

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

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

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

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

1.1.3. A combination of both of the above.

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

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

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

Effective date: June 9, 2006
Implementation date: January 1, 2007

State Plan Amendment #3 (Dental and vision services)
Effective date: October 1, 2007
Implementation date: January 1, 2008

State Plan Amendment #4 (Striking dental services for pregnant women)
Effective Date: November 8, 2007
Implementation Date: January 1, 2008

State Plan Amendment #5 (Revising upper income limit, clarifying coverage of unborn children and updating enrollment processes)
Effective Date: January 23, 2008
Implementation Date: February 8, 2008 (unborn children), March 1, 2008 (upper income limit)

State Plan Amendment #6 (Previously submitted on May 22, 2009 and withdrawn on August 17, 2009.)

Effective Date:

Implementation Date:

State Plan Amendment #7 (Enrollment cap – specified time frame

Effective Date: November 30, 2009

Implementation Date: December 1, 2009 through February 28, 2010

State Plan Amendment #8 (Enhanced dental benefits; prospective payment system; alternative managed care delivery system; citizenship documentation/Social Security Administration; external quality review)

Effective Date: July 1, 2010

Implementation Dates: July 1, 2010 (external quality review); July 1, 2010 (prospective payment system); July 1, 2010 (dental benefit enhancements); September 1, 2010 (managed care delivery system); September 1, 2010 (citizenship documentation/Social Security Administration)

State Plan Amendment #9 (Change method of delivery system from full-risk arrangement to fee-for-service/administrative service only arrangement; phase out alternative delivery system concurrent with the change from managed care to FFS/ASO)

Effective Date: January 1, 2012

Implementation Date: January 1, 2012

State Plan Amendment #10 (Network change from commercial network with commercial rates to TennCare Select Medicaid network with Medicaid rates; SCHIP budget; updated Attachment B Dental Procedure Codes)

Effective Date: October 1, 2013

Implementation Date: October 1, 2013

State Plan Amendment #11 (Submitted June 19, 2014 under a cover letter date June 18, 2014 and withdrawn September 2, 2014)

Effective Date:

Implementation Date:

State Plan Amendment TN 15-0012 (Updated Section 6.2 and Attachment A regarding covered benefits and copays and deleted Attachment B)

Effective Date: September 15, 2014

Implementation Date: September 15, 2014

State Plan Amendment TN 16-0014 (Clarification to Sections 4.3 and 4.4)

Effective Date: July 1, 2015

Implementation Date: July 1, 2015

State Plan Amendment TN 16-0015 (Updated information about covered benefits and copays)

Effective Date: April 1, 2016
Implementation Date: April 1, 2016

State Plan Amendment TN 18-0016 (Updated copays and compliance with MHPAEA)

Effective Date: October 2, 2017
Implementation Date: October 2, 2017

State Plan Amendment 20-0017 (Disaster-related flexibilities)

Effective Date: January 27, 2020
Implementation Date: In the event of a disaster, the State will notify CMS of its intent to provide temporary adjustments to the policies described in Sections 4.3 and 8.2 of this State Plan.

State Plan Amendment 20-0018 (Documenting coverage of behavioral health services)

Effective Date: October 24, 2019
Implementation Date: October 24, 2019

State Plan Amendment 21-0019 (Transition to managed care)

Effective Date: January 1, 2021
Implementation Date: January 1, 2021

Superseding Pages of MAGI CHIP State Plan Material

State: Tennessee

| Transmittal Number | SPA Group | PDF # | Description | Superseded Plan Section(s) |
|--|----------------------------|--------------|--|--|
| TN-14-0006 Effective/Implementation Date: January 1, 2014 | MAGI Eligibility & Methods | CS7 | Eligibility – Targeted Low Income Children | Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 |
| | | CS9 | Eligibility – Coverage From Conception to Birth | Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 |
| | | CS15 | MAGI-Based Income Methodologies | Incorporate within a separate subsection under section 4.3 |
| TN-14-0010 Effective/Implementation Date: January 1, 2014 | XXI Medicaid Expansion | CS3 | Eligibility for Medicaid Expansion Program | Incorporate within a separate subsection under section 4 |
| TN-14-0007 Effective/Implementation Date: January 1, 2014 | Establish 2101(f) Group | CS14 | Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards | Incorporate within a separate subsection under section 4.1 |
| TN-14-0008 Effective/Implementation Date: January 1, 2014 (Pending RAI) | Eligibility Process | CS24 | Single, Streamlined Application Screen and Enroll Process Renewals | Pending RAI |

| Transmittal Number | SPA Group | PDF # | Description | Superseded Plan Section(s) |
|---|---------------------------|--------------|--|---|
| TN-14-0009 Effective/Implementation Date: January 1, 2014 | Non-Financial Eligibility | CS17 | Non-Financial Eligibility – Residency | Supersedes the current section 4.1.5 |
| | | CS18 | Non-Financial – Citizenship | Incorporate within a separate subsection under section 4.1 |
| | | CS19 | Non-Financial – Social Security Number | Incorporate within a separate subsection under section 4.1.9 |
| | | CS20 | Substitution of Coverage | Supersedes the current section 4.4.4 |
| | | CS27 | Continuous Eligibility | Supersedes the current section 4.1.8 |
| TN-16-0013 Effective/Implementation Date: January 1, 2016 | | CS10 | Children With Access to Public Employee Coverage | Supersedes the current information on dependents of public employees in sections 4.1.7; 4.4.1 |

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

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

There are currently about 1.5 million children under age 19 residing in Tennessee. Approximately 56 percent of these children are covered through employer-sponsored insurance (ESI), 5 percent have individual coverage, 27 percent have Medicaid, 2 percent have other public coverage (such as CHAMPUS or Medicare), and 11 percent or just over 157,000 children are uninsured. As in most other states, ESI has slowly eroded over the last few years. Between 2000 and 2004 the number of children with ESI declined by more than 18,500 or 1.1 percentage point. Over the same period, the number of uninsured children grew by almost 45,000. Approximately 81,500 of these uninsured children are under 100 percent of the FPL and, therefore, are potentially Medicaid-eligible. Therefore, it is estimated that the target population for the CoverKids program is about 75,000 children whose family income is too high to qualify for TennCare.

(Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the March 2004 and 2005 Current Population Survey (CPS): Annual Social and Economic Supplements)

Over 80 percent of the population in Tennessee is white and 16.5 percent is African American. Hispanics comprise only about 2.2 percent of the population but this number is expected to double by 2010. Asians account for about 1.3 percent of the population. Geographically, about two-thirds of the African American population resides in Shelby (50 percent) and Davidson (16 percent) counties and Hispanics are primarily concentrated in 8 counties in the central part of the state. Only 4.8 percent of the population speaks a language other than English at home. No information is currently available regarding the uninsured population by age, race, ethnicity or geographic location from a Tennessee-specific survey. (Source: Tennessee Department of Health, "Populations of Color in Tennessee: Health Status Report," August 2006)

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

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

Tennessee's only public child health insurance program is TennCare which is administered by the Bureau of TennCare and covers Medicaid eligible children, as well as children eligible under Medicaid section 1115 demonstration authority. Eligibility levels for children in TennCare Medicaid are: infants to 185 percent of the FPL, ages 1 through 5 to 133 percent of the FPL, and ages 6 through 18 to 100 percent of the FPL. There are currently over 596,000 children enrolled in TennCare Medicaid. TennCare Standard, as described later in more detail, covers the demonstration population and is closed to new enrollment. Current enrollment in TennCare Standard is about 29,400 children.

Tennessee has moved aggressively to identify and enroll uninsured children who are eligible to participate in TennCare. For the first year of the TennCare program (1994), enrollment was open to individuals in an Uninsured eligibility category, which included children and adults at any income level who did not have access to health insurance through an employer. There also was an Uninsurable category, which was open to children and adults at any income level who had been turned down for health insurance due to a medical condition. There was massive publicity about the new program. The State retained a marketing firm to assist in the preparation of videos, television and radio spots and other materials to encourage people to enroll. A large TennCare Information Line was established to help people with questions and local health departments conducted major enrollment efforts in their communities. Providers such as community hospitals also worked to assist people enrolling in TennCare.

The success of these efforts is shown by the fact that the Uninsured category had to be closed at the end of December 1994 because the State was nearing its cap on the number of people who could be enrolled in TennCare. (The Uninsured category remained open to two distinct groups: people losing Medicaid eligibility and people losing access to COBRA coverage. Individuals in both groups had to lack access to health insurance through an employer or family member, and they had to apply within specified timeframes after losing coverage.) Although the Uninsured category was closed, enrollment of Medicaid eligibles and Uninsurables continued without interruption.

