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State/Territory Name: Maryland

State Plan Amendment (SPA) #: MD-23-0001-LEAD

This file contains the following documents in the order listed:

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

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

Children and Adults Health Programs Group

August 10, 2023

Tricia Roddy
Maryland Department of Health
201 W. Preston St., 5th Floor
Baltimore, MD 21201

Dear Tricia Roddy:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number MD-23-0001-LEAD, submitted on May 16, 2023, has been approved. This SPA has an effective date of July 1, 2022.

Through SPA MD-23-0001-LEAD, the state updates its two existing CHIP Health Services Initiative (HSI) programs. For Program #1: Healthy Homes for Healthy Kids, the state adjusted income eligibility limits from a fixed dollar amount to a percentage of the Department of Housing and Urban Development's Median Family Income by county. For Program #2: Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management, the state expanded services to two additional counties, and made revisions to service definitions and program metrics. Finally, additional technical corrections were made throughout the program descriptions. The SPA also revises the operational language for these programs to be evergreen so the income standard for Program #1 will adjust automatically and Maryland may expand Program #2 to additional counties without having to submit a SPA, as well as updating the blood lead reference value to align with current Centers for Disease Control and Prevention (CDC) guidance (5ug/dL to 3.5 ug/dL).

This approval is based on section 2105(a)(l)(D)(ii) of the Social Security Act (the Act) and 42 CFR §§ 457.10 and 457.618, which authorize use of title XXI administrative funding for HSIs that improve the health of children, including targeted low-income children and other low-income children. Consistent with section 2105(c)(6)(B) of the Act and 42 CFR § 457.626, title XXI funds used to support an HSI cannot supplant Medicaid or other sources of federal funding.

The state's total title XXI administrative expenditures may not exceed 10 percent of its total annual title XXI computable expenditures. The state shall ensure that the available title XXI administrative funding is sufficient to continue the proper administration of the CHIP program. If such funds become less than sufficient, the state agrees to redirect title XXI funds from the support of this HSI to the administration of the CHIP program. The state shall report annually to CMS the expenditures funded by the HSI for each federal fiscal year.

Your Project Officer is Ticia Jones. She is available to answer your questions and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8145
E-mail: Ticia.Jones@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (443) 934-2064. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

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

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

State/Territory: _Maryland
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b)) _____ Redacted _____8/9/23_____ (Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Laura Herrera Scott	Secretary, Maryland Department of Health
Ryan Moran	Deputy Secretary, Health Care Financing and Medicaid, Maryland Department of Health
_____	
Tricia Roddy	Deputy Medicaid Director, Maryland Department of Health
Debbie Ruppert	Executive Director, Office of Eligibility Services, Health Care Financing, Maryland Department of Health

_____

Disclosure Statement This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

This template outlines the information that must be included in the state plans and the State plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan

including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment**- This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, 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. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or

through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

  Medicaid Expansion- CHIP SPA Requirements
  In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:
    - 1 (General Description)
    - 2 (General Background)

  They will also be required to complete the appropriate program sections, including:
    - 4 (Eligibility Standards and Methodology)
    - 5 (Outreach)
    - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
    - 10 (Annual Reports and Evaluations).

  Medicaid Expansion- Medicaid SPA Requirements
  States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
    - 3 (Methods of Delivery and Utilization Controls)
    - 4 (Eligibility Standards and Methodology)
    - 6 (Coverage Requirements for Children's Health Insurance)
    - 7 (Quality and Appropriateness of Care)
    - 8 (Cost Sharing and Payment)
    - 11 (Program Integrity)
    - 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate

program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

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

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

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

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

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

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

Beginning in 1998, Maryland expanded access to health insurance under the terms specified in the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act, through creation of the Maryland Children's Health Program.

Maryland implemented a Medicaid expansion, called MCHP, effective July 1, 1998, and an SCHIP separate State program called MCHP Premium, effective July 1, 2001.

Maryland modified MCHP Premium effective July 1, 2003, and MCHP, effective September 1, 2003.

Maryland modified MCHP and MCHP Premium effective July 1, 2004.

Effective January 1, 2007. MCHP Premium transitioned all enrollees from its separate program to its Medicaid expansion program. The Medicaid expansion will include children with family income above 200 percent and at or below 300 percent of the Federal poverty level. Upon approval of this amendment, and after exhaustion of title XXI funds, the state will have the option of reverting to title XIX funds for children enrolled in the Medicaid expansion. The State will be permitted to use title XIX funds to cover CHIP enrollees only at times when title XXI appropriations are not available.

MCHP

MCHP, the Medicaid expansion, implemented July 1, 1998:

- Extended Medicaid coverage (using enhanced match funds) to eligible children under age 19 who were born after September 30, 1983 in families with income too high to qualify for SOBRA, but at or below 200 percent of FPL;
- Before October 1, 1983 in families with income above 40 percent FPL, but at or below 200 percent of FPL.

MCHP Premium

MCHP Premium, the separate State program, implemented July 1, 2001:

- Expanded eligibility for the Maryland Children's Health Program to include children with family income above 200 percent but at or below 300 percent of the federal poverty level (FPL), using enhanced match funds;

- Created a family contribution requirement for families with income above 200 but at or below 300 of FPL range (two flat amounts will apply - one applies to families with income above 200, but at or below 250 percent of FPL, and one applies to families with income above 250 but at or below 300 percent of FPL);

- Established an Employer Sponsored Insurance (ESI) program to provide comprehensive coverage through employer sponsored health benefit plans that meet all requirements for Title XXI enhanced match funding.

- Provided coverage to children who cannot be served by the ESI program through a stand-alone Medicaid look-alike program that enrolls eligible children in the current HealthChoice program; and,

- Increased eligibility (using regular match funds) for pregnant and postpartum women with income at or below 250 percent of FPL.

MCHP and MCHP Premium Program Changes—July, 2003 through June, 2004

Beginning July 1, 2003, Maryland made the following adjustments to MCHP and MCHP Premium:

MCHP (the Medicaid Expansion)

- Eliminated MCHP coverage for children enrolled in the Medicaid expansion program whose family income is above 185 percent of the Federal Poverty Level (FPL) but at or below 200 percent FPL. Note: This change became effective September 1, 2003, and these children were offered coverage through MCHP Premium, the State's separate child health program.

MCHP Premium (the separate State program)

- Effective July 1, 2003, eliminated Employer-Sponsored Insurance (ESI) as an

enrollment option for MCHP Premium-eligible children. Children enrolled in ESI plans prior to July 1, 2003 were transferred to HealthChoice, the Maryland Managed Care Program, at the end of their benefit coverage period before July 1, 2004.

- Effective July 1, 2003, froze enrollment in MCHP Premium for children in families with income above 200 percent FPL but not greater than 300 percent FPL. Children enrolled before that date, as well as children who applied before that date and were determined to be eligible on or after July 1, 2003, continued coverage as long as there was no break in eligibility.

- Reduced the lower income standard for MCHP Premium from 200 percent FPL to 185 percent FPL. Children currently receiving free health care coverage whose family income places them in the 185-200 percent income group have to pay a premium to continue coverage after September 1, 2003. The premium was set at 2 percent of FPL for a family of 2 at 185 percent FPL. The premium amount will be adjusted each April, as the FPL changes.

MCHP and MCHP Premium Program Changes, effective July 1, 2004

Effective July 1, 2004, Maryland made the following changes to MCHP and MCHP Premium:

MCHP (the Medicaid Expansion Program)

- Reinstated free MCHP coverage for children whose family income is above 185 percent FPL but at or below 200 percent FPL.

MCHP Premium (the Separate State Program)

- Lifted the enrollment freeze for children in families with income greater than 200 percent FPL but not greater than 300 percent FPL.

- Raised the lower income standard for MCHP Premium from above 185 percent FPL to above 200 percent FPL.

