variety of special studies, undertaken as a particular need has arisen or part of the "planned" R&E effort. Among the studies performed have been:

- Behavioral Health Care Access Study – This study¹⁷ was completed and submitted to CMS in 1998 and included intensive, on-site review of Health Plan compliance with behavioral health contract provisions established to address concerns related to provider specialization and the multiethnic, multilingual nature of the enrolled RlTe Care population.
- **Prenatal Care and Birth Outcome Study** – This study¹⁸, originally based on data through 1995 and reported in *RlTe Care Program Quarterly Report: October 1996 through December 1996*, was updated using Calendar Year 1999 birth certificate date from the Office of Vital Statistics of the Rhode Island Department of Health. Study results, using the 1995 data, were also published in the *American Journal of Public Health*¹⁹.
- **Infant Health Survey** – This survey²⁰ was conducted to assess the impact of RlTe Care on access to and the quality of pediatric primary care in an inner city high-risk population. The study was initiated prior to individuals enrolling

17 Birch & Davis Health Management Corporation. *RlTe care Behavioral Health Access Study*, 1998.

18 Griffin, J. *The Impact of RlTe Care on Adequacy of Prenatal Care and the Health of Newborns*, MCH Evaluation, Inc., March 2001.

19 Griffin, J. F., et. al. "the Effect of a Medicaid Managed Care Program on the Adequacy of Prenatal Care Utilization in Rhode Island," *American Journal of Public Health*, 89(4), April 1999, 497 – 501.

20 Griffin, J. *Changes in Access and Quality of Pediatric Health Care in Inner City Providence from 1993 to 1995: Results of the RlTe Care Infant Health Survey*, MCH Evaluation, Inc., April 28, 1998.

in Rlte Care Health Plans, so that the effects of Rlte Care could be clearly discerned. Specifically, the sample for this study involved two inner city birth cohorts. The first, 1993 Cohort (i.e., pre-Rlte Care), consisted of all resident births for Providence inner city census tracts 1 through 7, 12 through 14, 19 and 26 that occurred from March 1, 1993 through July 30, 1993. The second, 1995 Cohort (i.e., post-Rlte Care), consisted of all inner city births from the same census tracts and born from March 1, 1995 through July 30, 1995.

In 1998, Rhode Island received a demonstration grant from the Robert Wood Johnson Foundation's Center on Health Care Strategies to develop a *Health Indication System for Rhode Islanders on Medicaid*²¹. This project brought fundamental change through the establishment of the Evaluation Studies Workgroup and the emergence of a partnership between program staff and the Workgroup. The Workgroup includes researchers from Brown University, DOH, DHS, and contracted evaluation services (with MCH Evaluation, Inc.) This project produces health outcome measures from existing databases and surveys, and through special studies. The existing databases and surveys include:

- MMIS
- Linked Infant Birth/Death File
- Birth File
- Hospital Discharge File
- Health Interview Survey
- Behavioral Risk Factor Surveillance Survey

Among some of the special studies have been:

- A study²² of immunization status of 19- to 35-month-old children who had been continuously enrolled in Rlte Care for at least one year, based upon medical record reviews
- A study²³ of a documented blood lead screen test of children aged 19 to 35 months who had been continuously enrolled in Rlte Care for at least one year had, also based on medical record reviews

Special studies will continue to be performed as part of the State's quality strategy.

12 Contract Requirements

21 For more information on Rhode Islanders indicators, please see: <http://dhs.state.ri.us/dhs/reports/dhccresys.htm>.

22 Vivier, P. M., *et.al.* "An Analysis of the immunization status of preschool children enrolled in a statewide Medicaid managed care program," *The Journal of Pediatrics*, 139(5), November 2001, 624-629.

23 Vivier, P.M., *et.al.* "A Statewide Assessment of Lead Screening Histories of Preschool Children Managed in a Medicaid Managed care Program," *Pediatrics*, 108(2), 2001.

