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Nevada Title XXI State Plan

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

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

State/Territory: Nevada

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

Richard Whitley, MS
Director, Department of Health and Human Services

Date

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

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

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

Name: ~~Marta Jensen~~ Suzanne Bierman

Position/Title: Administrator, Division of Health Care Financing & Policy DHCFP

Name: ~~Shannon Sprout~~ Cody Phinney

Position/Title: Deputy Administrator, DHCFP

Name: ~~Ellen Creelius~~ Budd Milazzo

Position/Title: Administrative Services Officer IV, DHCFP

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Original Plan

Effective Date: July 1, 2011

Implementation Date: September 1, 2011

SPA #18-008 Purpose of SPA: To align the CHIP SPA with the Mental Health Parity Addiction and Equity Act.

Proposed effective date: October 2, 2017

Proposed implementation date: October 2, 2017

- 1.4- TC** **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The Department of Health and Human Services (DHHS), Tribes, Indian Health Service, Tribal and Urban Indian Organizations (I/T/U) residing within of the State of Nevada created a Tribal Consultation Process. The Tribal Consultation Process was signed and became effective March 2010. Below is a summary of the process for the Tribal Consultation Process:

Purpose – The purpose of the agreement is to establish an open and meaningful consultation process between the Nevada DHHS and the Indian Tribes in the State of Nevada to facilitate better communication and collaboration between the entities.

Agreement – The guiding principle of the agreement is to ensure that open and meaningful communication occurs in a timely manner for consultation between the parties regarding high-level policy changes that significantly impact Indian Tribes in the State of Nevada. Policy changes that significantly impact Indian Tribes refer to actions that have substantial Tribal implications with direct effects on one or more Indian Tribes, on relationship between the State of Nevada and Indian Tribes or on the distribution of roles on and responsibilities between the State of Nevada and Indian Tribes.

A copy of the tribe-state consultation process can be requested from the Division of Health Care Financing and Policy (DHCFP).

In addition to the tribe-state consultation process set forth between DHHS, Tribes, and I/T/Us;

The DHCFP will consult with all federally recognized Tribes and I/T/Us within the State of Nevada on all Medicaid state plan amendments, waiver requests, waiver renewals, demonstration project proposals and/or on all matters that relate to Medicaid and CHIP programs.

- a. The notification will describe the purpose of the state plan amendment, waiver request, waiver renewal, demonstration project proposal and/or on matter relating to Medicaid and CHIP programs and will include the anticipated impact on Tribal members, Tribes and/or I/T/Us. The description of the impact will not be Tribal member, Tribe and/or I/T/U specific if the impact is similar on all Tribal members, Tribes and/or I/T/Us.
- b. The notification will also describe a method for Tribes and/or I/T/Us to provide official written comments and questions within a time-frame that allows adequate time for State analysis, consideration of any issues that are raised and the time for discussion between the State and entities responding to the notification.
- c. Tribes and I/T/Us will be provided a reasonable amount of time to respond to the notification. Whereof, 30 days is considered reasonable.
- d. In all cases where Tribes and/or I/T/Us request in-person consultation meetings, the DHCFP will make these meetings available.
- e. The tribe-state consultation process allows for an expedited process for notification of policy changes due to budget cuts prior to changes being implemented. The Centers for Medicare and Medicaid Services (CMS) requires Medicaid state plan amendments, waiver requests and waiver renewals, which fall within this category to have a notification process prior to these documents being submitted to CMS.

Due to this, the State is instituting an expedited process which allows for notification to the tribes of at least one-week notice prior to the changes being implemented as agreed upon in the tribe-state consultation process or two weeks prior to the submission of the state plan amendments, waiver requests and/or waiver renewals, whichever date precedes.

Tribal notification for SPA 18-008 was distributed on March 28, 2018.

**Section 2. General Background and Description of State Approach to Child Health Coverage
(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))**

Uninsured Children

Based on the State Demographer's 2002 population estimates, the DHCFP has estimated that there are 69,000 children in Nevada who are uninsured living in families with incomes under 200% of federal poverty level. Of these, as many as 50% may be eligible for Medicaid. These numbers are based on limited and sometimes seemingly contradictory data.

For example, the U.S. Census Bureau estimates that for 1996, there were 45,000 uninsured children under 200% of federal poverty level in Nevada, but also estimated that there were 77,000 uninsured at all income levels. This would mean that less than 60% of all uninsured would be under 200% of federal poverty level. The national average is 73%. Only five other states (Alaska, Massachusetts, Vermont, Hawaii, and New Jersey) are under 60%, all of whom have significantly higher Medicaid eligibility levels than Nevada, resulting in a greater level of coverage for low-income children.

With regard to demographic data, the best information comes from a survey of the uninsured in Nevada completed in June 2000, and updated as of January 2003, by the Great Basin Primary Care Association and the State Demographer's 2002 population estimates. The following chart reports on these findings as follows:

Number of Uninsured Children in Nevada by Region

Age in Years	Washoe County	Clark County	Rural Counties	Totals
Less than 6	6,209	30,493	3,534	40,236
6 to 18	11,363	51,644	9,015	72,022
TOTAL	17,572	82,137	12,549	112,258

Estimates of Nevada Populations

According to the current Nevada State Demographer's data, Nevada's total population is 2,210,650. Nevada's children age 0-19 comprise the following races by age and sex:

Age in Years	White	Black	American Indian	Asian	Hispanic	Total
<5	103,601	11,157	1,594	9,563	33,471	159,386
5 to 19	298,148	32,108	4,587	27,521	96,325	458,689
Total	401,749	43,265	6,181	37,084	129,796	618,075

Language spoken at home by Nevadans

According to the 2000 Census Supplementary Survey Summary Tables, Nevada's language spoken at home is as follows:

Nevadans Age >5 years

78% Speak English at home
5% No English at home (see breakdown at right)
17% Don't speak English well

No English at home

81% Speak Spanish at home
19% Speak language other than English or Spanish

Public Health Insurance Coverage

Medicaid is Nevada's major public health insurance program. In 1967, Nevada implemented the Medicaid program for the Aid to Families with Dependent Children (AFDC) now Temporary Assistance for Needy Families (TANF), Child Welfare, Aged, Blind, and Disabled populations, and in 1985 implemented the Child Health Assurance Program (CHAP) for pregnant women and later for pregnant women with children. Nevada is at the federal minimums for eligibility, 133% of the federal poverty level (FPL) for children up to age six and 100% of FPL for children six and older born on or after October 1, 1983. Currently, TANF and CHAP Medicaid eligible children residing in Clark County are enrolled in mandatory managed care, with the exception of disabled children and those children who reside more than 25 miles from a primary care physician (PCP) and participating hospital, pursuant to NAC 695C.160.

Nevada Check Up

Nevada Check Up provides access to affordable health insurance to children in working, low-income families. The program features simplified mail-in eligibility applications and low premiums while providing a comprehensive health benefits package.

Differences between Nevada Check Up and Nevada Medicaid – There are areas where Medicaid policy and Nevada Check Up policy differ. They are:

- 1) Residential Treatment Centers (RTC) – In Nevada Check Up, it remains the HMO's responsibility to provide reimbursement for all medical care (physician, optometry, laboratory, dental and x-ray services, etc.) for participants who are receiving services in an RTC. The RTC bed day rate is covered by FFS.

In Medicaid, those who are admitted to an RTC are disenrolled from the HMO and receive all Medicaid-covered services as FFS recipients.

- 2) Severely Emotionally Disturbed (SED)/Seriously Mentally Ill (SMI) – In Nevada Check Up, this group must receive evaluation and medically appropriate services through a FFS provider if the family resides in a FFS area. In mandatory HMO geographic areas, SED determinations don't permit disenrollment from the HMO, so the HMOs will provide appropriate services. In Medicaid, once a diagnosis of SED or SMI is confirmed through evaluation, a recipient may elect to disenroll from the HMO and the HMO must notify the DHCFP of such election.

- 3) Newborns – In Nevada Check Up, if a family is expecting a child, whether the adult female in the home or one of the enrolled children, Nevada Check Up must be notified within 14 days of the birth, the newborn, if eligible, will be added to the family as of its date of birth. If the notification criterion is not met, the child, if eligible, will be added the next administrative month following notification. A newborn cannot be enrolled before a family’s start date. A newborn will begin services at the same time as the other children in the family. One exception for the Checkup program is if the mother has *other* coverage for the newborn, and she has other children enrolled in Nevada Check Up, the newborn will be enrolled in Nevada Check Up as of the first day of the next administrative month following date of birth.

In Medicaid, all children born to Medicaid-enrolled mothers are enrolled as of their date of birth.

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

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

Nevada currently has several initiatives to enroll children in Medicaid and Nevada Check Up. These include outreach and referral services to the Women, Infant, and Children (WIC) centers, Federally Qualified Health Centers (FQHCs), Nevada Early Intervention Programs, Family Resource Centers (FRCs), Family to Family program, Tribal Administrators, Tribal Clinics and Indian Health Services (IHS), Resources for the Early Advancement of Child Health (REACH) Program, Connecting Kids to Health Coverage, Nevada 211 and Nevada Health Link-Silver State Health Insurance Exchange. In addition, out stationed eligibility workers are in certain public hospitals and federally qualified health centers in order to provide these outreach and referral services. The descriptions of these programs are as follows:

1. The Medicaid program is administered by the Division of Health Care Financing and Policy and provides health coverage to low-income and disabled Nevada children. Nevada takes the following steps to enroll children in Medicaid:
 - a. Nevada State Welfare District Offices located throughout the state determine a person’s eligibility for TANF, CHAP, and Medicaid. If applicants appear to be Nevada Check Up eligible, rather than Medicaid, they are appropriately referred.

Out stationed sites (FQHCs, county hospitals, and local county health departments) help people apply for Medicaid or Nevada Check Up and send their applications and eligibility determination to the local Nevada State Welfare District Office.

Local public health agencies identify low income, uninsured children through referrals from a variety of sources including: WIC, child health and immunization clinics, community health and social services agencies, and schools.

2. Women, Infants and Children (WIC) provides nutritious food to supplement the regular diet of pregnant women, infants, and children under age five who meet state income standards. Women and children under five years old qualify if the combined family income is at or below 185% of the federal poverty level. WIC staff encourages pregnant women and parents in this program to apply for Medicaid or Nevada Check Up, depending on their income level.
3. Federally Qualified Health Centers offer health care to low-income people. Nevada has 13 federally qualified community health centers. The centers provide primary care services including care for acute and chronic illness, injuries, emergency care, diagnostic services and prescriptions.

Community health centers take the following steps to enroll children in Medicaid or Nevada Check Up:

1. Provide a financial screen for each new patient or family
2. Provide information on and explanation of the program(s) for which family members may be eligible.
3. Assist with completing applications and collecting required documentation.
4. Forward applications to the determining agency and communicate with family about eligibility status.

If a patient/family is not eligible for any program, the community health center will provide the health care services and will use its sliding fee scale according to family size and income to determine the fee.