MCHP Premium Program Changes Effective January 1, 2007: Medicaid Expansion

Effective January 1, 2007, MCHP Premium became part of the Medicaid Expansion Program, extending coverage for children under the mechanism of the state Medicaid plan to children eligible under Title XXI whose family income is greater than 200 percent but no greater than 300 percent of the federal poverty level (FPL).

MCHP and MCHP Premium

Effective in 2010, the Title XXI expansion program and the Title XIX Medicaid program adopted the CHIPRA 2009 "lawfully residing" option for women pregnant and 2 months

postpartum (Medicaid only) and for children with age under 19 (CHIP and Medicaid) and children aged 19 up to 21 (Medicaid only).

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

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

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

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

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

The State assures that it 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.

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

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

Original Plan
Effective Date: July 1, 2017

Implementation Date: July 1, 2017

SPA#MD-23-0001-LEAD

Purpose of SPA:
In this update, Maryland added new provisions related to lead poisoning and pediatric asthma Health Service Initiatives effective July 1, 2022. This submission will update existing CHIP HSI programs by making the general finance and operational language for these programs evergreen for future expansions, reporting metrics, expanding the service area to additional jurisdictions, as well as updating the blood lead reference value to align with current Centers for Disease Control and Prevention (CDC) guidance (5ug/dL to 3.5 ug/dL).

Proposed effective date: July 1, 2022

Proposed implementation date: July 1, 2022

Maryland's Modified Adjusted Gross Income (MAGI) SPA Roster

Transmittal Number	SPA Group	PDF Number	Description	Superseded Plan Section(s)
MD-14-0010 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	MAGI-equivalent standards, by age group; Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
MD-14-0011 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

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

The Department consulted with a representative from Native American LifeLines, an Urban Indian Health Program. The Department shared a redline version of the proposed CHIP HSI SPA along with a document summarizing the new benefit. Ms. Dickerson, Medical Case Manager, Appointed Committee Member on the Maryland Medicaid Advisory Committee (MMAC) of Native American Lifelines provided feedback and offered clarification on State recognized tribes in Maryland. The Department incorporated this feedback and listed the three State recognized tribes.

TN No: Approval Date Effective Date

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

1. Population
2. Number of uninsured
3. Race demographics
4. Age Demographics
5. Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified, by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

PUBLIC PROGRAMS PROVIDING HEALTH BENEFITS COVERAGE IN MARYLAND

Public programs in Maryland provide health coverage to children and adults across the State. The Maryland Medical Assistance program, which includes the Maryland Children's Health Program, provides creditable health coverage to eligible recipients and enrollees. Individuals who do not qualify for either Medicaid or the Maryland Children's Health Program may be eligible for programs funded exclusively with State funds or for Federally-funded programs (e.g., Children's Medical Services, funded under Title V of the Social Security Act.) These programs provide services that complement the Maryland Medical Assistance program or that target populations not eligible for Medical Assistance. An individual's eligibility for these public programs is generally determined by case managers at Local Departments of Social Services (LDSS) and LHDs.

Maryland Medical Assistance, MCHP and MCHP Premium

The Maryland Medical Assistance Program provides comprehensive health coverage on a statewide basis to low-income children and adults. As a result of Maryland's MCHP expansion in July 1998, eligibility for this creditable health coverage extended to eligible children under age 19 with family income at or below 200 percent of the Federal Poverty

Level (FPL). In general, these individuals have been enrolled in Maryland's Medicaid managed care program, HealthChoice.

Effective September 1, 2003 through June 30, 2004, MCHP was a Medicaid expansion program with eligibility for children in families with income at or below 185 percent FPL.
Effective July 1, 2004, the maximum qualifying income level for eligibility for MCHP returned to 200 percent FPL.

The MCHP Premium expansion, effective July 1, 2001, extended eligibility for creditable health coverage to children in families with income above 200 percent FPL but at or below 300 percent FPL. From July 1, 2001, through June 30, 2003, coverage was provided through enrollment in qualifying ESI plans or, if ESI was not available or didn't meet State qualifications, through HealthChoice, the Maryland Managed Care Program. Effective July 1, 2003, enrollment in ESI was discontinued. Effective September 1, 2003, through June 30, 2004, the base income level for MCHP Premium was reduced to 185 percent FPL.

Effective July 1, 2004, the base income level for MCHP Premium eligibility returned to 200 percent FPL.

Effective January 1, 2007. MCHP Premium transitioned all enrollees from its separate program to its Medicaid expansion program. The Medicaid expansion will include children with family income above 200 percent and at or below 300 percent of the Federal poverty level. Upon approval of this amendment, and after exhaustion of title XXI funds, the state will have the option of reverting to title XIX funds for children enrolled in the Medicaid expansion. The State will be permitted to use title XIX funds to cover CHIP enrollees only at times when title XXI appropriations are not available.

NON-MEDICAID, PUBLIC PROGRAMS

In addition to Medical Assistance and the Maryland Children's Health Program, Maryland has in place a number of alternative programs that enable children to access health care services. These include Children's Medical Services (CMS) (the Title V program for children with special health care needs), Community Health Centers (CHCs), and several local jurisdiction initiatives. While all of these programs provide vital services to low income and uninsured or underinsured individuals, they all have significant restrictions in the benefits they provide (capped funding, limited benefit packages, etc.). None of the programs described below provide creditable coverage as defined by Title XXI.

Children's Medical Services (CMS)

The Children's Medical Services (CMS) program is the Title V Program in Maryland that has traditionally assisted families in planning and obtaining specialty medical and

rehabilitative care. The program has provided for both direct and wrap-around specialty care services to eligible children with special health care needs. Program activities have concentrated on the purchase of direct care services through community providers, local health departments and academic institutions through both fee-for-service reimbursement and grants.

Prior to Maryland's MCHP expansion in July 1998, the CMS program provided specialty care services to approximately 6,500 children. Most of these children have since become eligible for the Maryland Children's Health Program and enrolled in the HealthChoice Program. As a result, the CMS program's focus is shifting from that of providing direct and wrap around services to that of systems building activities. During the transition, the program will continue to pay for direct and wrap around services for underinsured children who meet the program's eligibility criteria. At this time, CMS provides services to children who are uninsured (children 19 to 22 who have aged out of MCHP), underinsured, and undocumented, and meet the following eligibility requirements:

- Are age 22 or younger;
- Have or are at risk for disabilities, chronic illnesses, or health-related educational problems; and
- Are in families with adjusted income below 200 percent of the FPL.

WIC

Prior to the MCHP expansion, WIC participants were required to have a household income not exceeding 185 percent of the FPL. Concurrent with Maryland's MCHP expansion, the WIC program increased its income eligibility threshold to 200 percent of FPL. Besides establishing financial eligibility, WIC recipients must have an identifiable nutritional risk factor and be:

- Pregnant;
- Less than 6 months postpartum;
- Breast-feeding an infant up to one year old; or
- Less than five years of age.

In establishing eligibility only an individual's income is examined. Participants are eligible for food packages, nutritional counseling, and linkage to other health and social services. Food packages vary slightly depending on nutritional needs, but may include milk, cheese, juice, eggs, cereal, beans, peanut butter, infant formula, infant cereal, carrots and tuna fish.

Family Planning Program (Title X)

The target population for this program includes women of reproductive age (including adolescents) at risk for unintended pregnancy and poor pregnancy outcomes, although all women and men are eligible for services. Client fees are assessed according to a sliding fee scale based on ability to pay. Funding for this program is a combination of State and Title X Federal Family Planning Program funds. Enrollment is handled through local health departments, community health centers or Planned Parenthood Centers. Clients receive a broad range of preventive health services including contraceptive care, preconception care, education and counseling for all contraceptive choices and women's health issues, sexually transmitted disease diagnosis and treatment, HIV/AIDS prevention

services, breast and cervical cancer screening, cardiovascular screening and referrals for additional health and social services.