On April 1, 1997, the TennCare Uninsured category was re-opened for children under age 18 who lacked access to health insurance through an employer or family member. Local health departments were key players in conducting outreach for the program. Health Department staff distributed flyers, posters, signs and report card inserts to WIC and Head

Start programs, Offices of the Department of Human Services (DHS), Legal Aid Offices, churches, schools, day care and family resource centers, after-school programs, health fairs, hospital emergency rooms, children's museums, county hospital carnivals, the circus, fast food/grocery/variety stores used by low-income families, child advocacy groups, minority health coalitions, physicians offices, factories, companies not offering health coverage, and bank drive-in windows. Contests were held among clerks at local health departments to see who could enroll the most children. Presentations were made at universities and neighborhood associations, and print and broadcast media were used as well. Local health department personnel personally contacted families who had applied for coverage for uninsured children after the Uninsured category was closed in December 1994 and told them about this new opportunity to enroll their children.

In January 1998, the Uninsured category was expanded to include children under age 19 without access to health insurance. In addition, an open enrollment period was held for children under age 19 whose families had access to health insurance. Uninsured children with access to health insurance could enroll in TennCare only if their family incomes did not exceed 200 percent of the federal poverty level (FPL).

In September 1999, Tennessee received approval from CMS for a title XXI plan to provide expanded Medicaid eligibility to children born before October 1, 1983 who are under age 19 with family income at or below 100 percent of the Federal Poverty Level (FPL) and who could not have enrolled in TennCare prior to April 1, 1997 because enrollment was closed to them. The effective date for the plan was October 1, 1997. The outreach efforts described earlier included this target group. The title XXI plan provided coverage to children until October 1, 2002 when the (federally-mandated) phase-in to regular Medicaid for all children under age 19 with family income to 100 percent of the FPL was completed.

In July 2002, TennCare was revamped with the intention of dividing it into three programs: one for Medicaid eligibles (TennCare Medicaid), one for demonstration eligibles (TennCare Standard), and one for low-income persons who need help purchasing available insurance (TennCare Assist: this program has not been implemented). While enrollment continued uninterrupted in TennCare Medicaid, both the Uninsured and Uninsurable eligibility categories in TennCare Standard were closed to new enrollment except for certain "grandfathered" and "rollover" groups. The grandfathered group includes: 1) children under 200 percent FPL who lack access to insurance *and* were enrolled as of June 30, 2002; 2) children who are uninsurable ("medically eligible") at any income level *and* were enrolled as of June 30, 2002; and 3) children under 200 percent FPL with access to insurance who were enrolled in the Uninsured category as of December 31, 2001. Children

must be continuously eligible to be in the grandfathered group. The rollover group includes children under age 19 enrolled in TennCare Medicaid who are losing Medicaid coverage *and* are either: 1) a child who lacks access to insurance and has family income below 200 percent of the FPL, or 2) a child who is uninsurable (“medically eligible”) at any income level. The medically eligible category replaces the Uninsurable eligibility category and is determined through a medical underwriting process.

In June 2006, Governor Phil Bredesen signed legislation creating a multifaceted program called Cover Tennessee that is designed to provide health insurance to many of the State’s uninsured residents. Cover Tennessee includes a program that offers basic health insurance for the working poor, a high risk pool for those with pre-existing medical conditions, and CoverKids – a Title XXI program for children. CoverKids will be administered by the Division of Health Care Finance & Administration (HCFA). It is a separate child health program that will cover children in families with gross income to 250 percent of the FPL. In addition, families with gross income above 250 percent of the FPL will be able to purchase coverage for their children in CoverKids for the full premium cost. Tennessee is not requesting Federal matching payments for the portion of the program which covers families with income above 250 percent of the FPL.

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

There are no health insurance programs that involve a public-private partnership in the State of Tennessee.

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

The CoverKids program has been working with TennCare to assure coordination of coverage. The 95 county-level Department of Human Services offices that determine eligibility for TennCare will play a role in outreach to the target population, as many children who are not eligible for TennCare may be eligible for CoverKids. Local offices will include information with all *DHS (Medicaid)* denial letters that informs families that CoverKids is another option for health care coverage for their children. DHS will also send files listing the children denied Medicaid eligibility to the CoverKids *Administrative Contractor (AC)* for follow-up. Children who are eligible for TennCare Medicaid and

TennCare Standard are not eligible for CoverKids. In addition, TennCare includes information with all TennCare termination letters that informs families that CoverKids is another option for health care coverage for their children. Eligibility systems for CoverKids have been developed to screen for potential Medicaid eligibility and a process has been established to refer children to the appropriate program. (See Section 4 for further information.)

CoverKids will also build on many of the previous efforts to reach eligible children. Through outreach, CoverKids will collaborate and coordinate appropriate communications and resources with ongoing programs and efforts such as local health departments, WIC, Maternal and Child Health Block Grant, Head Start, and children's hospitals. CoverKids will also engage the efforts of private sector partners for no cost or low cost avenues for publicizing the program in local communities statewide. These efforts include working with providers across the state to outreach to their patients who need the program and to solicit their input on effective operation of the program. (See Section 5 for a more complete description of outreach efforts.)

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

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

3.1. 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.

N/A

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))

N/A

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.

Outpatient prescription drugs are carved out of managed care and provided to members on a FFS basis by the state's pharmacy plan administrator.

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

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

Managed care organization (MCO) (42 CFR 457.10)

Capitation payment

Describe population served: All separate CHIP enrollees receive their medical services from managed care organizations reimbursed on a capitated basis.

Prepaid inpatient health plan (PIHP) (42 CFR 457.10)

Capitation payment

Other (please explain)

Describe population served:

Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)

Capitation payment

Other (please explain)

Describe population served:

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

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

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

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

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

3.1.3 Nonemergency Medical Transportation PAHPs

- 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))

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 remittances but not a dental PAHP, please include this information.

N/A

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))

3.4.2.5 **Enrollee Requests for Disenrollment.**

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

Yes

No

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

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

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

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

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

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

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to

enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

- 3.5.2** The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))
- 3.5.3** The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.
- 3.5.4** The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:
- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
 - Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))
- 3.5.5** If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:
- The format is readily accessible;
 - The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
 - The information is provided in an electronic form which can be electronically retained and printed;
 - The information is consistent with the content and language requirements in 42 CFR 438.10; and
 - The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.
- 3.5.6** The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:
- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
 - Making oral interpretation available in all languages and written translation available in each prevalent non-English language;

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

3.5.7 ☒

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

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

- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

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

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

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

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

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
 - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
 - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
 - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the

service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;

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

- 3.5.11** ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))
- 3.5.12** ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).
- 3.5.13** ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directories as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))
- 3.5.14** ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:
- Which medications are covered (both generic and name brand); and
 - What tier each medication is on.
- 3.5.15** ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c)).
- 3.5.16** ☒ The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.
- 3.5.17** ☒ The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))
- 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

- 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))
- 3.6.4** The State assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)
- 3.6.5** The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:
- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
 - Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
 - Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b))
- 3.6.6** The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))

3.6.7 ☒ The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))

3.6.8 ☒ The State assures that each MCO, PIHP, and PAHP ensures that providers, in furnishing services to enrollees, provide timely access to care and services, including by:

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

3.6.9 ☒ The State assures that each MCO, PIHP, and PAHP has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care. (42 CFR 457.1230(b), cross-referencing to 42 CFR 438.207)

3.6.10 ☒ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

- Offers an appropriate range of preventative, primary care and

specialty services; and

- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

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

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

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

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

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

3.6.14 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue

medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))

3.6.15 The State assures that it has a transition of care policy that meets the requirements of 438.62(b)(1) and requires that each contracted MCO, PIHP, and PAHP implements the policy. (42 CFR 457.1216, cross-referencing to 42 CFR 438.62)

3.6.16 The State assures that each MCO, PIHP, and PAHP has implemented procedures to deliver care to and coordinate services for all enrollees in accordance with 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208, including:

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to 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))

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))
- 3.7.2** The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:
- ☒ Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));
 - ☒ MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));
 - ☒ MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting

within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));

- If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and
- MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3

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

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

3.7.4

The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of

providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

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

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

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

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

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

3.8 Beneficiary Protections

3.8.1 The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))

3.8.2 The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its

contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))

- 3.8.3** The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:
- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))
 - Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
 - Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

- 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

- 3.9.5** The State assures that the external medical review is:
- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
 - Independent of both the State and MCO, PIHP, or PAHP;