4. Nevada Early Intervention Programs
The Nevada Early Intervention Programs provide direct services to low-income children ages 0-3 under the Maternal and Child Health Block Grant (Title V). Services include well child clinic services, including developmental and physical assessments and immunizations. Children who appear to qualify for Medicaid or Nevada Check Up are encouraged to apply.
5. Family Resource Centers
A total of 26 Family Resource Centers (FRCs) have been established in high risk neighborhoods throughout Nevada, and an additional two are scheduled to open in the next year. The FRCs are community-based centers run by not-for-profit organizations with state grants and private contributions. Their aim is to provide information about available social services including Medicaid and Nevada Check Up, and how to access

those services. Sites also provide some services (e.g. child care) based on the needs of the community. Nevada Check Up staff have participated with Family Resource Centers in the coordination of health fairs.

6. Family to Family Program

The Family to Family program is an initiative aimed at informing new mothers of the services that are available to them and how to access such services. A total of two centers have been established throughout the state. These centers are community based and operate as public/private partnerships. New mothers are able to receive a home visit, get questions answered about parenting issues and services available to aid them in raising their children, including health insurance through Medicaid and Nevada Check Up.

7. Tribal Administrators, Tribal Clinics, and Indian Health Services (IHS)

Nevada Check Up staff attends and participates in meetings of the Native American Advisory Council, as mandated by Nevada law, in order to share information and receive advice as to the needs of the Native American tribes in Nevada. Application training and program updates are also provided by program staff.

8. The DHCFP is proposing the use of Health Services Initiative (HSI) funding to integrate the Resources for the Early Advancement of Child Health (REACH) program into after school programs serving the highest risk schools in Nevada that will be prioritized by the mandated environmental scan. The implementation of these innovative changes supports Nevada children in achieving a physical and emotionally safe environment by incorporating the REACH pilot project within the targeted schools. This approach will also allow the program to be scaled up or down based on available funding and the individualized school's needs. The individualized school needs will be identified per data tracking by utilizing the newly implemented statewide longitudinal data system to track outcomes and compare cohorts within the same school as well as compare to schools across the state.

The HSI public health approach allows the services to be provided to all children in a targeted area regardless of payer source. The DHCFP will work with current after-school program(s) to determine capacity for providing the services within their current structure or coordinate with community providers who have the capacity to create a collaboration to provide these services. The DHCFP will be working to identify these groups to determine the best model for payment of these programs based on the community infrastructure and capacity.

The HSI option allows the state to take a population health approach to behavioral health and early intervention for children. HSI also provides the flexibility to pilot the rising-risk concept across children ages 10 through 18 with the goal of being able to demonstrate the effectiveness of early intervention through the use of performance measures. The scope of services will target early intervention and preventive services and mental health resources to prevent the onset of a future behavioral health diagnosis. The DHCFP provides assurance that the HSI program will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

9. Connecting Kids to Health Coverage

The Connecting Kids to Coverage will identify children who are eligible for Medicaid and the Children's Health Insurance Program (CHIP) and support targeted strategies needed to enroll eligible children who do not have health coverage, including application assistance and outreach.

10. Nevada 2-1-1

Nevada 2-1-1, a program of the Financial Guidance Center, is committed to helping Nevada citizens connect with the services they need, whether by phone or internet. The goal is to present accurate, well-organized and easy-to-find information for the state and local health and human services program.

11. Nevada Health Link- Silver State Health Insurance Exchange

The state utilized Navigator Organizations, Certified Enrollment Assistant and is based on their attendance of community events, community involvement, and health care provider engagement eligibility screening.

2.2.2 The steps this 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.

Other than the referrals received from Family Resource Centers, there are no public/private partnerships in Nevada offering health insurance to low-income children.

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)) (42 CFR 457.80(c))

This issue is addressed in the above Section 2.2.

Section 3. Methods of Delivery and Utilization Controls

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

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

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

3.1.1 Choice of Delivery System

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

- No, the State does not use a managed care delivery system for any CHIP populations.
- Yes, the State uses a managed care delivery system for all CHIP populations.
- Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State’s managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2. **Chip eligible members that reside in urban Washoe or Clark counties are mandatorily enrolled into one of three contracted MCOs, and a dental PAHP.**

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care

services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

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

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

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

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

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

- No
 Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others. **Dental services are carved out of the MCO contracts and are provided under a contract PAHP vendor. Transportation (NET), school-based child health services, intermediate care facility for individuals with intellectual disabilities, targeted case management, skilled nursing facility benefits after 45 days, swing bed stays in an acute hospital over 45 days, hospice and orthodontic services are carved**

out of managed care and the State elects to provide these services to enrollees through fee-for-service.

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

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

- Managed care organization (MCO) (42 CFR 457.10)
 - Capitation payment risk adjusted per member per month capitation payment.
Describe population served: Nevada Check Up/CHIP members residing in urban Washoe and Clark counties.

- 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 risk adjusted per member per month capitation payment.
 - Other (please explain)
Describe population served:

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

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

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

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

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

3.1.3 Nonemergency Medical Transportation PAHPs

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

- The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):
- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
 - The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
 - The provision against provider discrimination in 42 CFR 457.1208.

- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

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

3.3 Rate Development Standards and Medical Loss Ratio

- 3.3.1 The State assures that its payment rates are:

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

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

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

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

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

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

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

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

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

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

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

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

3.4 Enrollment

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

3.4.1 Enrollment Process

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

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

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

- Yes
 No

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

- The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))
- The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably and does not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

- 3.4.2.1 The State assures that the State will notify enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2))
- 3.4.2.2 The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))
- 3.4.2.3 If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)
- 3.4.2.4 **MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.**
- The State assures that contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b))

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

3.4.2.5 Enrollee Requests for Disenrollment.

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

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

Yes

No

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

The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))

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

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

- During the 90 days following the date of the beneficiary's initial

enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;

- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

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

3.5 Information Requirements for Enrollees and Potential Enrollees

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

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

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

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

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

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

- The format is readily accessible;

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

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

- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP or PCCM entity service area;
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
- Requiring each MCO, PIHP, PAHP and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP and PCCM entity to notify its enrollees:
 - That oral interpretation is available for any language and written translation is available in prevalent languages;
 - That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
 - How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

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

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process

for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;

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

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

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

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

3.5.10 The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within

a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
 - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
 - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
 - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
 - What constitutes an emergency medical condition and emergency services;
 - The fact that prior authorization is not required for emergency services; and
 - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
 - The right to file grievances and appeals;
 - The requirements and timeframes for filing a grievance or appeal;
 - The availability of assistance in the filing process; and
 - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information

in alternative formats or languages;

- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

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

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

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

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

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

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

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

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

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

3.5.17 The State assures that MCOs, PIHP, 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 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 contact 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 sub contractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:

- The MCO, PIHP or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP or PAHP determine that the subcontractor has not performed satisfactorily;
- All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable sub regulatory guidance and contract provisions; and
- The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4

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

3.7.5

The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of

services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))

3.7.6 The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals and 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 proceed to the State review;
- Independent of both the State and MCO, PIHP, or PAHP;
- Offered without any cost to the enrollee; and
- Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))

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

3.9.7 The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP or

PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))

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

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

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

- The adverse benefit determination.
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
- The procedures for exercising the rights specified above under this assurance.
- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))

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

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

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

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

- ☒☐ Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:
 - An appeal of a denial that is based on lack of medical necessity.
 - A grievance regarding denial of expedited resolution of an appeal.
 - A grievance or appeal that involves clinical issues.
- ☒ All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- ☒☐ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
- ☒☐ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
- ☒☐ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))
- 3.9.14** ☒☐ The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))
- 3.9.15** ☒☐ The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 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 proceed to the State review;
- The review is independent of both the State and MCO, PIHP or PAHP; and
- The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))

3.9.24

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

3.9.25

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

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
- The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

3.9.26

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

3.9.27

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

3.10

Program Integrity

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

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

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

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

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

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

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

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

3.10.9 The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any

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

3.10.10 The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))

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

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

Encounter data in the form and manner described in 42 CFR 438.818.

Data on the basis of which the State determines the compliance of the MCO, PIHP or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.

Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.

Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.

Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities and subcontractors as governed by 42 CFR 438.230.

The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13 The State assures that:

It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM

entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))

It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and

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

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

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

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

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

3.11 Sanctions

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

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

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

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

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

- Yes
- No

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

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

3.12 Quality Measurement and Improvement; External Quality Review

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

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

3.12.1 Quality Strategy

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

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

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

- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a “significant change” for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

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

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

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

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

3.12.1.6 The State assures that it will submit to CMS:

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

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

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

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

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

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

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

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

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

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

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

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

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

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

3.12.2.2- Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

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

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

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

1) Measure and report to the State on its performance using the standard measures required by the State;

2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or

3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

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

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

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

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

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

3.12.4 Quality Rating

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

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

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

3.12.5 Quality Review

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

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

3.12.5.1 External Quality Review Organization

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

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

3.12.5.2 External Quality Review-Related Activities

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

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

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

3.12.5.2.3 The State assures that if the State elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will ensure that all information from a Medicare or private accreditation review for an

MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42 CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

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

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

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and

- A review, conducted within the previous 3-year period, to determine the PCCM entity’s compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

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

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

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

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

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

3.12.5.3.4 The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on

access and quality of care. The report includes at least the following items:

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

- An assessment of the degree to which each MCO, PIHP, PAHP or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

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

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

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

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

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

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

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

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

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

4.1.0 **Citizenship:** In accordance with Section 211 and Section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Nevada adopted policy adding a new eligibility requirement that children applying for Nevada Check Up who declare to be a United States citizen meet citizenship verification requirements. Nevada has implemented the SSA data file match process afforded under CHIPRA to comply with this requirement. In compliance with Section 211, NCU does not submit deemed newborns to SSA for citizenship verification. For children whose citizenship cannot be successfully verified by the Social Security Administration, Nevada provides applicants a reasonable opportunity period to provide satisfactory documentation of citizenship.

4.1.1 **Geographic area served by the Plan:** The plan is available statewide, in all 17 Nevada counties.

4.1.2 **Age:** The plan is available to children 0 through 18 years of age.

4.1.3 **Income:** Eligible children are from families whose gross annual incomes are at or below 200% of the federal poverty level. Income for the purposes of this plan means gross income before deduction of income taxes, employees’ social security taxes, non-health care insurance premiums, bonds, etc. Income includes the:

1. Monetary compensation for services, including wages, salary, tips, commissions or fees;
2. Net income from farm employment;
3. Social Security;
4. Dividends or interest on savings bonds, income from estates or trusts, net rental income, or income from any other source;
5. Government civilian employee or military retirement or pensions or veterans’ payments;
6. Private pensions or annuities;
7. Alimony or child support payments;
8. Regular contributions from persons not living in the household;
9. Other cash income. Other cash income includes, but is not limited to, cash amounts received or withdrawn from any source, including savings, investments, trust accounts and other resources that are readily available to the family; and
10. Unemployment Insurance Benefits.