One of the guiding principles for the State's quality strategy is having properly aligned contract requirements for the Health Plans, obligating them to be active participants in quality assessment and performance improvement. Some of these obligations have been described above (e.g., encounter data reporting and complaints, grievances, and appeals reporting). Two other long-standing contractual obligations have been for each Health Plan to perform at least three quality improvement studies each year and for each Health Plan to conduct its own member satisfaction survey.

DHS has amended the Rlte Care Health Plan Contract multiple times to ensure the Federal requirements and STCs, at least those that can be contractually based, were met. In June 2001, the Rlte Care Health Plan Contract were amended to conform to what the State believed were the managed care provisions of the Balanced Budget Act of 1997 (BBA). Thus, 16 changes were made to the contracts with the Health Plans at that time.

In reviewing the details of the June 14, 2002 *Final Rule* implementing the managed care provisions of the BBA, the State finds that it will need to make additional changes to the Rlte Care Health Plan Contract. These changes are due mostly to the *Final Rule's* language differing somewhat from the actual language in the statute. Thus, one component of the State's quality strategy is to amend the Rlte Care Health Plan Contracts prior to June 16, 2003 to bring them into compliance with the provisions of the *Final Rule*.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)); (42CFR 57.495)

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))

Same as Rlte Care.

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))

Same as Rlte Care.

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))

Same as Rlte Care.

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))

Same as Rlte Care.

SECTION 8. COST SHARING AND PAYMENT (SECTION 2103(E))

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

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

8.1.1. YES

8.1.2. NO, skip to question 8.8.

8.1.1-PW Yes

8.1.2-PW No, skip to question 8.8.

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

8.2.1. Premiums:

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)(B)); (42CFR 457.505(b))

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

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

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

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

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

8.4.1- MHPAEA There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

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

Yes (Specify: _____)

No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

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

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

Yes

No

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

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 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)); (42CFR 457.560(b) and 457.505(e))

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)

8.7

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

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

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

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

- 8.7.1.1. State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42 CFR 457.570(a))
 - 8.7.1.2. The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42 CFR 457.570(b))
 - 8.7.1.3. In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42 CFR 457.570(b))
 - 8.7.1.4 The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42 CFR 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))

Increasing creditable health care coverage among targeted low-income children and other low-income children through Rlte Care will be accomplished through four (4) key strategic objectives:

- Outreach and enrollment of eligible low-income children
- Increasing access to health care coverage and use of health care services
- Improving continuity and quality of care
- Containing medical costs

Each of these strategic objectives will be achieved by reaching a series of performance goals (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))

The performance goals for each one of the objectives delineated in Section 9.1 are shown in Tables 2 through 5 below:

Table 2

Outreach Performance Goals

Improve Outreach Efforts as Measured By:

- Increase the number of Medicaid-eligibles enrolled in Rlte Care
- Reduce the percentage of uninsured children
- Reduce the percentage of uninsured adults

Table 3

Access Performance Goals

Increase Continuity and Quality of Care as Measured by:

- Increase the number of enrollees who report that they have improved access to the health care
- Facilitate access to specialty resources through PCP referrals
- Improve access to health care by removing barriers including:

- Location
 - Transportation
 - Appointment waiting time
 - Language
- Enhance the benefit package and coverage available to eligible children

Table 4

Continuity and Quality Performance Goals

Improve Continuity and Quality of Care as Measured by:

- Improve use of age-appropriate prevention care
- Increase the number of primary care visits
- Reduce the number of lead poisoned children
- Increase preventive dental care

Table 5

Cost Containment Performance Goals

Contain Medical Costs as Measured by:

- Constrain the rate of increase in Medicaid expenditures per capita
- Decrease the inappropriate use of hospital emergency rooms
- Decrease inappropriate or preventable hospitalization (e.g., PID, asthma, otitis media, pneumonia, dehydration)

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))

Program evaluation, the final component of the quality monitoring strategy for RItE Care, is important for assessing whether RItE Care has achieved the performance goals it has established for RItE Care as written in Section 9.2. Progress or lack of progress toward these performance goals would dictate a need for any one or more of the following:

- Change in the Health Plan's or the Center for Child and Family Health's operational processes or priorities
- Reassessment and refinement of quality review methodologies
- Increase Health Plan accountability for noncompliance
- Revision or addenda to RItE Care Health Plan contracts or policies

- Revision of the program goals and objectives

Ninety days before the end of each fiscal year, CCFH staff will begin compiling information on the attainment of the performance goals specified in Tables 2 through 5. This will be done as an amalgam of the quality improvement and other monitoring activities to be undertaken.