- Offered without any cost to the enrollee; and
 - Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))
- 3.9.6** The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))
- 3.9.7** The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))
- 3.9.8** The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))
- 3.9.9** The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.
- 3.9.10** The State assures that the notice of an adverse benefit determination explains:
- The adverse benefit determination.
 - The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
 - The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
 - The procedures for exercising the rights specified above under this assurance.
 - The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))
- 3.9.11** The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))

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

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

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

Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

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

- 3.9.19** ☒ The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))
- 3.9.20** ☒ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))
- 3.9.21** ☒ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:
- The results of the resolution process and the date it was completed; and
 - For appeals not resolved wholly in favor of the enrollees:
 - The right to request a State review, and how to do so.
 - The right to request and receive benefits while the hearing is pending, and how to make the request.
 - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))
- 3.9.22** ☒ For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))
- 3.9.23** ☒ The State assures that if it offers an external medical review:
- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
 - The review is independent of both the State and MCO, PIHP, or PAHP; and
 - The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))
- 3.9.24** ☒ The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))

- 3.9.25** ☒ The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:
- The right to file grievances and appeals;
 - The requirements and timeframes for filing a grievance or appeal;
 - The availability of assistance in the filing process;
 - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
 - The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)
- 3.9.26** ☒ The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)
- 3.9.27** ☒ The State assures that if the MCO, PIHP, or PAHP, or the State review officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO, PIHP, or PAHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. (42 CFR 457.1260, cross-referencing to 42 CFR 438.424(a))

3.10 Program Integrity

- 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

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

3.12.1 Quality Strategy

- 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

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))

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))

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

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

- 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

- 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))

3.12.5 Quality Review

- 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

- 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))

- 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

- 3.12.5.3.1** The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))
- 3.12.5.3.2** The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).
- 3.12.5.3.3** The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:
- The EQRO has sufficient information to use in performing the review;
 - The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;
 - For each EQR-related activity (mandatory or optional),

- the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
- The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))

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

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

consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and

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

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

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

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

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

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

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

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

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

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

4.1.1. Geographic area served by the Plan: See SPA pages CS7 and CS9 for geographic area served by the State Plan.

4.1.2. Age: See SPA pages CS7 and CS9 for age requirements.

4.1.3. Income: See SPA pages CS7 and CS9 for income requirements.

4.1.4. Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. Residency (so long as residency requirement is not based on length of time in state): See SPA page CS17 for residency requirements.

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

4.1.7. Access to or coverage under other health coverage: Comprehensive employer-based coverage or other creditable health insurance will preclude enrollment in CoverKids.

For unborn children, this means that the mother is either uninsured, or her coverage does not include prenatal or maternity care.

4.1.8. Duration of eligibility: CoverKids provides 12 months of eligibility.

CoverKids provides continuous eligibility as described by SPA page CS27.

CoverKids may review, redetermine, and extend eligibility for an enrollee during the 12-month coverage period if doing so would align the enrollee’s future redetermination dates with those of

other household members. However, CoverKids will not shorten the eligibility period as a result of such a review.

4.1.9. Other standards (identify and describe):

When determining eligibility for the unborn child category, the unborn child or children are counted as if born and living with the mother in determining household size for the unborn child. An unborn child does not count toward the household size of other children in the household.

Excluded Children: The following individuals are not eligible for CoverKids.

- Children who appear to be eligible for Medicaid (even if not enrolled in Medicaid). This includes children who are eligible for TennCare Standard as uninsured or medically eligible.
- Children who are inmates of a penal facility or residents of an institution for mental diseases.
- Children who are covered under a group health plan or other creditable health insurance coverage.

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

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

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

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

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

The state's eligibility and enrollment processes operate in a manner consistent with the requirements of 42 CFR 457, subpart C. These processes are applied at the time of initial application and at redetermination, and ensure that eligible targeted low-income children are identified and appropriately enrolled in CoverKids.

The state's contracted managed care organizations (MCOs) and dental benefits manager (DBM) mail identification cards and member handbooks to enrollees upon receipt of enrollment information (via the 834 process).

Redeterminations of eligibility occur once every 12 months. As noted in Section 4.1.8, CoverKids may review, redetermine, and extend eligibility for an enrollee during the 12-month continuous eligibility period if doing so would align the enrollee's future redetermination dates with those of other household members; however, CoverKids will never shorten the eligibility period as a result of such a review.

Disaster-related Flexibilities

- At State discretion, requirements related to timely processing of applications may be temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area.
- At State discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area.
- At State discretion, the State may temporarily delay acting on certain changes in circumstances affecting CHIP eligibility for CHIP beneficiaries (other than the required changes in circumstances described at 42 CFR 457.342(a)) who reside and/or work in a State or Federally declared disaster area.

In the event of a disaster, the State will notify CMS of its intent to provide temporary adjustments to its policies as described above.

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

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

4.4. Describe the procedures that assure that:

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

For applications processed by the state for unborn children and newborns, Tennessee ensures that applicants who appear to be eligible for Medicaid are enrolled in Medicaid, and that eligible targeted low-income children are appropriately enrolled in CoverKids. These screening processes are used both at the time of initial eligibility determinations and at redetermination.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially

eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

When an applicant (or enrollee subject to redetermination) appears to be eligible for TennCare, the applicant is enrolled in TennCare.

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

When a TennCare applicant (or enrollee subject to redetermination) is determined ineligible for TennCare, the individual is enrolled in CoverKids, as appropriate.

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

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

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

See SPA page CS20 for substitution of coverage requirements.

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 American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

The State of Tennessee assures the provision of child health assistance to targeted low-income children in the State who are American Indians and Alaska Natives (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)). Enrollees identified as being an American Indian and Alaska Natives will not be charged copayments.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

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

The State's marketing and outreach efforts will be comprised of two components: (1) coordinated marketing outreach in conjunction with other Cover Tennessee initiatives through use of demographically targeted media campaigns and existing information dissemination channels and (2) outreach through partner programs, agencies, and organizations that have contact with families likely to have children eligible for CoverKids.

1) Coordinated Marketing Outreach

Collateral pieces such as brochures, posters and other materials will serve as tools for CoverKids outreach for widespread dissemination. These materials are used by communities to reach the target audience. The available information will include an application form for return mailing. All materials will direct readers to a toll free number for further information or questions. In addition, the state will do a kick-off, press event in one or more media markets. HCFA also will maintain a website with current information regarding the CoverKids program for access by the general public.

2) Outreach through Partner Programs, Agencies, and Organizations

CoverKids will work with a number of partners including schools and day care centers, other government programs, community service organizations, health care providers, professional associations, businesses, and faith-based organizations to publicize the program and encourage enrollment.

Schools: Schools and day care programs will be an important avenue for outreach to families. A contact person at each public school will be responsible for distributing brochures and applications to students. School nurses, Head Start programs, day care providers, private schools and home school organizations will also be provided with information about CoverKids to give to students and families.

Since 2007, CoverKids has partnered with the Tennessee Department of Education to distribute program information and enrollment instructions to every public school student in the state. Now in its fourth year, this campaign has resulted in the enrollment of approximately over 10,000 children and represents the program's strongest and most successful partnership.

Other Government Programs: State and local agencies will also distribute CoverKids brochures and applications. The Department of Human Services (which is responsible for TennCare eligibility, Child Care, Child Support, disability determination, TANF, Food Stamp, Home Energy Assistance, and Vocational Rehabilitation) has a central office in Nashville and offices in all 95 counties in the state. The Tennessee Health Department also has local offices in each county. Tennessee Early Intervention Services within the Department of Education (which serves children with special needs from birth through age 3) has service coordinators throughout the state. Each of these programs will be provided with information and application materials for the CoverKids program. Unemployment and Department of Motor Vehicles offices, WIC programs, public housing, homeless shelters, community centers, employment and training centers, recreation centers, and libraries are other locations for distribution of brochures and other information. CoverKids will also coordinate closely with TennCare to assure applicants to either program are referred to the appropriate program in a timely, efficient manner. (See section 4.4 for a complete description.) The CoverKids program will also work with the Tennessee Office of Minority Health and multicultural service agencies in local communities to reach diverse ethnic groups.

Providers: CoverKids will work with providers such as hospitals, community health centers, clinics, and physician groups to publicize CoverKids with brochures, newsletter articles, and education sessions. Major hospital systems and hospitals in Tennessee include Baptist Memorial, Methodist Healthcare, Mountain States Health Alliance, Wellmont Health Systems, West Tennessee Healthcare System, University of Tennessee Medical Center, St. Jude Children's Research Hospital, and Metro Nashville General Hospital. CoverKids will work with these and other Tennessee hospitals, clinics, and physician groups (especially pediatricians) to outreach to families.