- 4.1.4. **Resources (including any standards relating to spend downs and disposition of resources):** The Title XXI program has no resource requirements.
- 4.1.5 **Residency:** Nevada residency is required. In order to be considered for enrollment in Nevada Check Up, a child must be a citizen of the United States or be an alien who has legal immigration status. Nevada assures that the term qualified alien is, as defined by Public Law 104-193 as amended, a person who has been in the United States in a qualified alien status for at least five years, or meet the criteria defined by Section 214 of CHIPRA, certain non-citizen children are not subject to the five-year bar set forth in section 403 of Public Law 104-193. Such a child is eligible for the State Children’s Health Insurance Program (CHIP).
- 4.1.6. **Disability Status (so long as any standard relating to disability status does not restrict eligibility):** No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child will be referred to Medicaid and not enrolled in Nevada Check Up.
- 4.1.7 **Access to or coverage under other health coverage:** Questions about access to health care coverage, both public and private, are included on the application form. Monthly Third Party Liability cross matches are conducted for verification of health insurance coverage. A child will be found ineligible for the following reasons:
- 1) He/she has creditable health insurance;
 - 2) He/she has had coverage under an employer plan prior to the date of application. These include insurance coverage that was terminated due to the following reasons:
 - a. Loss of employment other than voluntary termination;
 - b. Death of the parent who was responsible for insurance coverage;
 - c. Change to new employment that does not provide an option for dependent coverage;
 - d. Change of address that results in no employer-sponsored coverage;
 - e. Discontinuation of health benefits to all employees of the applicant’s employer;
 - f. Expiration of coverage periods established by the Consolidated Omnibus Reconciliation Act of 1985 (COBRA);
 - g. Self-employment;
 - h. Termination of health benefits due to a long-term disability;
 - i. Termination of dependent coverage due to an extreme economic hardship on the part of either the employee or the employer.
 - j. Extreme financial hardship related to the cost of premiums, deductible payments, and/or co-payments.

- 4.1.8. **Duration of eligibility:** Once a child has been determined eligible and enrolled, he or she is eligible for up to 12 months of continuous coverage until the annual eligibility redetermination date, no later than one year from the most recent date of enrollment. The child may become ineligible when one or more of the following conditions apply:
- 1) The child moves out of state;
 - 2) The child becomes enrolled in Medicaid;
 - 3) The child obtains other creditable health insurance;
 - 4) The child turns 19 years old;
 - 5) The child is incarcerated in a penal institution;
 - 6) The child becomes deceased;
 - 7) The child gets married or is ordered a Decree of Emancipation;
 - 8) It has been determined that the child does not meet citizenship requirements and/or the parent/guardian has not provided satisfactory documentation establishing citizenship;
 - 9) The parent/guardian fails to pay quarterly premiums. Please refer to Section 8.7 for a description of consequences for failure to pay premiums timely;
 - 10) The child is a patient (ward of the state) in an institution for mental diseases at the time of initial enrollment or redetermination;
 - 11) During the course of a case review or audit process, it is determined the family provided erroneous information to the state or errors were made in the original determination or redetermination process, resulting in an incorrect eligibility determination;
 - 12) Nevada Check Up (NCU) is requested by the parent/guardian to voluntarily terminate the case;
 - 13) NCU loses contact with the household (is unable to contact the household by mail or phone).

Written notice will be provided to families when the quarterly premium is thirty days past due; Thirty additional days will be allowed to receive payment. Consequently, a 60-day grace period is allowed prior to disenrollment for failure to pay the quarterly premium.

Children can remain in the program annually, if they continue to meet the eligibility criteria.

- 4.1.9 Other standards: Social Security numbers are required for children being enrolled in the Nevada Check Up program, except for newborns. Social Security Numbers for newborns will be required on the child's first birthday.

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)) (42 CFR 457.320(b))

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

- 4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 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)) (42 CFR 457.350)**

Eligibility is determined through the completion of an application form which includes the following information:

- 1) Name, date of birth, resident address, gender, Social Security Number, citizenship status, age, ethnicity (optional) and relationship to applicant of all children in the household who are seeking enrollment;
- 2) Name of person(s) responsible for health care costs of a child;
- 3) All sources of income as defined in 4.1.3 from all persons residing in the household and contributing to or benefiting from the support of the household;
- 4) All adults residing in the household;
- 5) Insurance status, including whether a child is currently or has been insured within the last six months; and
- 6) If determined eligible: children declared to be citizens will be enrolled.

In addition, the applicant/participant must provide proof of income for each household member. Proof of income may include but is not limited to copies of two current pay stubs from each job dated within 90 days prior to the eligibility determination. For newly hired employees, a signed statement from their employer may be accepted. If self-employed, the applicant may be required to submit a copy of the most recently filed federal/state income tax return.

NCU may accept a client statement of income to determine eligibility for newborns.

Nevada Check Up (NCU) may require additional documentation to determine projected gross annual income from self-employment (including but not limited to bank statements and information about household expenses).

The applications are processed and those individuals found eligible are enrolled. If the family is found to have a prior unpaid premium balance, an approval letter is sent requesting the past due balance be paid, at which time the child will be enrolled. For those individuals found eligible without past due balances, an enrollment letter is sent along with an invoice for the first premium (which may be an amount sufficient to cover one, two or three months, depending on the date enrollment begins). Program enrollment begins on the first day of the next administrative month.

The enrollment letter includes the following information:

- Household Nevada Check Up ID number;
- Names of eligible children and their ID numbers;
- Name of health plan (Managed Care Organization (MCO) or Fee for Service (FFS));
- Effective month of enrollment; and

- The current amount due and the quarterly premium amount.

Native Americans who are members of federally recognized Tribes and Alaska Natives are exempt from premium payment.

For subsequent eligibility determinations, all children enrolled in the program will stay in the program as long as the family income is below the program maximum and they meet all eligibility requirements. If necessary, the applicant is sent a letter requesting additional or missing information.

Enrollees are required to notify Nevada Check Up immediately with any changes to their address and/or telephone number. Any mail returned indicating the family is no longer at the address may cause disenrollment due to “Loss of Contact”.

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

- Check here if this section does not apply to your state.**

Nevada Check Up will monitor the status of available State and Federal SCHIP funds. An enrollment cap will be placed on the number of new enrollees if it is necessary for the program to stay within available funds. Prior to implementation of an enrollment cap and waiting list, pursuant to NRS 422.2368, the State will provide 30 days of public notice and will conduct a public hearing. The State also will provide notification to CMS.

The enrollment cap may be set above or below current enrollment. If the cap is set below current enrollment levels, enrollment will be closed until the level of the cap is reached. If the cap is set above current enrollment levels, enrollment may continue until the cap is reached, and then enrollment will be closed. Once enrollment is closed, new applications will continue to be accepted through the normal process. NCU eligibility would be run on all applications. The applications of individuals that appear to be eligible for Medicaid would be forwarded to Medicaid for eligibility determination. Those applicants not eligible for Nevada Check Up will be denied with the appropriate reason. The applicants that are eligible for Nevada Check Up but are not able to be enrolled due to the enrollment cap will be denied utilizing the standard program denial process. Their denial reason will be, “denied enrollment due to enrollment cap.” These applicants will be notified of the waitlist process. They will also be notified that their child/ren may be eligible for Medicaid if their circumstances change while they are on the waitlist. They will be put on the wait list with a waitlist date equal to the date when Nevada Check Up received the completed application.

On a monthly basis, Nevada Check Up will make an assessment of the number of enrollees against the appropriated funds for the program. As additional funds become available (either through attrition of enrollees or more funding is identified) a determination will be made as to the number of new enrollees that can be accommodated with the identified funds. The applicants on the wait list will be

notified of the availability of coverage. Notification will go out first to those applicants with the earliest wait list date; thus a first come, first served process. To update eligibility, if the update is within the 12 month continuous coverage period, applicants would need to attest that there have not been any changes to their family circumstances (e.g. number in household, income, insurance status, and the like). If changes have occurred, the new information would be added into the Nevada Check Up database and eligibility redetermined. Enrollees determined eligible prior to any enrollment cap will not be impacted by this particular change so long as they continue to pay premiums timely and comply with any requests for information, including income, household, citizenship and identity verification. Enrollees who are disenrolled from the program for failure to timely pay premiums or for failure to timely complete their redetermination process or provide requested information will be precluded from reenrollment during any cap period and will be added to the wait list. These members will receive notice by direct mail informing them of their review rights as required by governing regulations.

4.4. Describe the procedures which assure:

4.4.1. The state explains the procedures used to ensure that children who have other creditable coverage or children who have access to coverage under a State health plan due to a parent's employment with a public agency do not receive coverage under SCHIP.

Nevada Check Up uses screening procedures at intake, annual eligibility determinations, and reevaluations that target 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). Children who are found eligible may receive health benefits under Nevada Check Up. (Section 2102)(b)(3)(A)) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42 CFR 457.350(a)(1)) 457.80(c)(3))

The application contains a screening question asking if the child has had other health care insurance or Medicaid coverage. If the child had past health care coverage, follow up questions are asked as to when and why the coverage ended.

In order to be enrolled in Nevada Check Up, children must have been without creditable insurance for at least six months prior to the date of application. This should provide a disincentive to families to drop current coverage. The exceptions to the six-month waiting period are for children losing Medicaid and for families who lose insurance due to circumstances beyond their control. In those cases, Nevada Check Up coverage would not be a substitution for coverage under group health plans and the six-month "waiting period" does not apply.

In order to ensure that those eligible for coverage under a State health plan are not enrolled in Nevada Check Up, completed applications and income documentation are screened to determine the place and nature of employment. Anyone who is identified as working for an organization listed in the Public Employee Benefit

Program employer list and/or those who provide a State agency pay stub and are eligible for benefits based on employment status, are denied coverage.

Nevada Check Up also provides Third Party Liability cross matches on a monthly basis with any participant who has been identified to have other medical coverage. Those participants appear on a report that identifies the policy holder, the policy carrier, effective dates of coverage and the policy type. This information is used to disenroll the participants who have other medical coverage and are receiving Nevada Check Up benefits.

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)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42 CFR, 457.350(a)(1) and 457.80(c)(3))

In order to assure that Medicaid eligible children are enrolled in Medicaid, Nevada takes the following steps:

- 1) A Medicaid application functions as both an application for Nevada Check Up and for Medicaid eligibility. All initial applications, redeterminations and reevaluations for Nevada Check Up and Medicaid are processed through the use of an electronic screening tool, single point of entry, that determines if a child may be eligible for Nevada Check Up or Medicaid.
- 2) Nevada Check Up enrollees are electronically screened daily to ensure that children are not enrolled in both Nevada Check Up and Medicaid.
- 3) Nevada Check Up also monitors referrals to DWSS to ensure timely Medicaid determinations.