Maryland Family Planning Program (Title XIX)
Maryland also operates a limited-coverage program that provides family planning and related preventive reproductive services to women who were eligible for comprehensive Medicaid coverage during pregnancy and the two month postpartum period, but lost their SOBRA eligibility at the end of their postpartum period. The Maryland Family Planning Program was originally established under a §1115 waiver. Maryland has been granted authority to expand its current §1115 Medicaid managed care program, HealthChoice, to include providing family planning and related preventive reproductive services to this population for five years postpartum.

LOCAL JURISDICTION INITIATIVES

Prior to Maryland's MCHP expansion, a number of local jurisdictions had developed initiatives that attempted, with extremely limited resources, to provide some coverage to low income children. A measure of success of MCHP is that many of the children served by these programs have become eligible for MCHP and gained comprehensive coverage through that program. As a result, a number of these gap filling programs have disbanded. Several local programs with different missions and target populations remain active and are described below.

Carroll County Children's Fund Health and Wellness Care Program
The Carroll County Children's Fund Health and Wellness Care Program is designed to provide primary and preventive health care for children ages birth to age 18 who do not qualify for Medicaid, or any publicly funded program. It is targeted at families who are not able to afford health insurance either on their own or through their employer. Eligibility is determined at the local level through the Carroll County Health Department. The Care program includes access to primary and preventive care, limited pharmacy assistance, basic diagnostic x-ray and laboratory services. The services provided to children are delivered through a partnership with Carroll County General Hospital, New American Health, LLC, and providers who participate in the Carroll County Contract Management Organization.

Montgomery County Care for Kids Program
The Care for Kids Program serves undocumented children in Montgomery County.

Prince George's County Medical Care for Children Partnership
The Medical Care for Children Partnership (a Catholic Charities Program) serves children between 200 and 250 percent of poverty. It serves children from birth to age 18 and undocumented children.

Healthy Teens and Young Adults Initiative
The Maryland Healthy Teens and Young Adults (HTYA) Initiative was developed as a Governor's Special Initiative in 1990. Designed to reach and serve young people at risk for unintended pregnancy, the program operates in three Maryland metropolitan

jurisdictions, Baltimore City, Prince George's County, and Anne Arundel County. There are also plans to expand services within the three jurisdictions in which HTYA currently operates, as well as to expand the initiative into other jurisdictions. The target population includes males and females ages 10-24. Service sites offer a holistic approach to health care and community-based prevention services. In addition to receiving counseling about a broad range of family planning methods, attention is also given to addressing clients' general health and psychosocial well-being. Special services for men have been developed ranging from mentoring to direct clinical services.

Community Health Centers

Maryland has a number of Community Health Center sites, including Federally Qualified Health Centers (FQHC), which are comprehensive primary care providers offering care to low-income, uninsured individuals on a sliding fee scale; Maryland Qualified Health Centers (MQHC), which are non-profit health centers providing the same scope of services as an FQHC and offer discounted fees to low-income uninsured; Health Centers; and Private Practice Centers (PRIV) which offer discounted fees to low-income uninsured.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. Health Services Initiatives- Describe if the State will use the health services initiative option as allowed at **42 CFR 457.10**. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10).

Background: Program #1 and Program #2

Two of the most prevalent and significant chronic conditions for children in Maryland are lead poisoning and pediatric asthma. Importantly, both conditions are linked to the physical environment and housing in ways that provide opportunities for upstream preventive interventions. Maryland has developed a Health Services Initiative (HSI) focused on these conditions to improve population health outcomes through improved linkage of clinical care and public health environmental interventions.

Childhood lead poisoning prevention continues to be a priority for Maryland. Several hundred

new cases of childhood lead poisoning are identified each year (blood leads at or above the U.S. Centers for Disease Control and Prevention (CDC) blood lead reference value (BLRV). The state is poised to identify even more cases due to recent changes in the federal BLRV. Exposure to lead can result in major physical and neurological damage to children, leading to serious consequences for their educational attainment and health including stunted brain development, reduced intelligence quotient (IQ), hearing and speech problems, learning disabilities, anemia, hypertension, renal impairment and immunotoxicity, among a range of other conditions. In addition, children who are lead poisoned are seven times more likely to drop out of school and six times more likely to become involved in the juvenile justice system.

While Maryland has made substantial progress in reducing the number of lead poisoned children each year, lead exposure, particularly in the form of paint chips or lead-contaminated dust from deteriorated lead-painted surfaces, continues to be an environmental hazard for many children. Out of an estimated 2,399,375 occupied residential units in Maryland, 437,441 (18.2%) were built before 1950 and 923,917 (38.5%) between 1950 and 1979. While a significant number of pre-1950 and 1950 to 1979 residential rental units have been made lead free, untreated pre-1950 and 1950 to 1979 units are highly likely to have lead-based paint.[1] As a result, Maryland's children, especially low-income children who live in older housing, are particularly at risk of lead exposure. In 2020 there were an estimated 560,837 children under 6 years of age in the State of Maryland. Of these, 110,158 were tested for blood lead, and 1.1% of all children tested had an elevated blood lead level (BLL, the term used in Maryland law and regulation) ≥ 5µg/dL. In 2020, all counties experienced a drop from the previous year in the number of children tested. In looking at the children who were tested with elevated BLL ≥ 5µg/dL, Baltimore City had the highest incidence across counties, closely followed by Allegany and Cecil County.[2]

In 2012, the CDC adopted a BLRV >5 micrograms/deciliter (µg/dL).[3] Just nine years later in 2021, and based on blood lead levels in children participating in the National Health and Nutrition Examination Survey, CDC announced in an October 28, 2021 press release[4] that it was further reducing the BLRV from 5 µg/dL to 3.5 µg/dL. Maryland has advised clinicians to follow the updated CDC guidance, and under Maryland law the reduced BLRV became the definition of an elevated BLL on October 28, 2022.

Pediatric asthma is a priority for Maryland as it contributes to increased healthcare utilization and spending, missed school days, and sub-optimal overall health and well-being in Maryland children. In 2018, approximately 9.7 percent of Maryland children had asthma.[5] Moreover, children with asthma miss an additional 2.3 days of school. Asthma was responsible for greater than $73 million dollars in hospital charges (2018) for Maryland children less than 18 years old. Pediatric asthma also has a significant impact on parental productivity.

Given the prevalence of asthma, Maryland has chosen to include pediatric asthma as one of the population health goals for improvement in its Statewide Integrated Health Improvement

[1] https://mde.maryland.gov/programs/land/Documents/LeadCommission/2020%20Annual%20Report%2c%20Childhood%20Blood%20Lead%20Surveillance%20in%20Maryland%20%282%29.pdf
[2] Ibid.
[3] https://www.cdc.gov/nceh/lead/acclpp/blood_lead_levels.htm
[4] https://www.cdc.gov/media/releases/2021/p1028-blood-lead.html
[5] https://phpa.health.maryland.gov/Documents/Maryland-Asthma-Control-Program-2017-Legislative-Report.pdf

Strategy (SIHIS).[6] The SIHIS goal for pediatric asthma in Maryland is a 42% overall reduction in the rate of ED visits for children age 2 - 17 years between the 2018 baseline rate of 9.2 visits per 1,000 children per year, and the 2026 target of 5.3 ED visits per 1,000 children.

Initiative Overview: Program #1 and Program #2

Maryland uses the health services initiative (HSI) option under Section 2105(a)(2) of the Social Security Act and 42 CFR 457.10 to advance a two-pronged initiative to combat in-home lead hazards and environmental triggers of asthma:

1) Program #1: Healthy Homes for Healthy Kids: Expansion of lead identification and abatement programs for low-income children through programs delivered by DHCD; and
2) Program #2: Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management: Expansion of county-level programs to provide environmental assessment and in-home education programs with the aim of reducing the impact of lead and other environmental toxins on vulnerable low-income children. The program is delivered by environmental case managers and community health workers (CHWs) seated in LHDs and conducted in counties with the greatest need. The Maryland Department of Health (MDH) Environmental Health Bureau (EHB) administers the Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program with the Maryland Medicaid program and Maryland Department of Environment (MDE).