Community Organizations and Businesses: CoverKids will be contacting community service, civic, and professional organizations to establish partnerships. These organizations include YMCAs, Chambers of Commerce, Kiwanis and Rotary clubs, and Junior Leagues. Businesses such as department and grocery stores, pharmacies, fast food chains, and insurance agents will also be asked to help distribute information through activities such as displaying posters and placing the CoverKids logo and toll-free phone number on bags, fast food tray liners, etc. Local faith-based organizations (e.g., synagogues, churches, mosques, temples) will also be involved in outreach.

To date, CoverKids has received a remarkable level of support from community and provider organizations interested in assisting with outreach and enrollment. At this point, CoverKids plans to make an array of tools available for groups interested in doing outreach and enrollment and to encourage programs with an affiliation to the state to utilize these tools. As

necessary, the state at a later date may decide to offer a more extensive grant or incentive program to encourage enrollment assistance from community organizations.

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

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state’s Medicaid plan, and continue on to Section 7.

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

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

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

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

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

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

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

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

6.1.4.1. Coverage the same as Medicaid State plan

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

- 6.1.4.3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage

Benefits under the CoverKids program were initially established using the benefits for the 2006 HMO option of the State Employee Health Plan as a benchmark. The CoverKids benefits package provides benchmark coverage plus additional benefits. CoverKids benefits are described below. The annual number of visits for outpatient mental health/ substance abuse and PT/OT/SP was increased from 45 to 52 per year per condition. Beginning in January 2008, the benefit package was modified to also include vision services. Beginning in July 2008, the benefit package included dental services. Beginning April 2009, outpatient and inpatient mental health/ substance abuse limits were removed pursuant to Section 502 of Children's Health Insurance Program Reauthorization Act of 2009.

CoverKids has more generous dental benefits than the State employee plan. The State will furnish CMS with a copy of the Dental Benefits Manager contract listing all covered dental codes at any time that contract is amended.

As of July 1, 2010, the six hundred dollar (\$600) dental benefit limit rose to one thousand (\$1,000). The program also added orthodontia benefits to members. A member must be enrolled in the program for twelve (12) months after the implementation date to obtain orthodontic benefits. The Orthodontia Lifetime Maximum Limit shall not exceed \$1,250 and is not part of \$1,000 annual benefit limit.

- 6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage
- 6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than

benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. Other (Describe)

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

- 6.2.1. Inpatient services (Section 2110(a)(1))
- 6.2.2. Outpatient services (Section 2110(a)(2))
- 6.2.3. Physician services (Section 2110(a)(3))
- 6.2.4. Surgical services (Section 2110(a)(4))
- 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. Prescription drugs (Section 2110(a)(6))
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. 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))

Hearing aids limited to one per ear per year up to age 5; limited to one per ear every two years thereafter.
- 6.2.11. Disposable medical supplies (Section 2110(a)(13))
- 6.2.12. Home and community-based health care services (See instructions) (Section 2110(a)(14))
 - Home Health Services with prior approval. Limited to 125 visits per enrollee per year.

- 6.2.13. Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.14. 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 consistent with the Hyde Amendment (Section 2110(a)(16))
- 6.2.15. Dental services (Section 2110(a)(17))

Dental Benefits will include preventive, diagnostic, restorative, endodontic, periodontic, implant, oral surgery, orthodontic, and adjunctive general services as follows:

- Diagnostic services
 - 2 oral examinations per year
- Preventive
 - Topical fluoride treatments (1 year of age and older) or fluoride varnish not to exceed twice a year up to age 14
 - Dental sealants for permanent molars – one per tooth per lifetime
 - 2 cleanings per year
 - Silver Diamine Fluoride – 4 applications per tooth per lifetime
- Emergency Services
 - 2 visits during office hours per year
 - 2 visits after office hours per year
- Restorative services
- Oral Surgery Services
- Radiographs
 - Bitewing x-rays once per year, 2 years of age and older
 - Full mouth x-rays once every three years
- Endodontic Services
- Periodontal Services
- Prosthetic Services
- Adjunctive General Services
- Orthodontic Services
 - Lifetime orthodontic maximum limit shall not exceed \$1,250 and is not subject to \$1,000 annual benefit limit.

The maximum annual benefit shall not exceed \$1,000 per child per year, except services as noted in Attachment B may be provided without counting toward the \$1,000 annual benefit limit.

Services specifically excluded from coverage are listed in Attachment C.

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

- 6.2.17. Care coordination services (Section 2110(a)(21))
- 6.2.18. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

Limited to 52 visits per year per type of therapy.

- 6.2.19. Hospice care (Section 2110(a)(23))
- 6.2.20. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

Vision Care which includes the following:

- Annual vision exam (including refractive exam and glaucoma testing)
- Prescription eyeglass lenses including bifocal or trifocal, fitting and dispensing fee (once every 12 months - \$ 85 maximum)
- Eyeglass frames (including routine replacement once every 24 months - \$100 maximum).
- Prescription contact lenses in lieu of eyeglasses (once every 12 months - \$150 maximum)

Approved optical services, supplies, and solutions must be obtained from licensed or certified ophthalmologists, optometrists, or optical dispensing laboratories participating with CoverKids. Prior approval is required for any other services or visual aids deemed to be necessary by recommendation of the provider.

- 6.2.21. Premiums for private health care insurance coverage (Section 2110(a)(25))

- 6.2.22. Medical transportation (Section 2110(a)(26))

Ambulance Service – Air and Ground: When medically necessary.

- 6.2.23. Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))

- 6.2.24. Any other health care services or items specified by the Secretary and not included under this section (Section

2110(a)(28))

In addition to the services indicated above, the CoverKids benefit package will also include:

- Emergency Care
- Chiropractic Care: Maintenance visits not covered when no additional progress is apparent or expected to occur.
- Routine Health Assessments and Immunizations in accordance with AAP and ACIP recommendations.
- Skilled Nursing Facility Services. Limited to 100 days per calendar year following an approved hospitalization.

Mothers of eligible unborn children who are over age 19 receive all benefits available under the CoverKids program, except for chiropractic services, routine dental services, and vision services.

6.2- BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

6.2.1-BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

- State-developed schedule
- American Academy of Pediatrics/ Bright Futures
- Other Nationally recognized periodicity schedule (please specify:)
- Other (please describe:)

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

6.3.1-BH Behavioral health screenings and assessments. (Section

2103(c)(6)(A))

6.3.1.1-BH The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

6.3.1.2-BH The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

The State utilizes the AAP/Bright Futures guidelines, which include a “toolkit” with a series of age appropriate tools that include screenings and assessments for alcohol and drug use, emotional security and self-esteem as well as developmental, behavioral, psychosocial, screening, and assessment forms. None of these tools are mandated and the American Academy of Pediatrics and Bright Futures do not recommend one tool over another. The MCOs will make access to these tools (screening and assessment) available. The MCOs are tasked with educating providers on the screening tool requirements as well as care coordination and service referrals if member needs cannot fully be met by the attending provider.

6.3.2-BH Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

6.3.2.1- BH Psychosocial treatment

Provided for:

Mental Health

Substance Use Disorder

Psychosocial treatment is a community-based treatment that promotes recovery, community integration, and improved quality of life for members who have been diagnosed with a behavioral health condition that significantly impairs their ability to lead meaningful lives.

Psychosocial treatment is covered as medically necessary (no limits).

6.3.2.2-BH Tobacco cessation

Provided for:

Substance Use Disorder

Tobacco cessation consists of counseling and products

intended to help members discontinue the use of tobacco products, including all indicated FDA-approved medications and nicotine replacement therapy (smoking deterrents).

Tobacco cessation is covered as medically necessary (no limits).

6.3.2.3-BH Medication Assisted Treatment

Provided for:

Substance Use Disorder

6.3.2.3.1-BH Opioid Use Disorder

6.3.2.3.2-BH Alcohol Use Disorder

6.3.2.3.3-BH Other

Medication assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, for treatment of substance use disorders. Covered MAT medications include naltrexone, buprenorphine, and methadone.

Medication assisted treatment is covered as medically necessary (no limits).

6.3.2.4-BH Peer Support

Provided for:

Mental Health

Substance Use Disorder

6.3.2.5-BH Caregiver Support

Provided for:

Mental Health

Substance Use Disorder

6.3.2.6-BH Respite Care

Provided for:

Mental Health

Substance Use Disorder

6.3.2.7-BH Intensive in-home services

Provided for:

Mental Health

Substance Use Disorder

Intensive in-home services provide frequent and comprehensive support to individuals with a focus on recovery and resilience. Intensive in-home services are provided through a team approach which includes a therapist and care coordinator who work under the direct clinical supervision of a licensed behavioral health professional.