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

A file containing detailed information about children who have been found ineligible for Medicaid is provided electronically to the Nevada Check Up program. This file will provide information on children who appear to meet the eligibility requirements for Nevada Check Up. This information is uploaded electronically into the Nevada Check Up database and these children are enrolled on the first day of the next administrative month following eligibility verification. At the same time the family is notified of eligibility, they are billed for the Nevada Check Up premium, including a date by which premium must be paid.

Children already enrolled in Nevada Check Up who are subsequently **placed in the custody or financial responsibility of an agency which provides child welfare services pursuant to the provisions of NRS 62A.380 or 432.010 to 432.085, inclusive, or Chapter 432B of NRS** are disenrolled and made eligible for Medicaid. Once the child is returned home, the household must notify Nevada Check Up of his/her residency status in order to re-enroll the child.

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)) (42 CFR 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.

Persons covered by insurance providing hospital and medical services are not eligible for benefits under Nevada Check Up. In order to apply for Nevada Check Up, children are required to have been without creditable insurance for at least six months prior to the date of enrollment. (Certain exceptions apply as noted in 4.1.7 and also include those whose only coverage was Medicaid) The Nevada Check Up application form includes a question regarding other insurance coverage within the last six-month period. The State gathers information on a monthly basis on the number of applicants who were denied because they had other insurance coverage in the last six months. This provides a disincentive to families to drop current coverage. Caseworkers review the applicants' pay stubs to determine if dependent premiums are being deducted by the employer.

The DHCFP monitors overall health insurance coverage for children and determines additional steps to be taken if substitution (crowd out) appears to be taking place. When applicants indicate they have had previous coverage within the past six months, there is further screening to determine the circumstances by which that coverage ended. The fiscal agent and the Managed Care Organizations screen claims for other insurance coverage and inform Nevada Check Up if other insurance is found, in which case a disenrollment notice is sent for the next administrative month.

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.

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.

4.4.4.4 If the state provides coverage under a premium assistance program, describe: The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period. The minimum employer contribution. The cost effectiveness determination.

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

Native American and Alaska Native children are provided the same opportunity for enrollment as all other children. These families are exempt from cost sharing.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish: Outreach to families of children likely to be eligible for 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)) (42 CFR 457.90)

Nevada Check Up conducts multi-faceted outreach and referral efforts to inform families of the availability of state sponsored health care coverage for children under both Nevada Check Up and Medicaid. These efforts are supported by the Northern and Southern Covering Kids and Families Coalitions' outreach efforts as well as other community partners.

Nevada has established a toll free telephone number for people who want an application form mailed. The number is also used for providing assistance in completing the application and answering questions about the program.

Assistance in Enrolling Children

The most important "assistance" provided is the use of a simple application form which enables most parents to submit applications without direct help. Community-based organizations are trained to assist families in filling out the application and answer questions applicants may have about the program.

Nevada Check Up also has an internet website which includes applications in English and Spanish for downloading. Families can print this application, complete it and mail to the designated address located on the application along with the necessary additional documents. The website also includes an electronic application which can be completed and submitted electronically as a single point of entry. The family is required to mail the income verification and other required documentation to be matched with the internet application.

Section 6. Coverage Requirements for Children’s Health Insurance

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

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

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

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

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

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

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

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

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

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

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

- The coverage includes benefits for items and services within each of the

categories of basic services described in 42 CFR 457.430:

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

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

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

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

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

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

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

- 6.1.4.** Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

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

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

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

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

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

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

6.1.4.4. Coverage that includes benchmark coverage plus additional coverage. CHIP enrollees receive coverage offered in the benchmark package and have added value benefit services through the HMO and State PEBP.

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

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

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

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

6.1.4.7. Other. (Describe) The state elects to provide a basic set of health care benefits that are focused on primary health care needs and that contain the cost of the benefit package. Specific covered services are described in Section 2 below.

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

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

- 6.2.** The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42 CFR 457.490)
- 6.2.1.** Inpatient services (Section 2110(a)(1))
Inpatient services include all physician, surgical, medical, mental health, substance use disorder and other services delivered during a hospital stay. Inpatient services covered in full.
- 6.2.2.** Outpatient services (Section 2110(a)(2))
Outpatient services include outpatient surgery – covered in full.
- 6.2.3.** Physician services (Section 2110(a)(3))
Physician services include medical office visits with a physician, mid-level practitioner or specialist. Covered in full. Preventive care (well-baby) and immunizations covered in full.
- 6.2.4.** Surgical services (Section 2110(a)(4))
Covered in full. See 6.2.1 for Inpatient Surgical Services and 6.2.2 for Outpatient Surgical Services.
- 6.2.5.** Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
See Section 6.2.2.
- 6.2.6.** Prescription drugs (Section 2110(a)(6))
Covered for inpatient and outpatient prescription drugs with no co-payment.
- 6.2.7.** Over-the-counter medications (Section 2110(a)(7))
Over-the-counter medications are covered when prescribed by an authorized medical provider. The participant may have up to two over-the-counter medications within a therapeutic class before a prior authorization is required.
- 6.2.8.** Laboratory and radiological services (Section 2110(a)(8))
Covered in full for physician-ordered services.
- 6.2.9.** Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
Family planning and prenatal maternity care covered in full.
- 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))
Services covered with continuing stay authorized by Quality Improvement Organization (QIO) like vendor. All covered treatment consistent with Medicaid Services Manual Chapter 400.
- 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))
Mental health professionals are subject to the following utilization criteria: Utilization criteria is based on the Intensity of Needs Determination. A standardized mechanism to determine the intensity of services needed based upon the severity of the recipient's condition. The intensity of needs determination is to be utilized in conjunction with the clinical judgment of the Qualified Mental Health Professional (QMHP) and/or trained Qualified Mental Health Associate (QMHA). This assessment was previously known as a level of

care assessment. Currently, the DHCFP recognizes the Level of Care Utilization System (LOCUS) for adults and the Child and Adolescent Screening Intensity Instrument (CASII) for children and adolescents. There is no level of care assessment tool recognized by the DHCFP for children below age six, however, providers must utilize a tool comparable to the CASII and recognized as a standard of practice in determining the intensity of needs for this age group.

- 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))

Durable medical equipment is dispensed, on prescription signed by a physician or physician extender (APN, PA), based on medical necessity and prior authorization. There are limitations which may only be overridden by authorized approval of written, medical justification.

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

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

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

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services and respiratory care services in a home, school or other setting.

- 6.2.15. Nursing care services (Section 2110(a)(15))
Skilled nursing covered with no limitations as long as medical necessity requirements have been met.

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

- 6.2.17. Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
Coverage for preventative, diagnostic and treatment, and other general dental services and emergency assessments. Medically necessary orthodontia is a benefit requiring prior authorization.

- 6.2.18. Vision screenings and services (Section 2110(a)(24))

- 6.2.19. Hearing screenings and services (Section 2110(a)(24))

- 6.2.20. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

Detoxification – Up to five hospital days, more if medical necessity warrants.
Treatment – Up to 21 hospital days, more if medical necessity warrants.

- 6.2.21. Outpatient substance abuse treatment services (Section 2110(a)(19))

The benefit is the same as 6.2.11 above.

- 6.2.22. Case management services (Section 2110(a)(20))

Targeted case management services are required to be provided by the Nevada Check Up program, consistent with the Medicaid Title XIX State Plan.

- 6.2.23.** Care coordination services (Section 2110(a)(21))
Care coordination services are required to be provided by the MCOs in the managed care portion of the Nevada Check Up program. Care coordination services are not currently available in the Fee-for-Service areas.
- 6.2.24.** Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders (Section 2110(a)(22))
Therapy Services, including group and individual treatment, are subject to utilization management criteria.
- 6.2.25.** Hospice care (Section 2110(a)(23))
Inpatient covered for up to six months; subsequent periods may be approved in 30-day blocs. Hospice may also include routine or continuous home care, respite care, counseling, appliances, supplies and pharmaceuticals. Curative services are provided to NCU participants in accordance with Section 2302 of the Affordable Care Act.

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

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

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

- 6.2.27.** Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))
Annual vision screening exam and glasses, hearing exams, medically necessary transplants as required under the Title XIX EPSDT program.
- 6.2.28.** Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.29.** Medical transportation (Section 2110(a)(26))
Hospital and emergency room transport are covered.

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

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

Benefits are subject to prior authorization and/or other utilization review controls as established

by the plan, except for emergency services. For areas not covered by an MCO, a Fee-for-Service benefit is provided with the same State Plan benefit package.

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

6.2.1-DC State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:

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

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

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

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

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

6.2.2.2-DC State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the

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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 is 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.

1. For the purpose of analysis for compliance with MHPAEA, MH/SUD inpatient benefits are defined as those services provided in a hospital or institutional setting under a physician's order for treatment for diagnostic codes listed in Chapter 5 in the most current ICD manual.

For the purpose of analysis for compliance with MHPAEA, M/S inpatient benefits are defined as those services provided in a hospital or institutional setting under a physician's order for treatment for diagnostic codes listed in all chapters of the current ICD manual, except for those diagnostic codes listed in Chapter 5.

2. For the purpose of analysis for compliance with MHPAEA, MH/SUD outpatient benefits are defined as those services provided in an outpatient, clinic, office or community setting under clinical supervision for treatment for diagnostic codes listed in Chapter 5 of the current ICD manual.

For the purpose of analysis for compliance with MHPAEA, M/S outpatient benefits are defined as those services provided in an outpatient, clinic, office or community setting

under medical supervision for treatment for diagnostic codes listed in all chapters of the current ICD manual, except for those diagnostic codes listed in Chapter 5.

3. For the purpose of analysis for compliance with MHPAEA, MH/SUD prescription drug benefits are defined as those medication services provided in a hospital, emergency department, or an outpatient, clinic, office or community setting under medical supervision for treatment for diagnostic codes listed in Chapter 5 of the current ICD manual.

For the purpose of analysis for compliance with MHPAEA, M/S outpatient benefits are defined as those services provided in an outpatient, clinic, office or community setting under medical supervision for treatment for diagnostic codes listed in all chapters of the current ICD manual, except for those diagnostic codes listed in Chapter 5.

4. For the purpose of analysis for compliance with MHPAEA, MH/SUD emergency care benefits are defined as those crisis intervention services provided in an emergency department, or a behavioral health outpatient, clinic, office or community setting under clinical supervision for treatment for diagnostic codes listed in Chapter 5 of the current ICD manual.

For the purpose of analysis for compliance with MHPAEA, M/S prescription drug benefits are defined as those medication services provided in a hospital, emergency department or an outpatient, clinic, office or community setting under medical supervision for treatment for diagnostic codes listed in all chapters of the current ICD manual, except for those diagnostic codes listed in Chapter

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.

ATTACHMENT F

[MHPAEA Final Report 2008 \(03-22-18\).pdf](#)

ATTACHMENT G

[MHPAEA-CHIP Monitoring plan \(03-23-18\).pdf](#)

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

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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: (42 CFR 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)) (42 CFR 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)) (42 CFR 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% 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)) (42 CFR 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)) (42 CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

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

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

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

- Yes
 No

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

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

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

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

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

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

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

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

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

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

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

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

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

- Yes
- No

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

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

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

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

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

Section 7. Quality and Appropriateness of Care

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

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

The DHCFP performs the same readiness review process, less those issues which are specific to Medicaid, prior to allowing the MCO contractor to deliver services under the Nevada Check Up program.