The HSI Program #1 and HSI Program #2 are two distinct programs. Program #1 serves eligible residents in the entire state of Maryland. Program #2 serves eleven specific counties in Maryland: Anne Arundel, Baltimore City, Baltimore County, Charles, Dorchester, Frederick, Harford, Montgomery, Prince George's, St. Mary's, and Wicomico. Anne Arundel and Montgomery County were added in July 2022.

Maryland counties that demonstrate need based on prevalence of moderate to severe asthma and/or elevated BLL are eligible to apply to participate in Program 2. They must also demonstrate their LHD's commitment to partnering to deliver home visiting services. The State uses available data from its designated Health Information Exchange and MDE's Childhood Lead Registry (CLR) to review cases from each jurisdiction. Maryland will continue to evaluate the participation of jurisdictions based on the prevalence of eligible children and the availability of state and Federal resources. Moving forward, MDH will notify CMS via email 60 days prior to beginning work in a new county.

Under both proposed programs, eligibility is limited to low-income children, who are (1) enrolled in Medicaid or MCHP *or* (2) Medicaid or MCHP eligible but not yet enrolled.

Program #1: Healthy Homes for Healthy Kids

Through an Interagency Agreement between MDH and DHCD, DHCD administers a lead identification and abatement program—HH4K. This program is built on DHCD's experience and expertise in this area. DHCD currently abates lead in an average of 110 homes in Maryland annually. Under HH4K, DHCD expanded its existing lead identification and abatement activities

[6] https://health.maryland.gov/phpa/OEHFP/EH/Pages/SIHIS.aspx

to focus on identifying lead-contaminated residential properties across Maryland where low-income children under the age of 19 reside or visit for at least 10 hours per week. The HSI programs create an opportunity to abate 70-200 *additional* homes in Maryland. Pregnant women are not eligible for the services proposed under the HSI.

Under Program #1, eligible properties include residential properties that are owner-occupied, occupied by a family member of the owner, or occupied by a tenant, as well as residential properties in the process of becoming licensed for, or currently maintaining a license for the provision of childcare services. HSI funds are not used for commercial, non-residential properties.

To qualify for services through Program #1, children must meet two primary requirements. First, they must be (1) enrolled in Medicaid or MCHP *or* (2) Medicaid or MCHP-eligible but not yet enrolled. Second, children must meet Maryland statute criteria[7] for an elevated BLL or the current CDC BLRV standard[8].

When lead is detected in the residential property occupied by the eligible child, DHCD provides lead abatement services to eligible properties reducing the overall risk of lead poisoning among low-income children in Maryland. If the lead abatement work requires for the families to vacate the premises following HUD guidelines, DHCD provides relocation support.

Program #1: Income Assessment

To the extent a child is not currently enrolled in Medicaid or CHIP, their income must be assessed. To qualify for Medicaid or CHIP, a child's household income must be at or below the adjusted income threshold of 322% of the federal poverty level (FPL).

DHCD currently utilizes the Median Family Income (MFI), set by the Department of Housing and Urban Development (HUD), to assess eligibility for its programs. The MFI is established by the HUD, and is updated on an annual basis[9]. Maryland uses the most current Closing Protection Letter and HUD MFI levels when determining eligibility. HUD computes MFIs based on available data for each metropolitan area, parts of some metropolitan areas, and each non-metropolitan county. DHCD's Research Department reviews and publishes the MFIs on a statewide basis, with adjustments for household sizes from 1 through 8 family members, organized by percent of the Median Income (i.e. 30%, 50%, 60% 80%, etc.). MFIs vary from location to location; for example, MFIs in Montgomery County, Maryland are higher than Somerset County, Maryland. Individual household income is reviewed and verified by DHCD as part of the application process for DHCD financing to ensure compliance with the Income limits established for various financing programs.

Due to resource restrictions, DHCD is unable to perform a modified adjusted gross income (MAGI) income assessment of potential program recipients. For purposes of Program #1, DHCD uses a percentage of the MFI adjusted to the CHIP income threshold of 322% FPL as the ceiling

[7] COMAR 10.11.04.02.
[8] The CHIP HSI SPA will apply whichever elevated BLL or BLRV value is the lower to eligibility criteria of these programs.
[9] https://www.huduser.gov/portal/datasets/il.html

for income eligibility. Maryland updates the MFI limit on an annual basis, based on HUD guidance. DHCD collects household size information to ensure the family is within the income limits to determine if the child is eligible to participate—e.g., does the family's income fall below the MFI ceiling for that area. Program history indicates that a small percentage of program applicants are not enrolled in Medicaid and require income verification prior to enrollment.

Specifically, under the 2016 HUD income limits[10], the median income for the rest of the state for a family of four is $90,500 and Washington, D.C. Primary Metropolitan Statistical Area (PMSA) median income limit is $109,500. In general, the MFI is higher than the income cutoffs for CHIP or Medicaid services. Therefore, DHCD verifies a child's eligibility for Program 1 by utilizing the percentage of the most current HUD MFI levels.

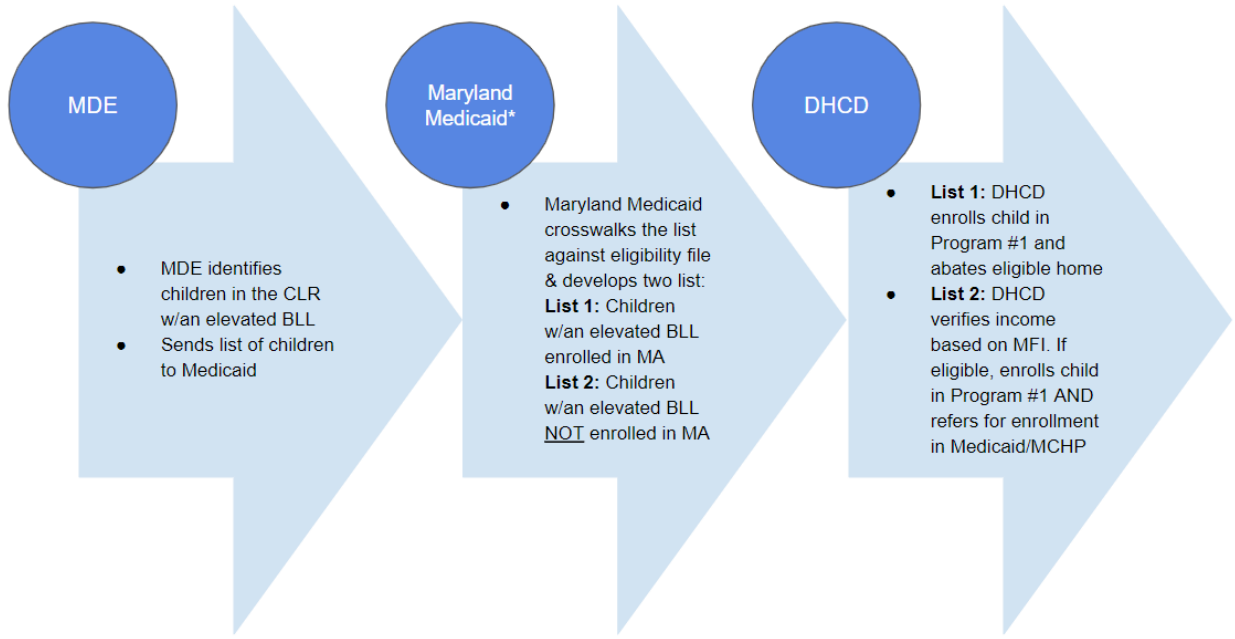
Program #1: Enrollment Strategies

Maryland uses two strategies for enrolling children in Program #1. These strategies are outlined below.