Intensive in-home services are covered as medically necessary (no limits).

6.3.2.8-BH Intensive outpatient

Provided for:

- Mental Health
- Substance Use Disorder

Intensive outpatient services are outpatient treatment services consisting of meetings, classes, and/or counseling for treatment of behavioral health conditions multiple times per week. Intensive outpatient programs provide a minimum of three hours per day of treatment, two to five days per week.

Intensive outpatient services are covered as medically necessary (no limits).

6.3.2.9-BH Psychosocial rehabilitation

Provided for:

- Mental Health
- Substance Use Disorder

6.3.3-BH Day Treatment

Provided for:

- Mental Health
- Substance Use Disorder

6.3.3.1-BH Partial Hospitalization

Provided for:

- Mental Health
- Substance Use Disorder

Partial hospitalization is short-term, intensive treatment for the diagnosis or active treatment of serious behavioral health conditions. Partial hospitalization services include physician services. Partial hospitalization programming typically occurs five to seven days per week for five or more hours

per day.

Partial hospitalization is covered as medically necessary (no limits).

6.3.4-BH Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))

Provided for:

- Mental Health
- Substance Use Disorder

Inpatient services are services delivered by a provider or institution at a 24-hour facility, including those at an inpatient hospital or residential setting.

Inpatient services are covered as medically necessary (no limits).

6.3.4.1-BH Residential Treatment

Provided for:

- Mental Health
- Substance Use Disorder

Residential treatment services include development of an individualized treatment plan, evaluation for medications and prescribing of medications, daily therapeutic activities including group therapy, recreational therapy, individual and family counseling, and grade-appropriate school.

Residential treatment is covered as medically necessary (no limits).

6.3.4.2-BH Detoxification

Provided for:

- Substance Use Disorder

Detoxification consists of admission into a hospital, residential treatment facility, or outpatient program where the member receives a clinically appropriate detoxification from drugs and/or alcohol.

Detoxification is covered as medically necessary (no limits).

6.3.5-BH Emergency services

Provided for:

- Mental Health
- Substance Use Disorder

Services needed to evaluate or stabilize an emergency medical condition.

Emergency services are covered as medically necessary (no limits).

6.3.5.1-BH Crisis Intervention and Stabilization

Provided for:

- Mental Health
- Substance Use Disorder

6.3.6- BH Continuing care services

Provided for:

- Mental Health
- Substance Use Disorder

6.3.7-BH Care Coordination

Provided for:

- Mental Health
- Substance Use Disorder

6.3.7.1-BH Intensive wraparound

Provided for:

- Mental Health
- Substance Use Disorder

6.3.7.2-BH Care transition services

Provided for:

- Mental Health
- Substance Use Disorder

6.3.8-BH Case Management

Provided for:

- Mental Health
- Substance Use Disorder

6.3.9- BH Other: Applied behavioral analysis (ABA)

Provided for:

- Mental Health
- Substance Use Disorder

ABA is a widely used strategy for addressing behavior problems among individuals with certain disorders, which considers antecedents (environmental factors that appear to trigger unwanted behavior), the behaviors themselves, and consequences that either increase or decrease future occurrences of that behavior.

ABA is covered as medically necessary (no limits).

6.4- BH Assessment Tools

6.4.1-BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

- ASAM Criteria (American Society Addiction Medicine)
 - Mental Health
 - Substance Use Disorders

- InterQual
 - Mental Health
 - Substance Use Disorders

- MCG Care Guidelines
 - Mental Health
 - Substance Use Disorders

- CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
 - Mental Health
 - Substance Use Disorders

- CASII (Child and Adolescent Service Intensity Instrument)
 - Mental Health
 - Substance Use Disorders

- CANS (Child and Adolescent Needs and Strengths)
 - Mental Health
 - Substance Use Disorders

- State-specific criteria (e.g. state law or policies) (please describe)
 - Mental Health
 - Substance Use Disorders

- Plan-specific criteria (please describe)
 - Mental Health
 - Substance Use Disorders

The state's plan administrator develops medical policies to supplement MCG guidelines for specific treatment modalities or care not sufficiently addressed by MCG.

- Other (please describe)
 - Mental Health
 - Substance Use Disorders
- No specific criteria or tools are required
 - Mental Health
 - Substance Use Disorders

6.4.2-BH Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

The State utilizes the AAP/Bright Futures guidelines, which include a "toolkit" with a series of age appropriate tools that include screenings and assessments for alcohol and drug use, emotional security and self-esteem as well as developmental, behavioral, psychosocial, screening, and assessment forms. None of these tools are mandated and the American Academy of Pediatrics and Bright Futures do not recommend one tool over another. The MCOs will make access to these tools (screening and assessment) available. The MCOs are tasked with educating providers on the screening tool requirements as well as care coordination and service referrals if member needs cannot fully be met by the attending provider.

6.2.5-BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

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

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

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.

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))

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.

Tennessee classifies covered benefits according to the following standards:

| Classification | Description |
|--------------------|---|
| Inpatient | All covered services delivered by a provider or institution at a 24-hour facility, including those at an inpatient hospital, residential, and/or SNF setting with a corresponding place of service code |
| Outpatient | All covered services delivered at an outpatient office, clinic, or community setting with a corresponding place of service code |
| Emergency | All covered services or items delivered in an emergency department with a corresponding place of service code |
| Prescription Drugs | Covered medications and drugs requiring a prescription |

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).

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.

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

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

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.

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

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.

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.

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

6.2.5.1-MHPAEA. Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

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))

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

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))

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.

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

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.

6.2.7-MHPAEA. The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1-MHPAEA. Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

State

Managed Care entities

Both

Other: The Administrative Services Organization (ASO) contracted with the state.

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: The Administrative Services Organization (ASO) contracted with the state.

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

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

6.3.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the

extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

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

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

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

Effective January 1, 2012, concurrent with the change from a full-risk (Preferred Provider Organization) to a Fee-for-Service/Administrative Service Only (FFS/ASO) model, CoverKids will no longer provide an Alternative Delivery System to children and pregnant women.

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

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

2105(c)(2)(B)(iii) (42CFR 457.1005(a))

- 6.4.2. Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)
- 6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))
- 6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))
- 6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

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

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

CoverKids will use the expertise of an independent evaluation contractor in the assessment of the CoverKids program. Quality and appropriateness of care will be assessed through the use of enrollee surveys, review of claims data, and medical record review. Both process and outcome measures will be considered when assessing the quality and appropriateness of care. Among the items to be used in tracking are claims data indicators such as whether children have a usual source of care, whether children are receiving the recommended well-child exams and are appropriately immunized; whether non-trauma based emergency room use is going down, how referrals are being made, whether specialty care and related services are being received, and patterns of prescription drug use. CoverKids plans to monitor consumer and provider satisfaction through surveys and informal communications with families, advocacy groups, and providers. In addition to these monitoring strategies, the State assures access to care through monitoring of the geographic distribution of providers.

Effective January 1, 2010, CoverKids has engaged an External Quality Review Organization (EQRO) to conduct a range of quality assurance activities. However, this step has been taken to promote quality outcomes in the program in general and not specifically in relation to oversight of a Managed Care Organization (MCO) as required in CHIPRA because CoverKids does not use an MCO model.

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

7.1.1. Quality standards

7.1.2. Performance measurement

The State ensures quality through contracted performance measures.

7.1.3. Information strategies

The contracted insurer will be required to provide key health indicators information.

7.1.4. Quality improvement strategies

The contracted insurer will be required to maintain an effective quality improvement program.

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

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

CoverKids member handbooks will explain the importance of, and recommended timing for well-child care visits and immunizations. Access is monitored through a number of methods including periodic review of the number and types of providers by county, review of claims data, review of enrollee survey data, feedback from families via telephone, e-mail, and postal service mail, and feedback from providers.

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

The health plan is required to maintain an adequate provider network that includes emergency room services. In addition, PCPs who participate in the health plan are required to have identified after hour patient access to address medical questions and concerns. Access to emergency services will be monitored through periodic review of the number and types of providers by county, review of claims data, review of enrollee survey data, feedback from families and feedback from providers.

The geographic access standard for children's primary care practitioners (pediatricians, general medicine and family practice physicians), at a minimum, will be a physician within 30 miles in rural area and 20 miles in urban area. The standard for acute care hospitals will be at least 1 facility within 30 miles. The standard for specialists assures that enrollees will, at a minimum, have access to a children's hospital where they may access specialty care. The CoverKids program will meet all geographic access standards for children's coverage within the new TennCare Select network.