Overall program monitoring to assure quality and appropriateness of care will be performed on an ongoing basis by the following activities:

- 1) Review and analysis of encounter and financial data;
- 2) Review of participant and provider complaints and grievances filed with the State Insurance and/or Health Division;
- 3) The compilation, review and investigation, where warranted, of consumer satisfaction data; and
- 4) Establishment of quality and performance measures for well-baby care, well child care, and immunization monitored through encounter data and chart review.

Contract monitoring is performed through the following actions:

- 1) Annual quality and operational review of each contractor;
- 2) Identical encounter data reporting (in form, format, and periodicity) as required under the Medicaid Managed Care program (to the extent that such services are program benefits under the contract);
- 3) Review of the contractors and contract data by an External Quality Review Organization (EQRO);
- 4) Generation of Health Plan Employer Data and Information Set (HEDIS) reporting, depending on program benefits under the contract, with the same periodicity, form and format as under the Medicaid Managed Care program;
- 5) Performing on-site review, if problems of a material nature arise;
- 6) Performance of a yearly member satisfaction survey by the DHCFP and/or the MCO contractors with review, analysis and follow-up (as required) by the State.
- 7) Complaints filed by enrolled participants with the MCO plans. Participating plans are contractually required to report complaints on a quarterly basis. These reports are shared with enrolled participants who request the information. In addition, the DHCFP will track the information on the number and type of complaints filed by participants enrolled in a plan. Complaint information is used by the DHCFP to identify plan performance needing improvement and to form the basis of future performance standards.

- 8) The DHCFP works with the state's two health insurance industry regulatory entities (i.e., the Division of Insurance and the Health Division) to ensure all publicly available data on health plan performance is known to the DHCFP.

**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
The state utilizes quality standards for the Nevada Check Up program identical to those currently used under the Medicaid Managed Care Program.

The following clinical areas of concern are monitored:

1. Comprehensive Well Baby and Well Child Periodic Health Screening

Standard

Well Baby/Well Child screenings comprise a comprehensive health and developmental history, unclothed physical exam, and vision, dental, and hearing evaluations with follow-up. When indicated appropriate diagnostic and treatment services must be provided. Periodic screening will be completed on behalf of all eligible children between the ages of 0 through 18, according to the most current HEDIS guidelines.

An interperiodic screening is one which is provided at medically necessary intervals to determine the existence of physical or mental illnesses or conditions of concern, or to follow up on previously diagnosed health problems. Such screening exams must be provided at the request of a parent, guardian, health, or educational professional.

2. Childhood Immunizations

Standard

Age appropriate immunizations will be documented in the medical record unless documentation is provided of exemption due to State law. Age appropriate immunizations required by the State are those recommended by a recognized medical academy and/or required by the Centers for Medicare and Medicaid Services (CMS) The MCO is responsible for implementing the most recent immunization schedule as endorsed by the American Academy of Pediatrics and the Nevada Health Division.

3. Family Planning

Standard

Family planning services are provided to Nevada Check Up eligible children, both male and female, of child bearing age.

4. Dental Services

Standard

Dental services (including medically necessary orthodontia, if prior authorized) are provided to Nevada Check Up eligible participants.

5. Medical Record Standards

Standard

The MCO must maintain medical records in accordance with Standard XII of the "Guidelines for Internal Quality Assurance Programs" as set forth in the CMS Medicaid guidelines.

6. Appointment Standards

Standard

Ninety percent of appointments must meet time criteria (both for waiting and for number of days between request and appointment).

7.1.2 Performance measurement

Performance measurements for each of the Quality Standards noted in 7.1.1 are similar to or the same as those currently utilized in the Medicaid Managed Care program.

1. Comprehensive Well Baby and Well Child Periodic and Interperiodic Health Assessments - Periodic screening

A. Measurement

1. Eighty Percent of Nevada Check Up eligible children who are enrolled for 12 months must have an age appropriate periodic screening. HMO or MCO compliance is monitored by a quarterly evaluation of encounter data and, if indicated, liquidated damages will be calculated based on the initial annual review; that is, 12 months of the contract year.

Liquidated Damage: (number of required Periodic screenings not completed) x (Periodic screening fee) = liquidated damage.

2. Annually, a chart sample of Nevada Check Up eligible children will be reviewed. During chart review, areas of critical concern are age appropriate developmental, dental, vision and hearing screenings with follow-up when indicated by diagnostic and treatment activities and/or referrals. The timely scheduling and completion of interperiodic screening upon request, accompanied by

necessary follow-up activities, will be assessed during the chart review.

Corrective action: If chart reviews suggest poor quality of medical care and/or inadequate follow up activities and treatment, the DHCFP may direct the MCO to conduct a study of particular areas of concern. In cases of immediate concern, a simultaneous referral to the Division of Insurance and the Health Division may be initiated for further examination of appropriateness and quality of care within the existing scope of each agency.

B. Method

Encounter data, chart review, analysis of number and nature of complaint reports, and participant/guardian surveys are analyzed and evaluated.

C. Frequency

The DHCFP will generate quarterly reports from encounter data with an annual cumulative report. An annual on-site review with an emphasis on chart review will be conducted by the DHCFP and/or an EQRO. Chart review may be conducted more often than annually, if indicated by encounter data, complaints, etc.

2. Childhood Immunizations

A. Measurement

Documentation showing 90% of Nevada Check Up eligible non-exempt participants, ages zero through two are appropriately immunized. Documentation showing 95% of Nevada Check Up eligible non-exempt participants, ages three through 18 are appropriately immunized. Nevada Check Up clients must have been enrolled for 12 months before compliance with required percentages is calculated. For tracking purposes in managed care, each immunization (vaccine) will include two encounter codes. One code will indicate administration of a specific vaccine; the second code will indicate a history of receiving a specific immunization.

An action plan will be required from the MCO if compliance is less than 90% for children ages zero through two and/or less than 95% for those who are ages three through 18.

B. Method

Encounter data, chart review, and analysis of number and nature of complaints reported.

- C. Frequency
The DHCFP generates quarterly reports from encounter data with an annual cumulative report. An annual review is conducted by the DHCFP and/or an EQRO.
3. Family Planning
- A. Measurement
80% of eligible participants of child bearing age receive age appropriate education and services regarding family planning. A chart sample of participants who are enrolled for at least six months will be reviewed for compliance. At a minimum, documentation indicating that family planning information was offered or provided must be evident in the participant's record. An action plan is required if the percent of compliance is less than 80%.
 - B. Method
Encounter data, chart review and verification of service from participants whose records were reviewed will be evaluated; analysis of number and nature of complaints reported, and participant/parent/ guardian surveys will be analyzed and evaluated.
 - C. Frequency
The DHCFP will generate quarterly reports and an annual cumulative report utilizing encounter data submitted by the MCO. The DHCFP will conduct an annual review. If the reviewed sample does not meet the minimum percentage criteria, follow-up will be conducted by the DHCFP staff.
4. Dental Services
- A. Measurement
Twenty percent of Nevada Check Up participants, ages three to five, who have been enrolled at least 12 months will receive at least one oral health screening, referral and follow-up for necessary diagnostic and preventive services; and, 50% of participants, ages five to 18, who have been enrolled for 12 months will receive at least one dental visit in the reporting year.
 - B. Method
Encounter data, chart review and verification of service from participants whose records were reviewed will be evaluated. An analysis of the number and nature of complaints reported, with the participant/parent/guardian surveys will be analyzed and evaluated.

C. Frequency

The DHCFP will generate quarterly reports and an annual cumulative report utilizing encounter data submitted by the MCO. The DHCFP will conduct an annual review. If the reviewed sample does not meet the minimum percentage criteria, follow-up will be conducted by the DHCFP and/or EQRO staff.

5. Appointment standards

A. Measurement

1. Appointments with primary care providers (PCP):

The MCO shall have procedures in place that ensure:

- a. Same day primary care provider appointments for symptoms which are of sudden or severe onset but which do not require emergency room service are available;
- b. Urgent care PCP appointments are available within two calendar days; and,
- c. Routine care PCP appointments are available within two weeks. This two-week standard does not apply to regularly scheduled visits to monitor a chronic medical condition, if the schedule calls for visits more frequently than once every two weeks.

2. Specialty appointments

For specialty referrals to physicians, therapist and other diagnostic and treatment health care providers the MCO shall provide:

- a. Same day appointments within twenty-four hours of referrals as in 1) (a) above;
- b. Urgent care appointments within three calendar days of referral; and
- c. Routine appointments within two weeks

3. Dental Appointments

- a. Initial appointment to a dentist is available within four weeks;
- b. Follow up appointments according to a plan of care within two weeks;
- c. Urgent care appointments within one week; and

- d. Emergency care (severe tooth ache, loss of tooth) within 24 hours.

4. Office Waiting Times

The MCO plans shall monitor and ensure that a participant's waiting time at the PCP or specialist's office is not more than one hour from the scheduled appointment time, except when the provider is unavailable due to an emergency. Office waiting times may be delayed when they "work in" urgent cases, when a serious problem is found, or when the patient had an unknown need that requires more services or education than was described at the time the appointment was made.

A Plan of Correction (POC) will be required if the 90% Standard is not met.

a. Method

The DHCFP and/or an EQRO will validate this annually by means of on-site observations, chart reviews, enrollee satisfaction surveys, review of grievances and interviews with enrollees.

b. Frequency

The DHCFP and/or the EQRO will conduct reviews of available data at least annually.

6. Medical Records Standards

A. Measurement

Of the 16 elements of medical record keeping, nine are critical and must be present in each record. The critical items for medical record keeping are as follows: 1) patient identification information; 2) personal/biographical data; 3) entry date; 4) provider identification; 5) legibility; 6) allergies; 7) immunizations; 8) medication information; and 9) identification of current problems.

A sample of the MCO's Nevada Check Up participants' medical records will be reviewed: 90% of records reviewed must contain medical record keeping and patient visit data items indicated as critical. An action plan will be required if the percent of standard is less than 90%.

B. Method

Medical records will be reviewed.

C. Frequency

Record reviews will be conducted annually by the DHCFP and /or an EQRO. If the reviewed sample does not meet the minimum criteria, a corrective action plan will be required from the MCO and follow-up will be done by the DHCFP staff.

(Please note that the specific standards may be altered as a result of contract negotiations.)

7.1.3 **Information strategies**

A new one-step application and enrollment process is being developed and was implemented as of July 2003. At the time of application completion, the head of household must choose a health plan from information provided on the application. Nevada Check Up eligibility specialists enters the MCO or Fee-for-Service information while determining eligibility.

Nevada Check Up enrolled families receive a handbook from their chosen health plan which describes the benefits provided to enrollees under the program. These materials also describe enrollee rights and responsibilities and the specific steps to file a complaint.