Program #1 Enrollment Strategy 1: Childhood Lead Registry

Maryland leverages MDE's CLR to enroll children in Program #1. The Statewide CLR provides state-level surveillance on BLLs in children. Children with the current CDC standard for elevated BLL, will be referred to Program #1.

Figure 1: Program #1's Overview of Enrollment using MDE's CLR Data



**The elevated BLL used in Maryland will be updated to reflect current CDC BLRV when there is a change in guidance.

[10] See Appendix A, AMI Chart with 2016 Income Limits As of June 2016.

MDE's CLR receives reports of all blood lead tests performed on Maryland children aged zero to six years. By law, a report is sent to MDE after a child receives a result from either an in-office (capillary) test or goes to a commercial laboratory for blood lead testing. If an elevated BLL exists, MDE contacts the corresponding LHD to inform them that a child in their jurisdiction has an elevated BLL, the level of that BLL, and the contact information for the child's family.

As of 2020, there were 1,171 children with elevated BLLs in the CLR. These children are categorized by:

1) a new case versus an on-going case of lead poisoning and
2) the child's BLL.

MDE is providing more LHDs with information about children with elevated BLL as Maryland transitions to testing all children in the State at ages 1 and 2 years. The previous standards mandated testing only for Medicaid-enrolled children and children living in targeted "high-risk" areas of the State. Again, elevated BLL is based on the most current CDC BLRV, although the statutory definition of elevated BBL at which MDE has authority to require landlord compliance may differ until Maryland statute is updated to comply with CDC BLRV.The aim of expanding mandatory testing for lead to encompass the whole State was to identify as many of the children affected by lead poisoning as possible. The State anticipates that the number of children and families who will be eligible to participate in Program #1 will increase in the short-term. However, based on historical trends in the areas where mandatory testing has been in place for two decades, we expect to see a reduction in the number of children with lead poisoning long-term as the housing stock is identified and abated.

Under Program #1, Maryland Medicaid utilizes CLR data from MDE. Then, Maryland Medicaid, with assistance from University of Maryland Baltimore County's Hilltop Institute, crossmatches the names and other identifying information of children with an elevated BLL, on the CLR with the Maryland Medicaid enrollment database. Medicaid provides DHCD with two lists based on the CLR data—one identifying eligible children currently enrolled in Medicaid or MCHP with an elevated BLL and a second identifying a list of children identified with an elevated BLL who are not currently enrolled in Medicaid or MCHP.

Children who are identified as already enrolled in Medicaid or MCHP are not be subject to further income verification to qualify for Program #1. Based on the list provided by Medicaid, DHCD contacts the eligible children's families and seek to enroll them in Program #1 to determine whether abatement is appropriate in the child's home.

If a child with an elevated BLL is not currently enrolled in Medicaid/MCHP, they are referred to Program #1 and their income eligibility is assessed against the adjusted MFI standard. If they meet the income eligibility requirements, they are enrolled in Program #1 and referred for assistance in applying for Medicaid/MCHP.

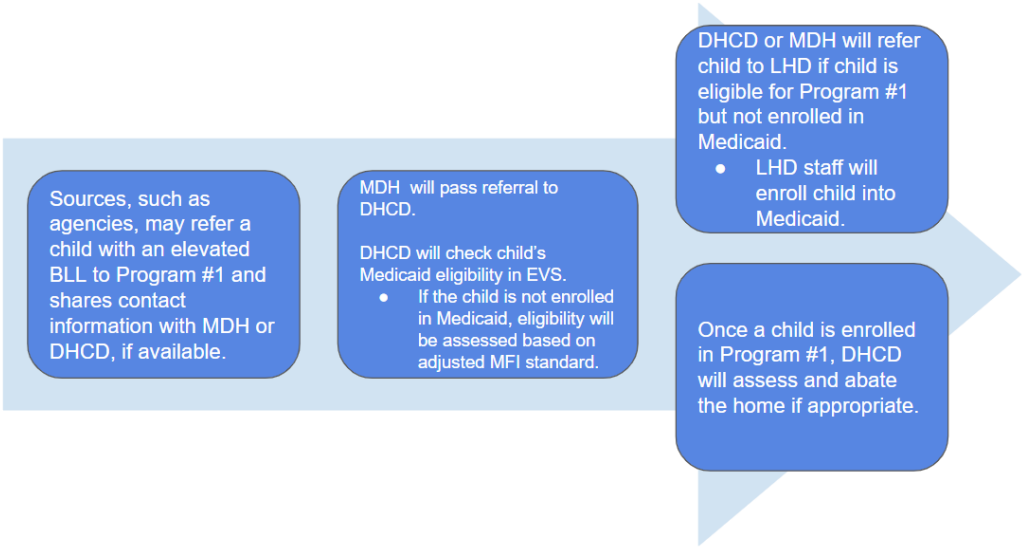
Program #1: Enrollment Strategy 2: Direct Referrals

As a second strategy for enrollment, MDH informs stakeholders about Program #1's services and participation criteria as well as details on how to refer the child to the Program. Program #1

accepts referrals from a wide variety of sources including:

- Primary care providers, specialists, other health professionals involved in the child's care
- Managed Care Organizations (MCOs)
- State and county social services agencies
- Local housing agencies
- Public health agencies (based on either direct inquiries from the public, or from health care providers following up on elevated blood lead tests;
- MDE, based on public inquiries, regulatory referrals from their enforcement unit, or notices of defect[11] from renters; and
- Requests from homeowners

Figure 2: Program #1 Enrollment Strategy Based on Referrals



MDH-EHB and DHCD provide flyers and information for the listed sources to distribute to potential families. Both entities budget for printing the necessary materials. DHCD then accepts the referrals and independently assess if the families are eligible for Program #1.

Medicaid grants specific DHCD staff access to Medicaid's Eligibility Verification System (EVS) to verify a child's enrollment in Medicaid. If the child is already enrolled in Medicaid/MCHP, DHCD enrolls them in Program #1 and begins the abatement work. If the family is found eligible for Program #1 based on income, but not enrolled in Medicaid/MCHP, DHCD or MDH enrolls the child in Program #1 and refers the family to a LHD for assistance in applying for Medicaid. For any such referral, DHCD or MDH shares the finder file with the LHD and Medicaid subsequently verifies whether the referred family was enrolled into Medicaid/MCHP.

Under Program #1, DHCD prioritizes the work to ensure the most vulnerable children are addressed first. DHCD uses the methodology presented in Table 1 to prioritize eligible properties for lead abatement under Program #1.

[11] A notice of defect is a legal notification instrument in Maryland law that renters in pre-1978 rental properties can submit to landlords and MDE which indicates there are defects in the rental property that could potentially pose a lead exposure risk to children.

Table 1: Prioritization Matrix Utilized by DHCD

Priority measure	Category	Points	Category	Points
Level of elevated BLL of a child living in the property.*	3.5-9µg/dL	1 point per child	10µg/dL and above	2 points per child
Number of children living in the property who have an elevated BLL, or who have a history of elevated BLL, and who are under the age of 6.	history of blood lead	1 point per child	Currently have elevated blood lead	2 points per child
Mother of the child who currently has an elevated BLL, or a history of elevated BLL, is pregnant, and resides in the property with the child.	history of blood lead	1 point per child	Currently have elevated blood lead	2 points per child

* If more than one child lives in the property and has elevated blood lead, award additional points accordingly.

This matrix allows the State to ensure that the most vulnerable children are given the highest priority for lead abatement services. As an example, if two families were accepted into Program #1, DHCD would use this matrix to determine which family to serve first. Family #1 has three children, two of whom are under the age of 6, one of whom currently has an elevated blood lead of 10µg/dL, the second of whom has a history of elevated blood lead. Family #2 has three children, but only one child under the age of 6 with an elevated blood lead at or above 3.5µg/dL, the current Maryland elevated BLL or CDC BLRV. The score for Family #1 is five points, whereas the score for Family #2 is three points; therefore, Family #1 would receive a higher priority for abatement services.