One aspect of the initial measure of network adequacy in the procurement of a plan administrator and network is the distribution and absence of plan participants. The state will employ a proxy, the distribution of children in households with incomes below the federal

poverty level, in executing the GeoAccess analysis.

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

The health plan is required to maintain an adequate provider network including specialists. Access to specialty services will be monitored through periodic review of the number and types of providers by county, review of claims data, review of enrollee survey data, feedback from families and feedback from providers. In the rare instance that the provider network is not adequate to meet a member's needs, the member will be referred out-of-network to obtain medically necessary services.

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

The health plan will be required to have policies in place to assure that prior authorizations of health services are completed within 14 days.

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? (42CFR 457.505)

8.1.1. YES

8.1.2. NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge 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: None

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments: Children will be subject to copayments for most services provided under the plan; however, no copayments will be charged for well-child visits, immunizations, or lab and x-ray services. There is also no copayment for ambulance services when deemed medically necessary by the health plan. For children in families with income at or below 200 percent of the FPL, co-payments will not exceed \$5.00, except the copayment for non-emergency use of the emergency room will be \$10. Copayments for children in families with income above 200 percent of the FPL will vary by service. Children receiving hospice services and pregnant enrollees are exempt from all copay requirements. Attachment A details the copayments for each income group.

At State discretion, cost sharing may be temporarily waived for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or Federally declared disaster area. In the event of a disaster, the State will notify CMS of its intent to provide temporary adjustments to cost sharing policies.

8.2.4. Other: None

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

Families of applicants and enrollees, providers, and the public will be informed of the cost-sharing requirements (including the cumulative maximum) in the CoverKids application and enrollment materials. Copayments are listed in the benefits booklet. Outreach workers and administrative staff who answer phone inquiries are trained to discuss with families the co-payments required and the annual out-of-pocket limit. The CoverKids eligibility and enrollment AC will notify the health plan of the families' annual income within the enrollment eligibility file. The health plan will determine the dollar amount of their out-of-pocket limit based on 5% of their annual income and include this information in the enrollees Explanation of Benefit correspondence. The health plan will electronically accumulate the money spent (including dental services) for cost sharing for eligible children in a family and notify the family via a letter when the dollar amount is met. The health plan's electronic claims system will annotate the child's file to notify providers that no further cost sharing is required.

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

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

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

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

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

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

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

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

Yes (Specify)

The State applies financial requirements (copays) to mental health and SUD benefits in the inpatient and outpatient benefit classifications.

No

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

Yes

No

8.4.6-MHPAEA. Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

8.4.7-MHPAEA. For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds (“substantially all”) of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

8.4.8-MHPAEA. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

The same reasonable methodology applied in determining the dollar

amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

- 8.5.** Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

Very few families are likely to exceed the 5 percent limit on out-of-pocket expenses because of the CoverKids copayment structure. For example, a single parent with one child (two person family) at 101 percent of the FPL (\$13,332 annually) would have an annual out-of-pocket maximum of \$667. This family could have a total of 134 doctor visits and prescriptions before reaching the limit on out-of-pocket expenses. A child in family of two at 151 percent of FPL (\$19,932 annually) could have 66 physician office visits before reaching the out-of-pocket maximum of \$996.

Families will be informed in all literature and outreach workers will be trained to educate families about the limit on out-of-pocket expenses. Upon enrollment in CoverKids, families will receive notification of the dollar amount of their out-of-pocket limit based on 5% of their annual income. The 5 percent annual cost sharing limit will be calculated by the CoverKids health plan at the receipt of enrollment information from the eligibility and enrollment AC. The health plan's accuracy in calculating the limit will be monitored by the State as a part of the audits it will conduct to verify the accuracy of the health plan's determinations. The health plan will also notify the family of the limit to the amount of copayments. The health plan will electronically accumulate the money spent on cost sharing for eligible child(ren) in a family and notify the family via a letter when the dollar amount is met. The health plan's electronic claims system will annotate the child's file to notify providers that no further cost sharing is required. In case of error caused by filing delays, families may request a manual review of their receipts and families will be reimbursed should computer notification fail to work. The health plan will be asked to submit reports to the State identifying families who have met their annual out-of-pocket limit.

- 8.6.** Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

The brochure explaining application and enrollment procedures will state that there is no cost sharing for American Indian/Alaska native children. If the family indicates on the application form that a child is American Indian or Alaskan Native, but does not provide tribal membership documents, a letter will be sent by the AC requesting this information when the child is determined otherwise eligible. Upon receipt of proof of federally recognized tribe status, the AC will notify the health plan to flag the child's electronic account to notify providers that copayments are not required. The health plan will be responsible to reimburse the family for any co-payments that may have been made prior to notification of exempt status.

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

A family who does not pay a required copayment remains enrolled in the program. An individual provider may at his discretion refuse service for non-payment of a copayment. The state does not participate in collection action or impose any benefit limitations if enrollees do not pay copayments.

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

The CoverKids Program does not disenroll anyone under the current system for non-payment of copayments. If the State makes changes in the program that would permit disenrollment we would make sure that:

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

(42CFR 457.570(c))

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

- 8.8.1. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2. No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)
- 8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above).
(Section 2105)(c)(7)(A)) (42CFR 457.475)

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

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

Strategic Objective 1: Increase health insurance coverage for targeted low-income children in Tennessee.

Strategic Objective 2: Improve the CoverKids eligibility, enrollment, and renewal process.

Strategic Objective 3: Increase access to health care services for targeted low-income children as a result of enrollment in CoverKids.

Strategic Objective 4: Improve health outcomes through appropriate utilization of health care resources for targeted low-income children through CoverKids.

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

Strategic Objective 1: Increase health insurance coverage for targeted low-income children in Tennessee.

Performance Goals:

- 1A. Reduce the percentage of low-income uninsured children in the state.

Measure: American Community Survey percentage of low-income (below 200% FPL) Tennessee children who are uninsured.

Strategic Objective 2: Improve the CoverKids eligibility, enrollment, and renewal process.

Performance Goals:

- 2A. Increase self-service portal functionality and usage for CoverKids applications, renewals, and case maintenance to ensure ease of the application process and to keep renewal churn low,

Measure: Percentage of online applications for eventual CoverKids approvals.

Measure: Percentage of CoverKids enrollees whose eligibility can be renewed through automated processes.

- 2B. Provide online tools to healthcare providers to assist potential CoverKids applicants and enrollees in the application, renewal, and case maintenance processes.

Measure: Number of active healthcare providers using the TennCare Access provider portal.

Measure: Number of CoverKids application approvals or eligibility renewals resulting from TennCare Access usage by providers.

Strategic Objective 3: Increase access to health care services for targeted low-income children as a result of enrollment in CoverKids.

Performance Goals:

3A. Maintain or reduce the incidence of Emergency Room usage.

Measures (AMB): Utilization of ambulatory care via Emergency Department (ED) Visits per 1,000 member months. Age breakouts include: <1, 1-9, and 10-19.

3B. Continue to track Comprehensive Diabetes Care HbA1c testing for members under 18.

Measure (CDC): HbA1c test performed during the measurement year, as identified by claim/encounter or automated laboratory data.

3C. Maintain or increase asthma medication ratio for children with Asthma.

Measure (AMR): Members with persistent asthma who have a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Age breakouts include: 5-11, 12-18.

Strategic Objective 4: Increase the use of preventative care for targeted low-income children.

Performance Goals:

4A. Increase the percentage of children and adolescents that receive age-appropriate immunizations.

Measures (CIS): For MMR, hepatitis B, VZV, and hepatitis A, count any of the following:

Evidence of the antigen or combination vaccine, or Documented history of the illness, or A seropositive test result for each antigen.

For DTap, IPV, HiB, pneumococcal conjugate, rotavirus, and influenza, count only: Evidence of the antigen or combination vaccine.

For combination vaccinations that require more than one antigen (i.e., DTap and MMR), the organization must find evidence of all the antigens.

Measure (IMA): Percentage of adolescents who turn 13 years of age during the measurement year, count any of the following:

For meningococcal, Tdap, and HPV count only evidence of the antigen or combination vaccine.

For meningococcal: at least on meningococcal serogroups A, C, W, Y vaccine between the members 11th and 13th birthdays.

For Tdap: at least one tetanus, diphtheria toxoids and acellular pertussis vaccine between the members 10th and 13th birthdays.