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

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. Immunizations
 - 9.3.7.2. Well childcare
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, please list: *Pap smears, mammograms*
- 9.3.8. Performance measures for special targeted populations.
- 9.4. The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)); (42CFR 457.720)
- 9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2));

(42CFR 457.750)

The State will compile the *Framework for Annual Report of the Child's Health Insurance Plans Under Title XXI of the Social Security Act* for each Federal fiscal year and submit it to CMS by January 1st of each year.

- 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))

This process was co-led, under the overall aegis of the Director of the Department of Human Services, by the Administrator of the Center for Child and Family Health and the Co-Chair of the Rlte Care Consumer Advisory Council. An initial public meeting was held on December 3, 1997, to explain to the public the opportunities and constraints provided for under Title XXI as well as to elicit public opinion on the directions the State's Title XXI program should take. It was the consensus of those in attendance at this meeting that the State should pursue the incremental approach to Title XXI reflected in the initial Plan submission, then to submit an amended Plan after conclusion of the public planning process. Subsequent public meetings were held on January 7 and 22, 1998. A Title XXI committee of the State's Federal Legislative Task Force was formed and met either monthly or bi-monthly through 1998 and 1999.

The Title XXI planning process has also entailed meetings with the other State

agencies having historic involvement with Medicaid:

- Department of Children, Youth and Families (DCYF)
- Department of Education (DOE)
- Department of Health (DOH)
- Department of Mental Health, Retardation and Hospitals (MHRH)

In addition, the Title XXI committee has included some 100 individuals representing an array of public and private interests including, for example:

- Governor's Office
- Legislative representatives
- State agencies
- RIte Care Consumer Advisory Council
- Office of Child Advocate
- RI ARC
- Urban League of Rhode Island
- RI KIDS COUNT
- Westbay Community Action
- Campaign to Eliminate Childhood Poverty
- RI Health Center Association
- United Way
- Family Voices
- RI Coalition for the Homeless
- Ocean State Action Health Plans

This is a similar group through which DHS worked in planning for welfare reform in the State. Thus, the Title XXI planning process had broad-based public input. The specific recommendations reflected in this Plan Amendment were adopted by the Title XXI Workgroup of the Federal Legislative Task Force, by consensus, at its September 1999 meeting.

During the Title XXI implementation phase, public involvement has been assured through the RIte Care Consumer Advisory Council which meets monthly. This is consistent with the State's approach to Title XXI by expanding RIte Care. The Consumer Advisory Council provides the public forum for addressing any aspect of RIte Care. In addition, the Consumer Advisory Council plays a critical role in reviewing State-developed materials to be sent to potential applicants/enrollees and in certain evaluation activities e.g., annual Member Satisfaction Survey.

DHS also established a Business Advisory Committee to provide advice and guidance on various aspects of the Section 1115 waiver.

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))

In 1999, the Rhode Island Department of Human Services (DHS) and the Narragansett Native American Tribe (Tribe) signed a formal consultation agreement to encourage the free exchange of information to improve collaboration between the State and the Tribe with regard to health services.

The State has sought comments from the Tribe on its Section 1115 waiver (and amendments) and SCHIP plans through a SCHIP planning committee and continues to encourage participation from the Tribe in RItE Care's ongoing Consumer Advisory Committee.

DHS has also developed an ongoing partnership to:

- Streamline the payment claims system for RItE Care members
- Facilitate meeting meetings between NHPRI and the Indian Health Center to allow the center to participate in NHPRI's provider network
- Exempt Native Americans from cost-sharing

9.9.1 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).