Program #1: Services

Once a referral is received by Program #1 through one of the two enrollment strategies and the child is deemed eligible, DHCD arranges for an environmental assessment of the child's residence (or other eligible property) to confirm lead contamination and determine the specific abatement work that is needed.

Under SPA 09-05[12] and as stated in the Maryland Code, Medicaid reimburses for environmental assessments that are performed by providers that are Lead Paint Risk Assessors accredited[13] by

[12] https://health.maryland.gov/mmcp/docs/09-05.pdf
[13] All persons performing lead paint inspections activities are trained and accredited by the MDE https://mde.maryland.gov/programs/land/leadpoisoningprevention/pages/leadinspectors.aspx; http://mde.maryland.gov/programs/Land/LeadPoisoningPrevention/Pages/inspectorscontractors.aspx

MDE who also have enforcement authority. The only accredited Lead Paint Risk Assessors who have enforcement authority are those employed by health departments or MDE; other (private sector) accredited Risk Assessors do not have authority to enforce Maryland law, only authority to conduct assessments and issue lead-free certificates. Assessments are reimbursable as long as they are performed by the aforementioned provider and the child has an elevated BLL. Maryland will continue to reimburse for these assessments using existing Medicaid funds (procedure code T1029). Except for Baltimore City Health Department and Prince George's County Health Department, the remaining 22 local health departments do not have accredited Lead Paint Risk Assessors on their staff, and therefore have not been eligible for reimbursement for environmental assessments. It requires at least a year to train and accredit a new Lead Risk Assessor, so even if LHDs committed to developing this capacity, there would be a lag time before the capacity could be in place.

Funds from the HSI are used to pay for environmental assessments that are conducted by Lead Paint Risk Assessors who do not have enforcement authority under Maryland law, such as those conducted by DHCD or private contractual environmental assessments.

DHCD contracts with licensed[14] sub-contractors who are accredited[15] to conduct the necessary lead abatement activities. The State provides coordinated and targeted lead abatement services to eligible properties to mitigate all lead risks and ensure the long-term effectiveness of abatement activities. Abatement services are defined as the removal of lead hazards, including:

- The permanent removal, or enclosure, or encapsulation of lead-based paint and lead dust hazards from an eligible residence.
- The removal and replacement of surfaces or fixtures within the eligible residence.
- The removal or covering of soil lead hazards up to the eligible residence property line.
- All preparation, lab sampling analysis, clean up, disposal, and pre- and post-abatement paint, dust, soil, and clearance testing activities associated with such measures.
- Clearance testing will meet the stands of HUD's Lead-Based Paint Hazard control and/or Healthy Homes Grants.

Once work has started on an eligible property, DHCD ensures all eligible surfaces and fixtures are abated. Eligible surfaces for abatement services include all structural components identified as hazards during the environmental investigation or the lead inspection/risk assessment including but not limited to: all window components, door and door frames, stairs, interior walls and ceilings, painted cabinets, interior railings, painted floors, exterior porches, exterior painted siding, exterior windows and trim, exterior trim boards, exterior painted siding, trim and doors on garages and other structures, and soil. A home shall not be deemed to have been abated until it passes a lead dust clearance test (see specifications below). DHCD has experience with lead abatement activities in the field including, knowledge of current materials, labor and other costs. MDH approves all projects before they begin.

[14] Contractors in the State of Maryland must maintain a license with the Maryland Home Improvement Commission: https://www.dllr.state.md.us/license/mhic/

[15] Any contractor performing lead abatement in Maryland must be trained and accredited by MDE: http://mde.maryland.gov/programs/Land/LeadPoisoningPrevention/Pages/inspectorscontractors.aspx

Program # 1 does not involve the replacement of water service lines to homes. The State does not utilize the HSI SPA to assess lead hazards in drinking water in most cases. In Maryland, when investigating the source of lead, the assessment typically finds that lead paint is the source of the exposure. The assessor typically asks families about other potential sources, such as: time spent in other countries; pottery; cosmetics; foods, spices, and candies; soil; and drinking water. Generally, testing of other potential sources is rare unless there is a strong indication that they may be contributing to lead exposure.

If it is determined that the source of lead exposure in the homes is from the water, and not from lead in the paint or soils, DHCD looks to funding sources other than this HSI to abate this problem. The State does not utilize the HSI SPA to replace service lines. However, it should be noted that most pediatric blood lead poisoning cases in Maryland continue to be related to exposure to lead in paint. If the source of lead exposure is related to water, the State utilizes HSI SPA funds to install water filters in the home.

In cases where a contractor determines that abatement is likely to fail without additional repairs[16] and certifies that the repairs are essential to maintain encapsulation integrity, these repairs will also be covered. HSI funds only cover repairs essential to prevent encapsulation failure due to moisture and include repairs to vapor barriers, roofs, ventilation systems, electrical systems, plumbing and foundations. All services necessary for encapsulation integrity follow the minimum standards as established by HUD for lead-based paint hazard control and/or Healthy Homes grants. In DHCD's experience only a subset of additional repairs are typically required for a given property.

For the purposes of this request, abatement does not include any of the following:

- Work that does not reduce a lead hazard or prevent the reoccurrence of lead-hazards in the home.
- Work not performed by an accredited lead abatement professional.
- Lead abatement as it pertains to sources of potable water in the home; or
- Work on properties that do not have a program eligible child, under the age of 19, residing or frequently visiting the structure.

The number of eligible properties that may be served by Program #1 depends on the per-unit costs. There is no absolute cap placed on per unit costs.

As mentioned under the assurances, the State will increase, not supplant, the number of homes being abated under DCHD's existing work. DHCD currently abates approximately 110 homes annually. Program #1 projects to serve between 70 - 200 *additional* eligible properties annually. Given these considerations, using existing funds and HSI funds, DHCD abates an estimated total of 180 – 310 homes annually.

To date, a waiting list has not been necessary to address all eligible families that present to DHCD for service. If the Program #1 started to receive more applicants than funding available,

[16] See HUD Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing (2012 Edition), Chapter 13, Section IV.C.3 Durability, p. 13-12.

the state would allow DHCD to utilize and monitor a waitlist to properly allocate resources. DHCD would work to confirm eligibility for complementary programs while on the waitlist.

DHCD ensures that abatement work successfully utilizes the following three-pronged strategy:

1) Only licensed and appropriately accredited professionals are allowed to perform the work.
2) Abated homes must pass an in-person visual lead dust clearance test, and obtain a limited-lead free certification to be considered abated; and
3) Quarterly reporting on quality metrics.

Specifically, when conducting the Scope of Work for Program #1, the following detailed requirements are utilized for ensuring the work is professional and complete.

Program #1 Abatement Requirement 1: Work by Licensed / Accredited Professionals

Only licensed contractors and accredited professionals perform the work. Individuals performing abatement services must be properly accredited by MDE.[17] Only a person accredited by MDE as a lead abatement supervisor or lead abatement worker may perform lead abatement activities in accordance with state law.

A *Lead Abatement Supervisor* is defined as an individual who has been trained by an accredited training program and accredited by MDE to supervise and conduct lead abatement services and to prepare occupant protection plans and abatement reports. A lead abatement supervisor is required for each lead abatement job and must be present at the job site while all abatement work is being done. This requirement includes setup and cleanup time. The lead abatement supervisor must ensure that all abatement work is done within the limits of federal, state, and local laws.

A *Lead Abatement W*orker is an individual who has been trained to perform abatement by an accredited training program and who is accredited by MDE to perform lead abatement.[18] Professionals accredited by MDE are issued a card containing the person's picture, name, certification number, and expiration date. All accredited professionals must work for a MDE accredited lead abatement company. The abatement company and its employees must use abatement methods approved by HUD and/or the U.S. Environmental Protection Agency (EPA) and in accordance with state laws and regulations.