The DHCFP will collect information from the health plans on a quarterly and annual basis. This reporting provides information on enrollment, demographics, ethnic characteristics, outreach efforts, use of medical and dental services, enrollee grievance information, and data on financial expenditures. Information is used by the DHCFP to document performance and assure adequate program accountability.

The Division, MCO and/or the External Quality Review Organization (EQRO) will conduct yearly consumer satisfaction surveys no more than three months after the end of the first year of the contract and every year thereafter. This data is compiled and analyzed. Where areas of concern exist, an audit will be performed and if the area of concern is valid, the MCO will be required to produce a plan of correction as is currently required under the Medicaid Managed Care program.

7.1.4. **Quality improvement strategies**

Quality improvement strategies, with which the MCO contractor must comply, are as follows:

1. Requirements for written policies and procedures regarding prior authorization standards and criteria, and for periodic review and updating of said policies and procedures;
2. Policies and procedures regarding utilization review activities, including reports to state agencies on methods from reviewing, and follow-up activities required based on the outcome of the review activities;
3. Establishment (including requirements) of a quality assurance program designed to direct, evaluate and monitor the effectiveness of health care

services provided to its enrollees. The program must include, as defined in the Nevada Statutes, without limitation:

- a. A method for analyzing the outcomes of health care services;
 - b. Peer review;
 - c. A system to collect and maintain information related to the health care services provided to enrollees;
 - d. Recommendations for remedial actions; and
 - e. Written guidelines that set forth the procedures for remedial action when problems related to quality of care are identified.
4. Corrective action plans will be required as indicated above, where quality standards, consumer satisfaction surveys or performance measurements are below those stated standards;
 5. In severe or blatant cases of non-compliance, the Division will assess liquidated damages for not meeting performance measures.

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

- 7.2.1. Access to well-baby care, well-adolescent care and childhood and adolescent immunizations. (Section 2102 (a) (7)) (42 CFR 457.495 (a)). Refer to Section 7.1.1., Item 1. & 2. Section 7.1.2., Item 1. & 2.

All Nevada Check Up participants are encouraged to seek well-baby and well-child care. The MCO contracts contain standards for well-baby and well-child visits at not less than the national baseline average, along with the immunizations recommended in Section 7.1.1., Number 2. The contract standards include establishing, maintaining, and reporting on records of these visits and immunizations. They are also required to send out reminder notices to families that a well-child check or immunization is due. FFS providers are expected to comply with the American Academy of Pediatrics periodicity schedule for well-baby and well-child care purposes.

The Medicaid Managed Care contract requires that HEDIS measurements be used to evaluate an MCO's performance. The MCO's HEDIS immunization measurement rates must be comparable to the HEDIS National Medicaid average. The contract includes provision for development of corrective action plans if performance is not adequate.

- 7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102 (a) (7)) (42 CFR 457.495 (6))

Emergency Services: The MCOs cannot require participants to seek prior authorization for services in a medical or behavioral health emergency. MCOs must inform their enrollees that access to covered emergency services is not restricted and that if the participant experiences a medical or behavioral health emergency, he/she may obtain services from a non-plan physician or other qualified provider without penalty. However, health plans may deny payment for such a visit should the visit be determined as a non-emergency using a

prudent layperson standard. The health plan may require members to obtain prior authorization for any recommended or requested follow-up care pursuant to the emergency.

- 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)) (42 CFR 457.495 (c)). Refer to Section 7.1.1., Item 6. and Section 7.1.2., Item 5.

Service Accessibility: The MCO must take measures to ensure compliance with the access standards. The DHCFP monitors MCO performance and will take action if problems are identified.

Access to care analyses will be based on the results of participant satisfaction surveys participant complaint data, and appointment scheduling. The number of participants enrolled will be used to determine the adequacy of the MCO's panel of PCPs and specialists.

The contract with managed care providers requires that their Enrollee Services Departments assist enrollees in obtaining out-of-area and out-of-network care. The children in Nevada Check Up's Fee-for-Service component are free to seek services from any Medicaid provider in the state. Out-of-state and out-of-network providers will be accepted if they are willing to abide by the terms of Nevada Check Up claims payment rates and processes. The participants enrolled in fee-for-service have more direct access to specialists and out-of-state providers in that their care is directed by their primary care physicians who will often make referrals for the participants. The Medicaid district offices will also assist Nevada Check Up families with access to care.

Twenty-Four Hour Coverage: The MCO must provide health care coverage to its members, 24 hours a day and seven days a week. The MCO must instruct their enrollees how to obtain services after business hours and on weekends.

Telephone Access: The MCO may require their PCPs to have primary responsibility for serving as after-hours "on-call" telephone resources to members with medical problems. Whether or not the plan assigns primary responsibility for after-hours telephone access to a PCP, it must have a 24-hour toll free telephone number for members to call, which must be answered by a live person.

Days to Appointment: The MCO must abide by the following appointment standards:

- Urgent medical or behavioral problems within 24 hours;
- Non-urgent "sick visits" within 48 hours, as clinically indicated;
- Routine, non-urgent or preventive care visits within two weeks: and

- In-plan, non-urgent mental health or substance abuse visits within two weeks.

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 receipt of request for services (Section 2102 (a) (7)) (42 CFR 457.495 (d))

State licensed MCOs are the principal health plan providers for enrollees who reside in areas served by managed care. Under Nevada Revised Statute 695C, these entities are subject to oversight and regulation by the Division of Insurance (DOI). The DOI is primarily responsible for monitoring initial capitalization and financial solvency. The Health Division is charged with monitoring quality of care and assuring the availability of and accessibility to health services.

Requests for prior authorization are within the purview of this section. The MCOs are allowed a maximum of 14 days from the date of receipt of the request to provide an answer. In accordance with Title 42CFR 457.495(d)(1), there is allowance for an additional 14 days if the participant requests an extension or if the health care provider determines additional information is needed. Nevada Check Up Fee-for-Service prior authorization requests are processed by the fiscal agent and are completed in the same manner and time frames as are required for Medicaid.

To obtain licensure, certain requirements regarding availability and access must be satisfied by an MCO. These requirements are:

- Coverage for basic health services, including emergency services;
- Provisions for access to primary care physician for each subscriber;
- Evidence of arrangements for the ten most commonly used specialists;
- Policies on obtaining referrals for specialty care;
- Physician and provider network capacities.

Many of these requirements are evaluated: initially upon licensure; upon request for service area expansion; and periodically through complaint and grievance monitoring; and on-site visits by both Divisions.

To participate in the Nevada Check Up program, MCOs must establish and maintain provider networks with sufficient number of providers in each contracted geographic service area. The MCOs' networks must contain all provider types necessary to provide to its enrollees a continuum of services which includes primary and preventive care and includes the diagnosis, management and treatment of a variety of diseases and conditions, as well as specialized care to handle complex health problems. The MCO must include the provider types necessary to furnish the prepaid benefit package, including: hospitals; physicians (primary care and specialists); mental health and substance abuse providers; nursing homes; and pharmacies. If an MCO is unable to provide the medically necessary covered service within its provider network, it must

allow the participant to obtain the service through an out-of-network provider. The MCO must facilitate the referral to an out-of-network provider on behalf of the enrollee and must reimburse the out-of-network provider at not less than the Medicaid FFS rate for the covered service. MCOs shall not include in their networks any medical provider who has been sanctioned by Medicare or Medicaid.

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?

8.1.1. YES

8.1.2. NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing and 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: A quarterly premium is charged per family based on gross income, except for American Indians who are members of federally recognized Tribes and Alaska Natives, who are exempt from premiums. Starting April 1, 2008, families whose incomes are at or above 176% of FPL, the premium is \$80 per quarter (\$320 per year). For families whose incomes are at or above 151% FPL but at or below 175% FPL, the premium is \$50 per quarter (\$200 per year). For families whose incomes are at or above 36% FPL up to 150% FPL, the premium will be \$25 per quarter (\$100 per year) and these families are offered the option of paying their premium monthly, rather than quarterly. For families whose incomes are below 36% FPL, the premium is zero. These enrollees are either Medicaid referrals or have assets that would preclude their enrollment in Medicaid.

Families whose incomes are at or below 150% FPL are notified on the premium notice that Nevada Check Up premiums may be paid on a monthly basis.

8.2.2. Deductibles: There are no deductibles.

8.2.3. Coinsurance: There is no coinsurance.

8.2.4 Other:

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

The cost sharing information is explained to potential enrollees through the application, which includes a chart of income eligibility and premium payment amounts on its cover. If changes are necessary to the cost sharing requirements of Nevada Check Up, all current enrollees are notified by letter of the changes and effective dates. Public hearings are held to allow the public to comment on any proposed changes to cost sharing in Nevada Check Up.

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

- 8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)
- 8.4.2. No additional cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)
- 8.4.3. No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103 (e) (1) (A)) (42 CFR 457.515 (f))

8.5 Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5% of such family's annual 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 referral given by the State for overpayment by an enrollee: (Section 2103 (e) (3) (B)) (42 CFR 457.560 (b) and 457.505 (e))

The cost sharing requirements are set at very low levels so it is extremely unlikely that any families over 150% of FPL could approach the 5% cap. For a family of two at 150% of FPL, the 5% cap is \$994 ($\$19,898 \times .05$); the total Nevada Check Up annual premiums are \$100. For a family of two at 166% of FPL, the 5% cap is \$1,101 ($\$22,020 \times .05$); the total Nevada Check Up annual premiums are \$200. For a family of two at 200% of FPL, the 5% cap is \$1,327 ($\$26,531 \times .05$); the total Nevada Check Up annual premiums are \$320.

To further illustrate how low Nevada Check Up's premium amounts are, a family of two with income of \$13,265 is at 100% FPL and, if eligible for enrollment in Nevada Check Up, would pay \$100 each year in premiums, less than 1% of their income. The maximum allowed for SCHIP cost sharing in this case is \$663 per year. At the extreme low level (36% FPL) of those charged premium fees, the 5% cap equals \$239 annually and Nevada Check Up premium totals \$100.

The State does not impose any other co-payment or deductible.

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)) (42 CFR 457.535)

The instructional section of the application states that premiums are waived for any household with an American Indian or Alaska Native child. Additionally, the application includes an ethnicity question and through self-declaration, the family indicates each child's ethnicity. This information is utilized to derive the premium notices. The Nevada Check Up database includes an edit to set the premium amount to zero if an American Indian or Alaska Native child is in the household.

8.7. Please 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))

The applications will be processed and those found eligible are enrolled subject to a full enrollment limitation. Written notice will be provided to families, no later than seven days after the start of the grace period, when the quarterly premium is past due; additionally, a final notice indicating disenrollment will be sent 30 days prior to the potential disenrollment action. (Notices generate at system cutoff approximately five days prior to the end of the month and are mailed the next day allowing at least 30 days' notice) If payment is not received prior to the intended disenrollment date the children will be disenrolled at the end of the two-month grace period. All past due balances must be paid prior to new enrollment. (i.e. Premium request for January/February/March (new coverage period) is mailed November 29, 2011. If payment not received, late notice mailed December 7, 2011. No payment, final notice mailed January 24, 2012, indicating termination effective February 29, 2012. If payment is received by February 24, 2012, coverage will continue.)