Coverage of eligible children under 19 as provided for in Section 214 of the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) who are otherwise eligible aliens lawfully residing in the United States was authorized by the Rhode Island General Assemble in approving the 2010 State Budget, thus the public was informed through the State's customary legislative process.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe:

- 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. Cost-sharing payments have been accounted for and the Net Benefit Costs are net of cost-sharing.

CHIP Budget

STATE:	FFY Budget
Federal Fiscal Year	2019
State's enhanced FMAP rate	89.80%
Benefit Costs	
Insurance payments	\$0
Managed care including allocation of FQHC Wrap Payments & Risk Share to CHIP	\$92,148,924
<u>per member/per month rate</u>	\$239 PMPM
Fee for Service	\$7,087,194
Total Benefit Costs	\$99,236,118
(Offsetting beneficiary cost sharing payments)	\$0
Net Benefit Costs	\$99,236,118
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	\$8,171
General administration	0
Contractors/Brokers	\$407,150
Claims Processing	0
Outreach/marketing costs	0
Health Services Initiatives	\$2,970,405
Other	0
Total Administration Costs	\$3,385,726
10% Administrative Cap	\$10,220,652
Cost of Proposed SPA Changes	\$415,322
Federal Share	\$92,154,416
State Share	\$10,467,428
Total Costs of Approved CHIP Plan	\$102,621,844

Rhode Island CHIP Budget

Addition of SCHIP coverage for legally present children as allowed under CHIPRA (SPA #7)	LPR CHILDREN AGES 0-18 FPL 0 - 250%	LPR CHILDREN AGES 0-18 FPL 0 - 250%	OTHER COVERED POPULATIONS SCHIP eligible children	Total
	QUARTER ENDED SEPT 2009	FFY2010	FFY2010	FFY2010
State's enhanced FMAP rate	66.81%	66.84%	66.84%	66.84%
Member Months	3,846.00	15,384.00	166,059.08	181,443.08
Benefit Costs				
Payments to Managed Care Plans	\$712,237	\$2,884,461	\$27,877,141	\$30,761,602
Insurance Payments (RIteShare)				
<i>per member/per month rate @ # of eligibles</i>	\$185.19	\$187.50	\$167.87	\$169.54
Fee for Service	\$148,559	\$594,238	\$9,089,533	\$9,683,770
Total Benefit Costs	\$860,797	\$3,478,699	\$36,966,674	\$40,445,373
Offsetting beneficiary cost sharing payments (Prem Coll'n)	0	0		
Net Benefit Costs	\$860,797	\$3,478,699	\$36,966,674	\$40,445,373
<i>per member/per month rate @ # of eligibles</i>	\$223.82	\$226.12	\$222.61	
Administration Costs				
Personnel	\$288,856	\$61,778	\$656,495	\$718,273
General administration	\$235,049	\$50,271	\$534,205	\$584,476
Contractors/Brokers	\$1,235,910	\$264,329	\$2,808,900	\$3,073,229
Claims Processing	\$43,910	\$9,391	\$99,798	\$109,189
Outreach/marketing costs	\$2,412	\$516	\$5,483	\$5,999
Other	\$1,114	\$238	\$2,530	\$2,768
Total Administration Costs	\$95,644	\$386,522	\$4,107,412	\$4,493,934
10% Administrative Cap	\$95,644	\$386,522	\$4,107,408	\$4,493,930
Federal Share	\$638,998	\$2,583,514	\$27,453,917	\$30,037,430
State Share	\$317,443	\$1,281,707	\$13,620,166	\$14,901,873
TOTAL COSTS OF APPROVED SCHIP PLAN	\$956,441	\$3,865,221	\$41,074,082	\$44,939,303

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
- 10.1.2. The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))
- 10.1.3. The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

SECTION 11. PROGRAM INTEGRITY**(SECTION 2101(A))**

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

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

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

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

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

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

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

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

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

SECTION 12. APPLICANT AND ENROLLEE PROTECTIONS (SECTIONS 2101(A))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan.**