For HPV: at least two HPV vaccines at least 146 days apart between members 9th and 13th birthdays.

- 4B. Increase the percentage of children and adolescents who have the recommended well-child or well-care visits.

Measures (WCV): For ages 3-11, 12-17, and 18-21: Percent of children and adolescents who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner.

Measure (W30): Members who had the following number of well-child visits with a PCP during the last 15 months:

Visits in the first 15 months: Children who turned 15 months old during the measurement year: Six or more well-child visits

Visits for age 15 months – 30 months: Children who turned 30 months old during the measurement year: Two or more well-child visits

- 9.3.** Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:

(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

- The strategic objectives and accompanying performance goals have been initiated based on the desire of Tennessee to plan, implement and administer a successful SCHIP program. The CoverKids program will contract with an External Quality Review Organization (EQRO) to assist with evaluation of the performance goals and strategic objectives. The EQRO's responsibilities will include establishing baseline levels and collecting and analyzing data for each goal.

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

- 9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. The reduction in the percentage of uninsured children.
- 9.3.3. The increase in the percentage of children with a usual source of care.
- 9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. Other child appropriate measurement set. List or describe the set used.
- 9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
 - 9.3.7.1. Immunizations
 - 9.3.7.2. Well childcare
 - 9.3.7.3. Adolescent well visits
 - 9.3.7.4. Satisfaction with care
 - 9.3.7.5. Mental health
 - 9.3.7.6. Dental care
 - 9.3.7.7. Other, please list:
- 9.3.8. Performance measures for special targeted populations.
- 9.4.** The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)
- 9.5.** The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

CoverKids will comply with the annual assessment by submitting a report, utilizing the Framework for Annual Evaluation developed by the National Academy for State Health Policy in conjunction with state SCHIP staff and CMS on an annual basis. This report will be completed by CoverKids staff with the assistance of our EQRO. The EQRO will be responsible for evaluating the CoverKids strategic objectives and goals described in sections 9.1 and 9.2 and will provide data and analysis for the preparation of annual reports. The annual

report will be submitted to the Secretary by January 1 following the end of the federal fiscal year.

- 9.6.** The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)
- 9.7.** The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))
- 9.8.** The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)
- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1132 (relating to periods within which claims must be filed)
- 9.9.** Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Benefits Administration and CoverKids program representatives have held a number of meetings during the summer of 2006 to inform the public and provider groups about plans for CoverKids and obtain input on program design. The meetings took place in various locations throughout the state to facilitate participation of a wide range of groups, including four children's hospitals and representatives from a number of advocacy groups. The following meetings have been held:

- Vanderbilt Children's Hospital - CEO, administrators, and hospitalists - 7/20
- Nashville area community pediatric providers - 7/20
- T.C. Thompson Children's Hospital (Chattanooga) - CEO, administrators, and hospitalists - 7/25
- Chattanooga area community pediatric providers - 7/25
- East Tennessee Children's Hospital (Knoxville) - CEO, administrators, and hospitalists - 7/26

- Knoxville area community pediatric providers - 7/26
- LeBonheur Children's Hospital (Memphis) - CEO, administrators, and hospitalists - 7/28
- Memphis area community pediatric providers - 7/28
- Governor's Office of Children's Care Coordination Steering Committee (advocacy groups) - 8/5
- TN Commission on Children and Youth - convening of children's advocacy groups - 8/25

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

There are no recognized Indian Tribes within the State of Tennessee; however, CoverKids is coordinating with the Tennessee Director of Indian Affairs to assure that Native American families residing within the state are informed of the CoverKids program and aware that there is no cost sharing for eligible Native American/Alaska Native children. (See also section 8.6.)

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

Eligibility, benefits and cost sharing were discussed during the public meetings described above and public input was considered in the design of this plan. Brochures and informational materials developed for the program will include descriptions of eligibility, benefits and cost sharing.

Public notice of the change in eligibility rules (Amendment #7) was provided by publishing Emergency Public Necessity Rules in accordance with State law. The Emergency Public Necessity Rules were published on October 12, 2009.

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

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

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

CHIP Budget

| STATE: Tennessee Federal Fiscal Year 2021 | Current Budget | With SPA 21-0019 |
|--|--------------------|--------------------|
| State's enhanced FMAP rate | 76.27% | 76.27% |
| Benefit Costs | | |
| Insurance payments | 8,757,679 | 8,757,679 |
| Managed care | 54,000,000 | 280,118,263 |
| Fee for Service | 272,418,397 | 46,300,134 |
| Total Benefit Costs | 335,176,076 | 335,176,076 |
| (Offsetting beneficiary cost sharing payments) | (2,025,023) | (2,025,023) |
| Net Benefit Costs | 333,151,053 | 333,151,053 |
| Administration Costs | | |
| Personnel | 0 | 0 |
| General administration | 42,000 | 42,000 |
| Contractors/Brokers (e.g., enrollment contractors) | 1,542,277 | 3,848,000 |
| Administrative Services | 1,631,849 | 1,819,365 |
| Outreach/marketing costs | 15,000 | 15,000 |
| Other (e.g., indirect costs) | - | - |
| Health Services Initiatives | - | - |
| Total Administration Costs | 3,231,126 | 5,724,365 |
| 10% Administrative Cap | 37,016,784 | 37,016,784 |
| Federal Title XXI Share | 256,558,688 | 258,460,281 |
| State Share | 79,823,491 | 80,415,137 |
| Total Costs of Approved CHIP Plan | 336,382,179 | 338,875,418 |

The Source of State Share Funds: The State share funds come from revenue generated by the State and are appropriated through the budgeting process. None of the State share of the funds are provided by the enrollees.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12.1. Eligibility and Enrollment Matters

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

Upon denial of eligibility (including suspension or termination of enrollment), a parent will be notified by mail of the reason for the denial and the process to notify CoverKids if the parent believes the denial is in error. Parents may also request a review for situations in which eligibility determination have not been made in a timely manner. Parents will first be directed to call the eligibility and enrollment AC's toll-free number and report additional information or clarify information on the applicant's account. The AC will document the call and any additional information/clarification provided. The family may also file a request for review in writing. The information or clarification will be input into the AC eligibility system and a review of eligibility will be initiated. AC eligibility staff may request senior management input into this decision. If the information provided does not result in the child being eligible, the parent will be notified of the reason the denial was upheld. If the parent disagrees with the denial, the notification letter will inform the parent that they may submit a formal request in writing to Benefits Administration, to be reviewed by the state-level CoverKids Eligibility Appeals Committee.

The member will have 30 days from the issuance of the letter to submit a request for a formal appeal. Receipts of requests for review will be acknowledged in writing within 10 days, including notification that that member will receive a decision within one calendar month. The Eligibility Appeals Committee is the impartial entity that reviews eligibility and enrollment matters and is composed of five Benefits Administration staff. The Committee will meet weekly to review requests for reconsiderations of denials. (This schedule may be altered depending on the volume of requests for review.) If the Committee disagrees with the decision of the AC, the child will be enrolled in CoverKids. If the Committee agrees with the decision to deny eligibility, a letter will be sent to the parent detailing the reason for denial. The decision of the Eligibility Appeals Committee will be the final recourse available to the member. If at any level of dispute, the appropriate party determines the child is eligible for enrollment in CoverKids, the enrollment will become effective retroactive to the first day of the month following the initial eligibility determination.

Reviews of general eligibility and enrollment matters will be completed within a 90-day timeframe. Expedited reviews will be completed within 10 days from the initial receipt of the request for review. The appropriate notices will be

issued within those timeframes. Notices for denials, suspension, or termination of enrollment, or failure to make a timely eligibility determination will include information on the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited timeframes for review, the manner in which review can be requested and the circumstances under which enrollment may continue pending review.

The State assures that in the review process, enrollees have the opportunity to fully participate in the review process (including representing themselves or have representatives of their choosing in the review process) and review information relevant to the review of the decision in a timely manner; decisions are made in writing; impartial reviews are conducted in a reasonable amount of time and consideration is given for the need for expedited review when there is an immediate need for health services. Enrollees will remain enrolled pending completion of the review in the case of suspension or termination of enrollment.

12.2. Health Services Matters

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

For health services matters, CoverKids will use a process that includes both internal review by the insurer and external review by Benefits Administration. The State's contract with the insurer will require the insurer to have grievance/complaint procedures for denials, delays, reductions, suspensions, or terminations in providing or paying for health services and for failure to approve, furnish or provide payment in a timely manner. These procedures must include participation by a pediatrician in the review, must be followed prior to appealing to the state, and must be completed within 30 days. Expedited reviews (within 72 hours) will be available for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional perceives the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning.