American Indians who are members of federally recognized Tribes and Alaska Natives are exempt from paying premiums.

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

- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, co-payments, coinsurance, deductibles, or similar fees prior to disenrollment. (42 CFR 457.570 (a))
 - Participating families are always given 30 days written notice of any action that will result in their disenrollment from Nevada Check Up.
- 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))
 - Families who receive notices of impending disenrollment are encouraged to respond with documentation that will assist eligibility staff to modify their premium and allow their continued enrollment in Nevada Check Up.
- 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))
 - Nevada Check Up denies enrollment and refers all children to Medicaid who appear to be Medicaid eligible at the time of application. Families who are Medicaid eligible must apply for Medicaid and cooperate with the Medicaid eligibility process. These families are not considered for enrollment in Nevada Check Up until any Medicaid questions have been resolved and/or their circumstances change with the result that they are no longer Medicaid eligible. Cost sharing is always adjusted based on family income.

- The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570 (c))
 - Nevada Check Up letters always include information on how to request a review of any decision that impacts the family's enrollment.

8.8. The state assures 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)) (42 CFR 457.220)
 - The DHCFP ensures that no Federal funds accounts for in any way to make them appear as if they were part of a state match.
- 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)) (42 CFR 457.224)
 - Cost sharing funds received by Nevada Check Up are used only to defray administrative costs of the program.
- 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this title. (Section 2105 (c)(6)(A)) (42 CFR 457.626 (a)(1))
 - Nevada Check Up does not provide insurance to families who have private insurance or have access to affordable private insurance.
- 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)) (42 CFR 457.622(b)(5))
 - Medicaid eligibility is determined by DWSS eligibility specialists and is in compliance with Federal standards.
- 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)) (42 CFR 457.475)
 - The DHCFP assures that abortion coverage is only that which complies with the rules set forth in the citations listed above.
- 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)) (42 CFR 457.475)
 - The DHCFP assures that abortion coverage is only that which complies with the rules set forth in the citations listed above.

Section 9. Strategic Objectives and Performance Goals for the 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)) (42 CFR 457.710 (b))

The strategic objectives for the Nevada Check Up program are to:

1. Increase the availability of comprehensive low-cost health coverage for children at or below 200% FPL, and not eligible for Medicaid.
2. Provide an application and enrollment process which is easy for targeted low income families to understand and use.
3. Improve accessibility to dental providers for children enrolled in Nevada Check Up.
4. Through the administration of the Covering Kids and Families grant, assure the participation of community-based organizations in outreach and education activities.
5. Assure a high degree of participant satisfaction with the Nevada Check Up program.

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

The following performance goals and measures will be used to evaluate the program's effectiveness:

- 1.1 Increase the percentage of children enrolled in Nevada Check Up by 5% annually, thus decreasing overall uninsured child rates in Nevada.
- 1.2 Process applications and enroll Nevada Check Up applicants within 30 days from the date the application is received.
- 2.1 Provide timely application completion assistance through dial up telephone support in both English and Spanish.
- 2.2 Simplify the Nevada Check Up application from a two-step to a one-step process.
- 2.3 Create and implement an annual quality improvement review of the Nevada Check Up business processes.
3. Achieve year to year improvements in the percentage of targeted low income children that have had a visit with a dental provider during the year.
- 4.1 Achieve effective outreach and education activities by community-based organizations in collaboration with Covering Kids and Families.
- 4.2 Achieve annual increases in the number of outreach and education activities for Nevada Check Up provided by community-based organizations in collaboration with Covering Kids and Families.
- 4.3 Increase school-based outreach programs in the State of Nevada, resulting in an increase in the number of Nevada Check Up applications submitted that are directly attributable to school-based outreach activities.
5. Achieve a high degree of satisfaction with parents and guardians of Nevada Check Up participants as measured by an annual survey.

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)) (42 CFR 457.710 (d))

The primary source for measuring the five performance indicators will be an annual survey of the uninsured. The baseline will be established from a survey recently completed for Great Basin Primary Care Association by Decision Analytics, Inc. Additionally, data from the Bureau of the Census regarding poverty and insurance status, data for the Nevada Division of Insurance on health care covered lives and enrollment data for Medicaid and Nevada Check Up will be used to confirm the established performance indicators.

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

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. Immunizations
 - 9.3.7.2. Well child care
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, please list: _____
- 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)) (42 CFR 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)) (42 CFR 457.750)

The state’s plan for the assessments and reports will include an annual update of a survey on insurance coverage for children in Nevada. This survey will initially be used to determine the extent of coverage and related crowd-out issues, but will be designed to allow for additional questions on health status, access to care and other issues as appropriate.

The state will also perform surveys of families on the program regarding access to care, grievance resolution and overall satisfaction. HEDIS reporting will be evaluated for quality of health coverage.

The information will be compiled by state staff and will address each of the performance goals included in Section 9.2. Variances will be addressed and evaluated to determine policies to improve the performance of the program. Also, performance goals will be reevaluated and changes made as appropriate.

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))(42 CFR 457.720) (42 CFR 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. (42 CFR 457.710 (e)) (42 CFR 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)) (42 CFR 457.135) (42 CFR 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)) (42 CFR 457.120(a) and (b))

Public input on the design and implementation of the plan has been accomplished through various means:

- a) The Department of Human Resources prepared a four-page outline designed as a program framework. The outline was used to solicit public comment at four public hearings held throughout the state:

October 22, 1997 in Las Vegas
December 4, 1997 in Fallon
December 5, 1997 in Reno
December 10, 1997 in Las Vegas

b) The Legislative Committee on Health Care is a standing committee of Nevada's Legislature. The Committee held monthly meetings for a period of time after October 1997, at which the Nevada Check Up program was discussed. In addition to six legislators, approximately 25 other interested parties were also represented including:

- State agencies
- County agencies
- Hospitals
- Labor unions
- Health Maintenance Organizations (HMOs)
- Physicians and other health professionals
- Federally Qualified Health Centers (FQHC)
- Native American Advocacy Groups
- American Association of Retired Persons
- Legal Services Statewide Advocacy Office
- Children's Advocacy groups

The recommendations of the legislative body as well as the comments from the public and private sectors were taken into consideration in the drafting of the State Plan. Once available for distribution, copies of the State Plan were mailed to all persons who requested a copy in writing; and to all interested person and entities who participated in the initial public hearing process previously described. The state plan is also available through the Internet on the DHCFP/Nevada Check Up website.

In order to ensure ongoing involvement with the public, Nevada Check Up works closely with other public agencies and the Covering Kids and Families (CKF) Coalition. The Coalition monitors the progress of two local outreach projects in Northern and Southern Nevada, and rural outreach activities targeted at sustaining the CKF goals of outreach, coordination and simplification. Coalition members are recruited from a broad segment of the community and their mission is to promote awareness of children's health care coverage through the SCHIP and Medicaid programs.

Nevada Check Up notifies all applicants and participants of changes to the program in writing. Program modifications relating to enrollment levels, eligibility criteria and/or cost sharing require public hearings. The public hearings are widely advertised as to date, time, location and subject matter.

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)) (42 CFR 457.120 (c))

The Department of Health and Humans Services (DHHS) and the Tribes, Indian Health Service, Tribal Organizations and Urban Indian Organizations (Tribes and I/T/U) residing within the State of Nevada have established an agreement in accordance with the established Tribal Consultation Process. NCU follows the same process as the Nevada Medicaid State Plan.

Representatives of Indian tribal organizations and advocacy groups are members of the Statewide Covering Kids Coalition, which conducts meetings and also includes representatives from Medicaid and Nevada Check Up.

Nevada Check Up participates in Native American Advisory Council meetings, as required by state law, to provide information to the council and to receive advice about the effectiveness of certain marketing and training activities. Nevada Check Up has conducted training in application completion, along with the necessary inclusion of required documentation, for Tribal Clinic staff. This training allows the clinics to help their patients complete a Nevada Check Up application and attach the required documents before it is submitted to the state. This training has reduced the number of applications placed in pending status because of missing information.

Nevada Check Up staff attends and participates in quarterly Inter-Tribal Council meetings and other events.

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).

- 9.9.2 Public notice is provided pursuant to NRS 422.2368. Public hearing was provided for the sections related to citizenship, premiums, transportation and newborn SSN requirements. Appropriate publishing and postings were completed on November 6, 2009 and the hearing was conducted on December 8, 2009 for policies related to citizenship. Premiums policies were appropriately published and postings were completed on February 5, 2010 with the hearing conducted on March 9, 2010 so that anyone interested could comment. Transportation policies were published and postings were completed on July 22, 2011 the hearing was conducted on August 23, 2011. The eligibility manual was posted for public hearing August 12, 2011 and the hearing was conducted on September 13, 2011.

Public notice is provided pursuant to NRS 422.2368. Public hearing was provided for the sections related to adding back services per legislative directive effective July 1, 2009. Appropriate publishing and postings were completed on June 12, 2009 and the hearing was conducted on July 14, 2009 so that anyone interested could comment.

For updates effective September 1, 2008, public notice is provided pursuant to NRS 422.2368. Public hearing was provided for the changes to established coverage in this State Plan on August 26, 2008. Appropriate publishing and postings were completed on July 25, 2008 and the hearing was conducted to solicit feedback.

Public notice is provided pursuant to NRS 422.2368. Public hearing was provided for the sections related to the premium increase in this State Plan on March 11, 2008. Appropriate publishing and postings were completed on February 5, 2008 and the hearing was conducted so that anyone interested could comment.

For the proposal to eliminate provisional enrollment, public notice was provided pursuant to NRS 422.2368. The public hearing was conducted on July 13, 2004. Appropriate publishing and postings were completed in timely fashion and the hearings were conducted in a manner that encouraged interested parties to express their opinions.

9.10 Provide a one-year projected budget. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

A suggested financial form for the budget is attached. The budget must describe:

- Planned use of funds, including:
 1. Projected amount to be spent on health services.
 2. Projected amount to be spent on administrative costs, such as: outreach, child health initiatives, an evaluation; and
 3. 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.
- In July 2004, Nevada Check Up discontinued the practice of provisional enrollment. Although the actual impact is unknown, it appears to be budget neutral.

The budget for the Nevada Check Up program is included below for Federal Fiscal Years (FFY) 2003 and 2004. The amounts represent the maximum funding that is being committed to the program, even though full enrollment may not be achieved. Actual cost may be significantly lower. The state's share of funding comes through appropriations from the State General Fund.