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 Medicaid (DHS) Fair Hearing process. The DHS Fair Hearing process is available to any applicant or enrollee for review of denial of eligibility, failure to make timely determination of eligibility, and suspension or termination of enrollment including disenrollment for failure to pay cost-sharing. An expedited DHS Fair Hearing when there is an immediate need for health services. The procedures for review assure:

- Reviews are conducted by an impartial person in accordance with 42 CFR 457.1150
- Review decisions are timely in accordance 42 CFR 457.1160
- Applicants and enrollees have an opportunity to:
 - Represent themselves or have representatives of their choosing in the review
 - Timely review their files and other applicable information relevant to the review of the decision
 - Fully participate in the review process, whether the review is conducted in person or in writing, including presenting supplemental information during the review process
 - Receive continued enrollment in accordance with 42 CFR 457.1170

Health Services Matters

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

There are multiple avenues for an enrollee for external review of a delay, denial, reduction, suspension, or termination of health services in whole or in part, including determination about the type and level of services, and failure to approve, furnish, or provide payment for health services in a timely manner. The enrollee may avail herself or himself of the DHS Fair Hearing process described in Section 12.1. The enrollee may also avail herself or himself of the external review process through the Rhode Island Department of Health, provided for under State law.

These reviews are completed in accordance with the medical needs of the patient, and are completed within the timeframes specified in 42 CFR 457.1160.

Enrollees may also avail themselves of Health Plan internal review processes, although such reviews need not be conducted prior to enrollees availing themselves of DHS Fair Hearings or DOH external reviews.

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.

All enrollees in RItE Share may avail themselves of the Medicaid (DHS) Fair Hearing process.

ATTACHMENT A

SCHEDULE OF IN-PLAN BENEFITS

Page 1 of 8

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Inpatient Hospital Care	Up to 365 days per year based on medical necessity	Yes
Outpatient Hospital Services	Covered as needed, based on medical necessity. Includes physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, respiratory therapy, and other Medicaid covered services delivered in an outpatient hospital setting. (Health Plans have the option to deliver these types of services in other appropriate settings.)	Yes
Physician Services	Covered as needed, based on medical necessity; up to three GYN visits annually to a network provider is covered without a PCP referral	Yes
Family Planning Services	Women covered as described in Attachment F (non-extended family planning group receives same family planning benefit as extended family planning group)	Yes

ATTACHMENT A

Page 2 of 8

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Prescription Drugs	Covered when prescribed by a Health Plan physician/provider (or other physician for SED and SPMI) Generic substitution required unless specified otherwise by physician.	Yes
Non-Prescription Drugs	Covered when prescribed by a Health Plan physician/provider; limited to non-prescription drugs covered by the Rhode Island Medical Assistance Program	Yes
Laboratory Services	Covered when ordered by a Health Plan physician/provider (or other physician for SED and SPMI), including urine screens	Yes
Radiology Services	Covered when ordered by a Health Plan physician/provider	Yes
Diagnostic Services	Covered when ordered by a Health Plan physician/provider (or other physician for SED and SPMI)	Yes

ATTACHMENT A

Page 3 of 8

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
<p>Mental Health and Substance Abuse Services- Outpatient</p>	<p>Both short- and long-term treatment covered as needed based on medical necessity, subject to stop-loss limitations in Definition Section 1.30 and groups/services out-of-plan in Attachment B. Includes methadone maintenance, outpatient methadone detoxification, collateral visits, and medically necessary court-ordered services subject to limitations described in Attachment B</p>	<p>Yes, except for groups screened-out as described in Attachment B and subject to stop-loss in Section 1.30</p>
<p>Mental Health and Substance Abuse Services- Inpatient</p>	<p>Both short- and long-term treatment covered as needed, based on medical necessity. (Butler Hospital may be used for services). Includes day treatment, partial hospitalization, and residential treatment, except for residential treatment for children ordered by DCYF, and except for residential substance abuse treatment for children age 13 to 17. Covered residential treatment includes therapeutic services but does not include room and board, except in a facility accredited by the Joint Commission on accreditation of Healthcare Organizations ("JCAHO"). Covered services subject to limitations described in Attachment B</p>	<p>Yes, except for groups screened-out, as described in Attachment B and subject to stop-loss provisions in Section 1.30</p>