DHCD affirms there is a sufficient workforce available in Maryland that is licensed according to the specifications to perform this work.

Program #1 Abatement Requirement 2: Post-Abatement Lead Dust Clearance

The State recognizes that abatement activities are only eligible for federal assistance when performance of these activities can be demonstrated to be effective in abating all identified lead hazards (excluding water). State and federal law dictate that a clearance test must be performed after any lead abatement work is finished to verify the work area is safe enough for the eligible

[17]Maryland's training and Accreditation requirements, Maryland Department of the Environment (2017). http://www.mde.state.md.us/programs/Land/LeadPoisoningPrevention/InspectorsandContractors/Pages/Programs/LandPrograms/LeadCoordination/inspectorscontractors/inspectors_abatementservices.aspx

[18] Ibid.

resident(s) to return. On the inside of a house or apartment, the dust is tested to confirm that abatement work has not created lead dust hazards that can poison young children, other occupants, or pets living in the building as defined in state law.

Only an accredited Lead Paint Inspector Technician, Lead Paint Visual Inspector or Lead Paint Risk Assessor,[19] who is independent of the abatement company, may perform clearance testing after abatement work is completed. An accredited inspector is defined as an individual who has been trained by an accredited training program and accredited by MDE to conduct inspections and take samples for the presence of lead in paint, dust, and soil for the purpose of abatement clearance testing. DHCD has assured that there is a sufficient workforce available in Maryland that is accredited according to the specifications to perform this work.

During clearance testing, an interior visual inspection is delivered in person on the property by the inspector to see if the identified lead hazards have been abated. These professionals also inspect for the presence of any visible dust or paint chips. If any problems are found, the abatement supervisor must resolve all of them before the clearance testing may continue. After the visual inspection passes, the Lead Paint Visual Inspector or Lead Paint Risk Assessor must take dust wipe samples that are sent to a laboratory for analysis. Clearance dust samples must be taken from the floors, windowsills, and window troughs in the rooms where work was done. At least one sample must be taken from outside the work area if containment was used and from each unique passageway. If no containment was used, then dust wipe samples may be taken in any room. A floor and a window in at least four rooms must be sampled. The samples must be tested for lead by an EPA approved laboratory. After exterior paint abatement work is completed, a Lead Paint Visual Inspector or Lead Paint Risk Assessor must perform a visual inspection of the outdoor work area to ensure that the lead hazards were properly addressed. The Lead Paint Visual Inspector or Lead Paint Risk Assessor will then look for any paint chips on the ground including the foundation of the house, garage, or below any exterior surface abated. If paint chips are present, the abatement company must remove the chips and debris from the site and properly dispose of them before the clearance can be finished. In Maryland, no dust wipe clearance testing is required for abatement on the exterior of a house. The results of the clearance testing will be maintained by the State. These testing results will have numbers with units of measurement; the units are different for dust and soil.

The Environmental Protection Agency and HUD regulations define clearance lead levels with the values and units of measurement shown in the Table 2. These levels provide the basis for the lead dust clearance process for HH4K.

Table 2: Lead Dust Clearance Standards[20]

Material Tested	**Considered hazardous if lead is present at or above these levels***
Bare soil (child play areas)	At or above 400 parts per million (ppm) of lead in the soil
Bare soil (other areas)	At or above 1200 ppm of lead
House dust (floors)	At or above 10 micrograms of lead per square foot of sampled area

[19] Ibid.

[20] https://www.federalregister.gov/documents/2021/01/07/2020-28565/review-of-dust-lead-post-abatement-clearance-levels

	($\mu g/ft^2$)
House dust (window sills)	At or above 100 $\mu g/ft^2$ of lead
House dust (window troughs)	At or above 400 $\mu g/ft^2$ of lead
Paint tested by an X-Ray Fluorescence (XRF) analyzer	Equal to or more than 1.0 milligrams per square centimeter (mg/cm^2) of lead on a deteriorated sampled surface or an elevated dust wipe sample corresponding to the lead surface.
Paint tested by paint chip analysis	Equal to or more than 0.5% (one half of 1 percent) lead by dry weight, or equal to or more than 5,000 ppm of lead in paint.

*All levels indicated in the table above will be utilized until and unless more stringent guidelines are promulgated at the state or federal level.

Program #1: Monitoring Performance, Measuring Progress: Quality Metrics/Reporting Requirements

This HSI abates identified lead hazards from homes and improves the health of Medicaid and CHIP eligible individuals. Providing enhancement and expansion of the lead hazard removal program reduces the potential for ongoing exposure or re-exposure to lead hazards for the eligible populations.

In order to monitor the performance and quality of HH4K, the State tracks the following key metrics and report to CMS quarterly, along with other metrics required by CMS:

1. Number of families with eligible children on MDE's CLR who are contacted and informed that they may be eligible to participate in HH4K;
2. Number of referrals received by DHCD to participate in HH4K;
3. Proportion of referrals received that were subsequently enrolled in HH4K;
4. The number of homes scheduled for lead hazard abatement;
5. The number of homes in which lead hazard abatement has occurred;
6. Number of homes abated for CHIP or Medicaid children under the age of 19;
7. Record of actual services provided in each house;
8. Clearance testing results for each home abated, as well as proportion of homes abated that pass the lead dust clearance test the first time in the post-abatement period;
9. Percentage of children receiving blood lead testing under EPSDT statewide and in the areas targeted by this HSI; and
10. Percentage of children with an elevated BLL statewide who have received services under this HSI.

Other metrics may be added at the agreement of the state and CMS during implementation of the HSI.

Program #2: Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management

The MDH Environmental Health Bureau administers the Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management Program (Program 2) in conjunction with MDE. In State Fiscal Year (SFY) 2021, 1,333 children enrolled in Program #2 received three or

more home visits.

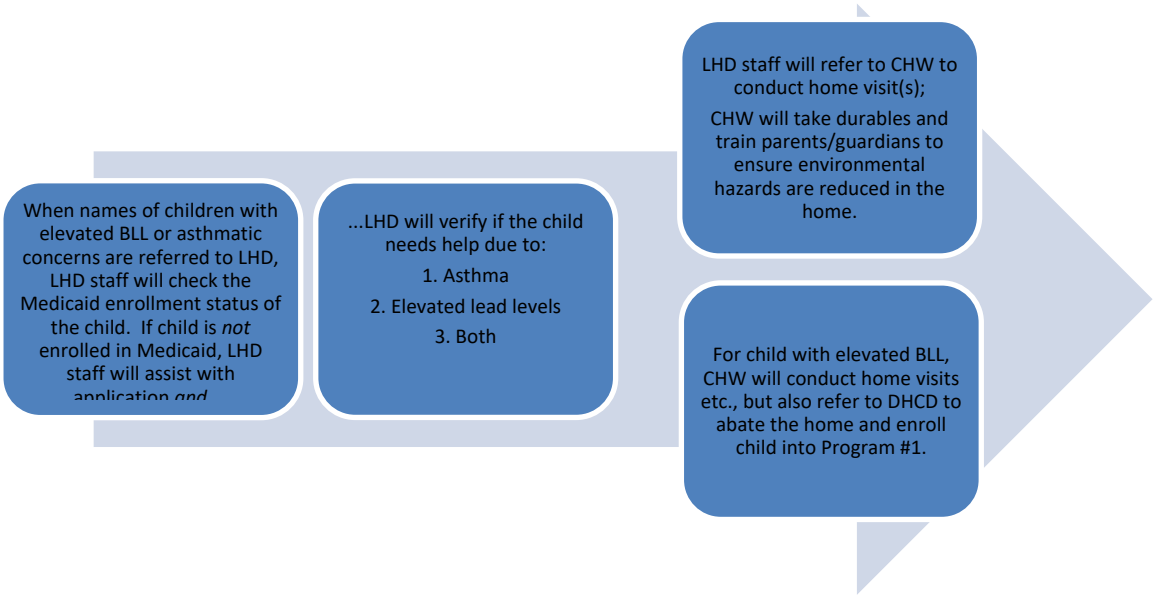
Beginning in SFY 2018, the State's CHIP HSI expanded this program to build environmental case management and CHW capacity in LHDs. This program is a part of an integrated approach to a patient- and community-centered medical home targeting health conditions that have a strong environmental component. Program #2 focuses on improving health outcomes for children with an elevated BLL as well as children with asthma. Improvements in health outcomes are achieved via a combination of

1) Reductions in environmental hazards in the home;
2) Increased medical case management by the primary care provider; and
3) Environmental case management by the LHD in conjunction with the primary care provider and the family.