CHIP Budget Template			
STATE: <u>NEVADA</u>	FFY Budget	Budget Increase/ decrease For Requested SPA	New Budget with SPA Budget Increase/ decrease
Federal Fiscal Year	FFY 2012	FFY 2012	FFY 2012
State's enhanced FMAP rate	69.34/30.66	69.34/30.66	69.34/30.66
Benefit Costs			
Insurance payments	\$0	\$0	\$0
Managed care	\$26,021,136	\$(844,059)	\$25,177,077
<i>per member/per month rate</i>			
Fee for Service	\$9,709,321	\$(202,306)	\$9,507,015
Total Benefit Costs	\$35,730,457	\$(1,046,365)	\$34,684,092
(Offsetting beneficiary cost sharing payments)	\$(1,595,613)	\$0	\$(1,595,613)
Net Benefit Costs	\$34,134,844	\$(1,046,365)	\$33,088,479
Administration Costs			
Personnel	\$1,429,601	\$0	\$1,429,601
General administration	\$1,449,975	\$0	\$1,449,975
Contractors/Brokers	\$0	\$0	\$0
Claims Processing	\$33,458	\$0	\$33,548
Outreach/marketing costs	\$0	\$0	\$0
Other	\$0	\$0	\$0
Total Administration Costs	\$2,913,034	\$	\$2,913,034
10% Administrative Cap (Net Benefit Costs /9)	\$3,792,760	\$	\$3,676,498
Federal Share	\$25,688,999	\$(725,549)	\$24,963,449
State Share	\$11,358,879	\$(320,816)	\$11,038,064
TOTAL COSTS OF APPROVED CHIP PLAN	\$37,047,878	\$(1,046,365)	\$36,001,513

Source of State Fuds: State General Fund

FFY projected numbers based on State Fiscal Year (SFY) 2010 actual numbers and SFY 2011 budgeted numbers.

FFY 2011 Actual Average Monthly Enrollment: 21,234
 FFY Actual Average Annual Benefit Child per Child: \$
 FFY 2012 Projected Average Monthly Enrollment 18,033
 FFY 2012 Projected Average Annual Benefit Cost per Child: \$1,225

FFY 2009 projected savings are SFY 2009 budget projection for capping dental at \$600, eliminating orthodontia, and eliminating non-medical vision care: \$698,966.00.

SFY 2010 projected cost for adding back orthodontia, EPSDT, non-medical vision and removal of dental cap is (\$997, 318.00) per SFY.

SFY 2008	BUDGETED ENROLLMENT	ACTUAL ENROLLMENT	BUDGET VS. ACTUAL ENROLLMENT	GROWTH RATE BUDGETED	GROWTH RATE ACTUAL
July	29,723	29,728	-5	-9.13%	-0.57%
August	29,699	29,969	-270	-0.08%	0.81%
September	29,851	30,204	-353	0.51%	0.78%
October	29,686	29,919	-233	-0.55%	-0.94%
November	29,757	30,184	-427	0.24%	0.89%
December	30,005	29,456	549	0.83%	-2.41%
January	30,213	29,178	1,035	0.69%	-0.94%
February	30,459	28,896	1,563	0.81%	-0.97%
March	30,572	28,751	1,821	0.37%	-0.50%
April	30,974	28,158	2,816	1.31%	-2.06%
May	31,128	27,625	3,503	0.50%	-1.89%
June	31,306	26,832	4,474	0.57%	-2.87%
Monthly Average	30,281	29,075	Annual Growth Rate	-4.45%	-2.54%

SFY 2009	BUDGETED ENROLLMENT	ACTUAL ENROLLMENT	BUDGET VS. ACTUAL ENROLLMENT	GROWTH RATE BUDGETED	GROWTH RATE ACTUAL
July	26,593	25,998	595	-15.05%	3.11%
August	26,357	25,889	468	-0.89%	-0.42%
September	25,032	24,881	151	-5.03%	-3.89%
October	25,000	24,140	860	-0.13%	-2.98%
November	25,000	23,893	1,107	0.00%	-1.02%
December	25,000	23,356	1,644	0.00%	-2.25%
January	25,000	22,888	2,112	0.00%	-2.00%
February	25,000	22,525	2,475	0.00%	-1.59%
March	25,000	22,527	2,473	0.00%	0.01%
April	25,000	22,437	2,563	0.00%	-0.40%
May	25,000	22,562	2,438	0.00%	0.56%
June	25,000	22,444	2,555	0.00%	-0.52%
Monthly Average	25,248	23,628	Annual Growth Rate	-16.62%	-18.73%

SFY 2010	BUDGETED ENROLLMENT	ACTUAL ENROLLMENT	BUDGET VS. ACTUAL ENROLLMENT	GROWTH RATE BUDGETED	GROWTH RATE ACTUAL
July	25,998	22,101	-3,897	3.99%	1.53%
August	25,889	21,999	-3,890	-0.42%	-0.46%
September	24,881	21,576	-3,305	-3.89%	-1.92%
October	24,140	21,534	-2,606	-2.98%	-0.19%
November	23,893	21,823	-2,070	-1.02%	1.34%
December	22,737	21,515	-1,222	-4.84%	-1.41%
January	22,888	21,623	-1,265	0.66%	0.50%
February	22,525	21,858	-667	-1.59%	1.09%
March	22,527	22,125	-402	0.01%	1.22%
April	22,640	21,537	-1,103	0.50%	-2.66%
May	22,753	21,612	-1,141	0.50%	0.35%
June	22,867	21,255	-1,612	0.50%	-1.65%
Monthly Average	23,645	21,713	Annual Growth Rate	-8.57%	-5.33%

SFY 2011	BUDGETED ENROLLMENT	ACTUAL ENROLLMENT	BUDGET VS. ACTUAL ENROLLMENT	GROWTH RATE BUDGETED	GROWTH RATE ACTUAL
July	22,737	21469	-1,268	-0.57%	1.01%
August	22,937	21430	-1,507	0.88%	-0.18%
September	23,187	20898	-2,289	1.09%	-2.48%
October	23,487	21146	-2,341	1.29%	1.19%
November	23,837	21299	-2,538	1.49%	0.72%
December	24,237	21002	-3,235	1.68%	-1.39%
January	24,687	21201	-3,486	1.86%	0.95%
February	25,187	21188	-3,999	2.03%	-0.06%
March	25,737	20951			
April	26,337	21368			
May	26,987	21228			
June	27,677	21139			
Monthly Average	25,753		Annual Growth Rate		

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)) (42 CFR 457.750)

10.1.1. The progress made in reducing the number of uninsured low-income children and other factors requested as part of the Annual Report template provided by CMS.

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

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

10.3-D Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the state to the Human Resources and Services Administration for posting on the Insure Kids Now! website. Nevada met the August 4, 2009 deadline for posting of both the dental package and dental provider information. The provider list updates will be sent the first of the month following a quarter.

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 states' 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)) (42 CFR 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)) (42 CFR 457.935 (b))

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 (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

Eligibility and Enrollment Matters

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

Enrollees and applicants are informed of program eligibility requirements at the time of application and re-enrollment. In addition, they are assured of and informed about timely processing of application requirements. They are informed of their right to request a review for the following adverse actions:

- Denial of eligibility;
- Failure to make a timely determination of eligibility;
- Suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.

Enrollees and applicants are provided a written notice of decision explaining any adverse actions regarding eligibility and enrollment and have the right to request a review, followed by a state fair hearing, regarding such action. In addition, they have the right to request services continue pending the outcome of the review and hearing process. The agency will continue services if the enrollee requests a review and/or hearing in writing within 10 days of the notice date.

A review and/or hearing will not be granted if the sole issue is a change in the State Plan, federal or state law, requiring automatic change in eligibility, or a change in the health benefits package that affects all applicants or enrollees, or a group of applicants or enrollees without regard to their individual circumstances.

The applicant or enrollee may be granted an opportunity for a review and a fair hearing, if a written request for such is submitted within 30 days after the date of the notice of the decision. The review is conducted by a Reviewing Officer (RO) who is the Chief of Medicaid and Nevada Check Up Services or his/her designee. The RO must be an impartial party who has not been involved in the investigation or initial determination of the adverse action in question. The RO sets the review in a timely manner, based on the need for a standard review, or submitted justification from the health plan or physician for an expedited review. Enrollees or applicants may represent themselves or have a representative(s) of their choosing participate in the review process, which may be conducted in person or by telephone. Enrollees have the right to review their files and other applicable information relevant to the review of the decision.

The RO prepares a written decision based on documentation in the case file and any supporting documentation or statements provided during the review process. The RO then provides the written decision in a timely manner as per the standard or expedited review mandates.

The written decision includes the date of the review, the findings of fact, any conclusions of law, the decision whether to affirm the adverse action, and the enrollee's or applicant's right to request a state fair hearing pursuant to state statute.

If the applicant requests a hearing, the request for hearing is referred to the DHCFP Hearings and Policy Unit, which will notify the Department of Administration (DOA) to schedule the fair hearing. In providing a fair hearing through DOA, the conduct of such is pursuant to Medicaid Services Manual Chapter 3100.

Health Services Matters

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

Participants are assured of their opportunity for an external review of the following adverse actions:

- Delay, denial, reduction, suspension or termination of a health services, in whole or in part, including a determination about the type or level of services; and
- Failure to approve, furnish, or provide payment for health services in a timely manner.

Participants are provided a written notice of decision explaining any adverse actions regarding health services matters and have the right to specifically request an external review, followed by a state fair hearing, regarding such action. In addition, they have the right to have services continue pending the outcome of the review and/or hearing.

A review and/or hearing will not be granted if the sole issue is a change in the State Plan, federal or state law requiring automatic change in eligibility, or a change in the health benefits package that affects all applicants or enrollees, or a group of applicants or participants without regard to their individual circumstances.

The applicant or participant may be granted an opportunity for a review and a fair hearing if a written request for such is submitted within 30 days after the date of the notice of the decision. The review is conducted by a Reviewing Officer (RO) who is the Chief of Medicaid and Nevada Check Up Services or his/her designee. The RO must be an impartial party who has not been involved in the investigation or initial determination of the adverse action in question. The RO sets the review in a timely manner, based on the need for a standard review or submitted justification from the health plan or physician for an expedited review. Participants may represent themselves or have a representative(s) of their choosing participate in the review process, which may be conducted in person or by telephone. Participants have the right to review their files and other applicable information relevant to the review of the decision. If the participant requests an external review, the request for review is forwarded to the Hearings and Policy Unit and is scheduled in a timely manner by the unit supervisor or his/her designee.

The RO, or Hearings Supervisor, prepares a written decision based on documentation in the case file and any supporting documentation or statements provided during the review process. The RO, or Hearings Supervisor, then provides the written decision in a timely manner in accordance with the standard or expedited review mandates. The written decision includes the date of the review, the findings of fact, any conclusions of law, the decision whether to affirm the adverse action, and the enrollee's right to request a state fair hearing pursuant to state statute.

The request for hearing is referred to the DHCFP Hearings Unit, which will notify the Department of Administration (DOA) to schedule the hearing requested. In providing a fair hearing through DOA, the conduct of such a hearing is pursuant to Medicaid Services Manual Chapter 3100.

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.**

Not applicable.