ATTACHMENT A

Page 4 of 8

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
EPSDT Services	Provided to all children and young adults up to age 21, (described in greater detail in Section 2.06.02.02) Includes tracking, follow-up and outreach to children for initial visits, preventive visits, and follow-up visits. Includes interperiodic screens as medically indicated. Includes multi-disciplinary evaluation and treatment for children with significant developmental disabilities or developmental delays	Yes, for all EPSDT services except those described in Attachment 2.B

ATTACHMENT A

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Home Health Services	Covered if ordered by a Health Plan physician. Includes private duty nursing and homemaking/personal care services when medically necessary. Personal care/homemaking services include such tasks as assisting the client with personal hygiene, dressing, feeding, transfer, ambulatory needs, and household tasks incidental to the client's health needs. These homemaking tasks might include making the client's bed, cleaning the client's living areas such as bedroom and bathroom, and doing the client's laundry and shopping. These services may be provided for Rlte Care members and his/her children if the member is unable, because of illness or disability, to provide caretaking functions for herself/himself and her/his child(ren). Does not include respite care, relief care, or day care.	Yes
School-Based Clinic Services	Covered as medically necessary at four designated sites	Yes

ATTACHMENT A

Page 6 of 8

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Emergency Room Services and Emergency Transportation Services	Covered, for emergency services (Section 2.09.03), or when authorized by a Health Plan Provider, or in order to assess whether a condition warrants treatment as an emergency service	Yes
Nursing Facility Care	Covered when ordered by a Health Plan physician	Yes, subject to stop-loss provisions in Section 1.30
*Services of Other Practitioners	Covered if referred by a Health Plan physician	Yes
Podiatry Services	Covered as ordered by Health Plan physician	Yes
Optometry Services	For adults 21 and older, benefit is limited to examinations that include refractions and provision of eyeglasses if needed once every two years, and other medically necessary treatment visits for illness or injury to the eye. For children under 21, covered as medically necessary with no other limits	Yes

*Practitioners certified and licensed by the State of Rhode Island including nurse practitioners, physician assistants, social workers, licensed dietitians, psychologists, and licensed nurse midwives.

ATTACHMENT A

Page 7 of 8

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Hospice Services	Up to 210 days lifetime maximum as ordered by a Health Plan physician. Services limited to those covered by Medicare	Yes
Durable Medical Equipment	Covered as ordered by a Health Plan physician. Includes surgical appliances, prosthetic devices, orthotic devices, and medical supplies. Includes hearing aids and molded shoes	Yes
Early Intervention	Covered as included within the IFSP as described in Section 2.07.04.01, subject to stop-loss limitations in Section 1.30	Yes, up to the first \$3000 for speech, language, hearing, physical, and occupational therapies
Nutrition Services	Covered as delivered by a licensed dietitian for certain medical conditions as defined in Attachment E and as referred by a Health Plan physician	Yes
Group Education/Programs	Including childbirth education classes, parenting classes, and smoking cessation programs and services	Yes

ATTACHMENT A

Page 8 of 8

SERVICE	SCOPE OF BENEFIT (ANNUAL)	PLAN CAPITATED FOR BENEFIT
Transportation Services (Non-Emergency)	Covered non-emergency transportation services include bus passes, and also includes para-transit services, when authorized/arranged by the Health Plan through RIPTA Coordinator	Yes
Interpreter Services	Covered if a Health Plan has more than 100 members or 10 percent of its Rite Care membership, whichever is less, who speak a single language other than English as a primary language	Yes
Transplant Services	Covered when ordered by a Health Plan physician	Yes, subject to stop-loss limitations in Section 1.30

ATTACHMENT B

SCHEDULE OF OUT-OF-PLAN BENEFITS

Page 1 of 4

These benefits are not included in the capitated benefit and are not the responsibility of the Health Plan to provide or arrange. The Health Plan is expected to refer to and coordinate with these services as appropriate. These services will be provided by existing Medicaid-approved providers who will be reimbursed directly by the State on a fee-for-service or contractual basis