After the insurer's internal review is completed, the parent of an enrollee who disagrees with the decision may request further review by submitting a letter or form to Benefits Administration. The Appeals Coordinator within Benefits Administration will review the matter and gather supplemental information from the family, physician, and/or insurer as needed. The Appeals Coordinator may also request review by the by state's independent medical consultant. Reviews generally are completed within 16 days and the member will be notified in writing of the decision. It is anticipated that most appeals will be resolved either through the insurer's internal process or at this level.

If the appeal is not resolved, the request will be scheduled for impartial review by the CoverKids Review Committee. The Committee will meet once per month to consider any appeals and will be composed of five members, including Benefits Administration staff and at least one licensed medical professional, selected by the Commissioner or his designee. The parent will be given the opportunity to review the file, provide supplemental information and appear in person. The parent will receive written notification of the final decision, normally within one week from the date of the Committee meeting. The decision of the CoverKids Review Committee is the final recourse available to the member.

Internal and external reviews will be completed within 90 days. Reviews by both the Appeals Coordinator and the Committee may be expedited (completed within 72 hours) for situations in which a benefit determination or a preauthorization denial has been made prior to services being received and the attending medical professional perceives the medical situation to be life threatening or would seriously jeopardize the enrollee's health or ability to attain, maintain or regain maximum functioning. All required notices, including the final notice of the results from the CoverKids Review Committee, will be issued within the specified timeframes (90-days or 72 hours, as applicable). Notices for denials, delays, reductions, suspensions, or terminations in providing or paying for health services and for failures to approve, furnish or provide payment in a timely manner will include information on the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited timeframes for review, the manner in which review can be requested and the circumstances under which enrollment may continue pending review.

The State assures that in the review process, enrollees have the opportunity to fully participate in the review process (including representing themselves or have representatives of their choosing in the review process) and review information relevant to the review of the decision in a timely manner; decisions are made in writing; impartial reviews are conducted in a reasonable amount of time and consideration is given for the need for expedited review when there is an immediate need for health services.

12.3. Premium Assistance Programs

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

Attachment A – CoverKids Cost Sharing

| Benefit | Family Income Less Than 200% FPL | Family Income Between 200% and 250% FPL |
|--|--|--|
| Annual Deductible | None | |
| Preexisting Condition Requirement | None | |
| Physician Office Visit | \$5 copay (primary care physician or specialist) | \$15 copay (primary care physician); \$20 copay (specialist) |
| Inpatient Care | \$5 per admission (waived if readmitted within 48 hours for same episode) | \$100 per admission (waived if readmitted within 48 hours for same episode) |
| Prescription Drug Copay | \$1 generic; \$3 preferred brand; \$5 non-preferred brand | \$5 generic; \$20 preferred brand; \$40 non-preferred brand |
| Maternity | No copay for prenatal visits or for hospital admission for the birth of a child | No copay for prenatal visits or for hospital admission for the birth of a child |
| Routine Health Assessment and Immunizations | No copays for services rendered under American Academy of Pediatrics guidelines | |
| Emergency Room | \$10 copay per use for non-emergency | \$50 copay per use for non-emergency |
| Chiropractic Care | \$5 copay (maintenance visits not covered when no additional progress is apparent or expected to occur) | \$15 copay (maintenance visits not covered when no additional progress is apparent or expected to occur) |
| Ambulance Service (air and ground) | No copay (100% of reasonable charges when deemed medically necessary by claims administrator) | |
| Lab and X-ray | No copay - 100% benefit | |
| Physical, Speech and Occupational Therapy | \$5 copay per visit (limit of 52 visits per year per type of therapy) | \$15 copay per visit (limit of 52 visits per year per type of therapy) |
| Inpatient Mental Health Treatment | \$5 copay per admission (waived if readmitted within 48 hours for same episode) | \$100 copay per admission (waived if readmitted within 48 hours for same episode) |
| Inpatient Substance Abuse Treatment | \$5 copay per admission (waived if readmitted within 48 hours for same episode) | \$100 copay per admission (waived if readmitted within 48 hours for same episode) |
| Outpatient Mental Health and Substance Treatment | \$5 copay per session | \$15 copay per session |
| Dental | \$5 copay per visit; no copay for routine preventive oral exam, x-rays, cleaning and fluoride application) | \$15 copay per visit; no copay for routine preventive oral exam, x-rays, cleaning and fluoride application |
| <ul style="list-style-type: none"> Annual Benefit Maximum Per Child | \$1,000 | |

Attachment A – CoverKids Cost Sharing - continued

| Benefit | Family Income Less Than 200% FPL | Family Income Between 200% and 250% FPL |
|--|--|---|
| Orthodontic Services (as of July 1, 2010) <ul style="list-style-type: none"> • 12-month waiting period* | \$5 copay | \$15 copay |
| <ul style="list-style-type: none"> • Lifetime Maximum Per Child** | \$1,250 | |
| Vision Care | \$5 copay for prescription lenses and frames OR contact lenses; no copay for preventive annual exam and glaucoma testing | \$15 copay for prescription lenses and frames OR contact lenses; no copay for preventive annual exam and glaucoma testing |
| Annual Out-of-Pocket Maximums | 5% of annual family income | |

*There is a 12-month waiting period before orthodontic benefits are paid.

**The lifetime orthodontics maximum limit does not apply to the family annual out-of-pocket maximum.

Attachment B – Dental Services Not Subject to Limit

The following dental services may be provided before counting toward the annual benefit limit of \$1,000 on dental services.

| Type of Dental Service | Number of each service allowed prior to counting toward the \$1,000 benefit cap | Service by Dental Procedure |
|-------------------------------|--|---|
| Preventive | One (1) service | Child and adult prophylaxis |
| Diagnostic Services | One (1) service | Periodic and comprehensive oral evaluations |
| Emergency Services | Two (2) services | Palliative (emergency) treatment of dental pain – minor procedure and office visit – after regularly scheduled hours |
| Restorative Services | Two (2) services | One, two and three surface amalgam fillings and one and two surface anterior composite fillings |
| Extractions | Two (2) services | Erupted tooth or exposed root, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of a mucoperiosteal flap if indicated, removal of residual tooth roots (cutting procedure) |
| Radiographs | One (1) service | Intraoral – complete series, intraoral – periapicals, bitewings – one and two images |
| Anesthesia | Whenever medically necessary | Inhalation of nitrous oxide/analgesia, anxiolysis, non-intravenous conscious sedation |

Attachment C – Excluded Dental Services

Dental services excluded from coverage under CoverKids include:

| Procedure Name |
|---|
| Oral evaluation for a patient under three years of age and counseling with primary caregiver |
| Re-evaluation post-operative office visit |
| Caries risk assessment and documentation, with a finding of low risk |
| Caries risk assessment and documentation, with a finding of moderate risk |
| Caries risk assessment and documentation, with a finding of high risk |
| Nutritional counseling for control of dental disease |
| Oral hygiene instructions |
| Preventive resin restoration in a mod. to high caries risk patient perm tooth conservative rest of an active cavitated lesion in a pit or fissure that doesn't extend into dentin: includes placmt of a sealant in radiating non-carious fissure or pits. |
| Sealant repair - per tooth |
| Removal of fixed space maintainers |
| Distal shoe space maintainer - fixed - unilateral |
| Unspecified preventive procedure, by report |
| Inlay and onlay restorations |
| Prefabricated porcelain/ceramic crown – primary tooth |
| Prefabricated esthetic coated stainless steel crown - primary tooth |
| Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development |
| Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation |
| Immediate partial dentures |
| Abutment supported crowns |
| Bone graft at time of implant placement |
| Extraction, coronal remnants - primary tooth |
| Mobilization of erupted or malpositioned tooth to aid eruption |
| Surgical repositioning of teeth |
| Removal of odontogenic cysts and tumors |

| Procedure Name |
|---|
| Collection and application of autologous blood concentrate product |
| Excision of pericoronal gingiva |
| Limited orthodontic treatment of the primary dentition |
| Limited orthodontic treatment of the adolescent dentition |
| Replacement of lost or broken retainers |
| Evaluation for moderate sedation, deep sedation or general anesthesia |
| Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician |
| Therapeutic drug injection - 2 or more medications by report |
| Infiltration of sustained release therapeutic drug--single or multiple sites |
| Behavior management, by report |
| Fabrication of athletic mouthguard |
| Occlusal guard--hard appliance, partial arch |
| Enamel microabrasion |
| Internal or external bleaching |
| Teledentistry – synchronous; real-time encounter |
| Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review |