ELIGIBLE GROUP	<i>BENEFIT(S) PROVIDED OUT-OF-PLAN</i>
All Rlte Care Enrollees	<p>Dental services</p> <p>Court ordered mental health and substance abuse services in which the court order specifies a non-network provider</p> <p>AIDS non-medical case management</p>
Children	<p>All out-of-plan benefits listed above in "All Rlte Care Enrollees"</p> <p>Early intervention in natural settings or center-based health and education programs for children at risk for being developmentally delayed, in excess of plan limits</p> <p>Special Education services as defined in the child's Individual Education Plan (IEP) for children with special health needs or developmental delays</p> <p>Lead Program home assessment and non-medical case management provided by Department of Health or Lead Centers for lead poisoned children</p> <p>Non-medical case management for Head Start children</p>

ELIGIBLE GROUP	<i>BENEFIT(S) PROVIDED OUT-OF-PLAN</i>
<p>Children (Continued)</p>	<p>Residential substance abuse treatment services for adolescents aged 13 to 17</p> <p>Residential Treatment for children ordered by DCYF; covered benefits exclude room and board except in a JCAHO-accredited facility</p> <p>Children's Intensive Services (administered by DCYF)</p> <p>Comprehensive Emergency Services (administered by DCYF)</p> <p>Child sexual abuse evaluations, parent/child evaluations, and DCYF-ordered emergency room evaluations prior-approved by the State, (medically necessary follow up therapy is an in-plan benefit)</p> <p>DCYF ordered administratively necessary inpatient days prior-approved by the State</p> <p>Intensive community-based treatment prior approved by the State (administered by DCYF)</p> <p>Early Start Programs (administered by DCYF)</p> <p>The following services are not covered by the Rhode Island State Medicaid Plan, but are Medicaid covered services as defined by the Social Security act. They are covered if medically necessary for Rlte Care eligible children under age 21, subject to prior approval from the State and will be paid on a fee-for-service basis, and include:</p> <ul style="list-style-type: none"> • Chiropractic services

ELIGIBLE GROUP	<i>BENEFIT (S) PROVIDED OUT-OF-PLAN</i>
Women	<p>All out-of-plan benefits listed above in “All Rlte Care Enrollees”</p> <p>Adolescent Self-Sufficiency Collaborative</p>
Seriously and Persistently Mentally Ill (SPMI) Adults and Seriously Emotionally Disturbed (SED) Children	<p>In accordance with Sections 2.07.03.01 and 2.07.03.02, at such time that SPMI and SED individuals are identified , these individuals will have all out-of-plan benefits listed above in “All Rlte Care Enrollees” and, in addition will receive the following mental health services out-of-plan:</p> <ul style="list-style-type: none"> • Individual, group, and family therapy • Acute psychiatric inpatient hospitalization • Emergency room visits for psychiatric emergencies • Day treatment • Inpatient psychiatric facility services for individuals under age 21 or 22 if confined beyond 21st birthday • Community psychiatric supportive treatment

ATTACHMENT B

Page 4 of 4

ELIGIBLE GROUP	<i>BENEFIT (S) PROVIDED OUT-OF-PLAN</i>
Seriously and Persistently Mentally Ill (SPMI) Adults and Seriously Emotionally Disturbed (SED) Children (Continued)	<ul style="list-style-type: none"> • Multi-disciplinary psychiatric treatment planning • Mobile treatment team • Crisis intervention <p>Seriously Emotionally Disturbed Children, in addition to receiving all above mental health benefits out-of-plan, will also receive all benefits listed in “Children” above</p>
Postpartum Women Enrolled in Extended Family Planning Only	No out-of-plan benefits for this group
Pregnant Women Who Do Not Meet Current Medical Assistance Citizenship or Residency Requirements, or Who Are Greater than 250 Percent of the FPL	No out-of-plan benefits for this group