The funds under Program #2 are not used to pay for additional primary care services; these funds are only used to support the environmental case managers and CHWs. The HSI funds hazard reduction in the home and environmental case management by the LHD. This includes staff funding (environmental case managers and CHWs) at the LHD level, required durables, and LHD overhead. Funds are not used to reimburse any Medicaid covered services, including but not limited to primary care and care coordination. Program #2 is not time limited.

This expanded program improves the State's ability to address existing disparities in health outcomes for childhood asthma and lead poisoning. A strength of the program is the interagency partnership between the Maryland Medicaid program, EHB, and MDE. Figure 3 below provides an overview of Program #2 service delivery.

Figure 3: Program #2 Overview



Program #2: Eligibility

To qualify for services through Program #2, children must meet three primary requirements. First, they must be (1) enrolled in Medicaid or MCHP *or* (2) Medicaid or MCHP -eligible but not yet enrolled. Second, they must reside in one of the participating counties in Maryland.[21] Finally, they must have:

1) A diagnosis of moderate to severe asthma; or
2) An elevated BLL according to the current Maryland elevated BLL or the CDC BLRV22; or
3) A diagnosis of moderate to severe asthma AND an elevated BLL (see Figure 4 below for definitions of moderate to severe asthma).

The expanded program started in SFY 2018 with pilots in nine counties: Baltimore City, Baltimore County, Charles County, Prince George's County, St. Mary's County, Harford County, Frederick County, Wicomico County, and Dorchester County. In 2022, Program #2 expanded to include Anne Arundel County and Montgomery Counties. These jurisdictions were selected because they have experience with elements of the expanded program, and demonstrated a need for increased capacity.

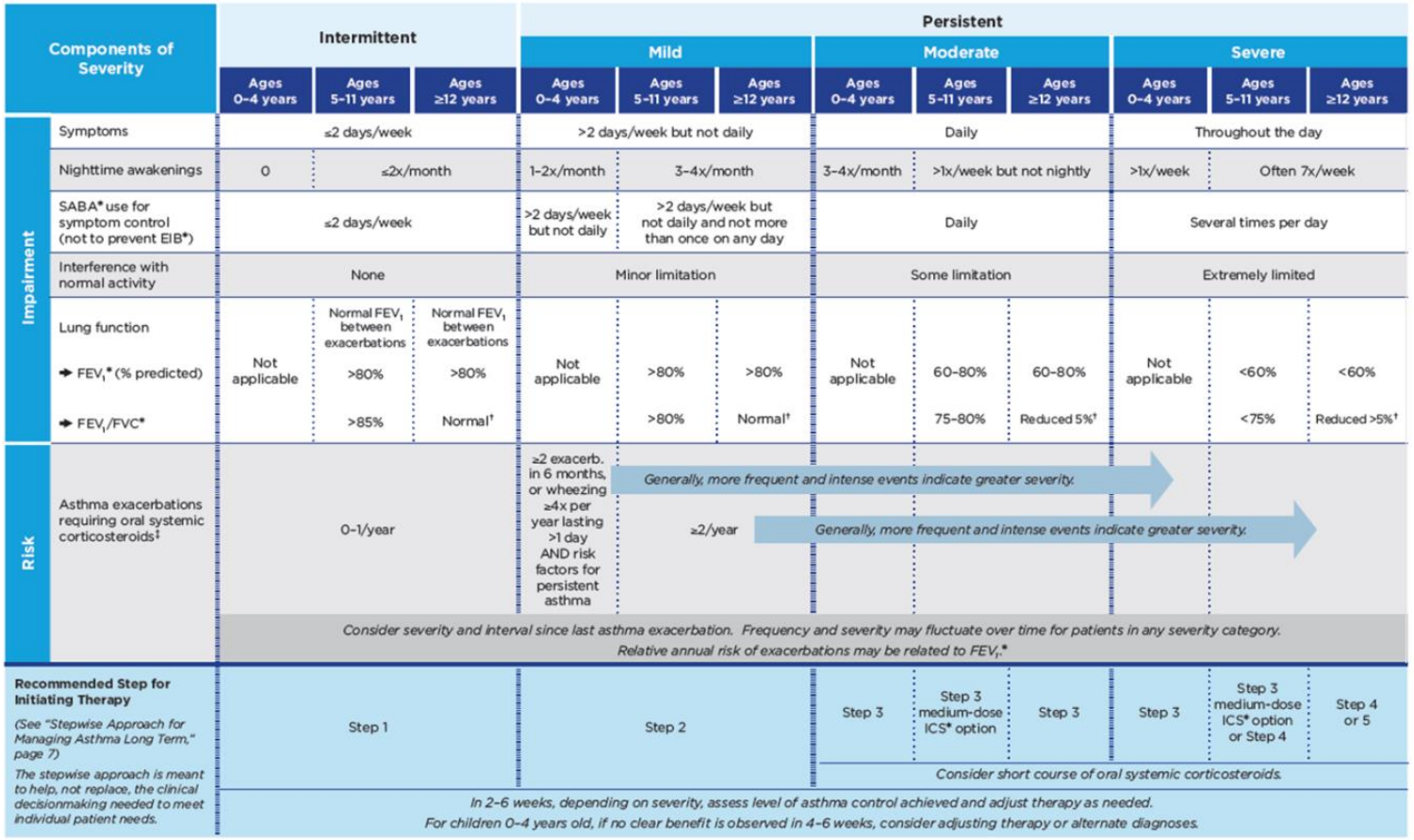
To the extent eligible children served under HH4K live within the geographic area of Program #2 and meet Program #2's other qualifications, they are eligible to receive services. If there is a child with an elevated BLL in a home, Maryland's goal is to also enroll the child into HH4K and abate the lead sources in the home.

LHDs are already active partners with the Medicaid program and play a role in enrolling individuals into the Medicaid and MCHP Programs. They have the capacity to verify whether a child is currently enrolled in benefits using Medicaid's EVS. If a child is identified as possibly eligible for Program #2 and is not yet enrolled in Medicaid or MCHP, the LHD will assist them in applying for benefits using Maryland Health Connection before enrolling them in Program #2.

[21] Baltimore City, Baltimore County, Charles County, Prince George's County, St. Mary's County, Harford County, Frederick County, Wicomico County, and Dorchester County. Expanded counties in 2022 include: Anne Arundel and Montgomery Counties.
[22] The CHIP HSI SPA will apply whichever elevated BLL or BLRV value is the lower to eligibility criteria of these programs.

Figure 4: Moderate to Severe Persistent Asthma Definitions Utilized by Program #2

Level of severity (Columns 2–5) is determined by events listed in Column 1 for both impairment (frequency and intensity of symptoms and functional limitations) and risk (of exacerbations). Assess impairment by patient's or caregiver's recall of events during the previous 2–4 weeks; assess risk over the last year. Recommendations for initiating therapy based on level of severity are presented in the last row.



* **Abbreviations:** EIB, exercise-induced bronchospam; FEV_1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICS, inhaled corticosteroid; SABA, short-acting $beta_2$-agonist.

† Normal FEV_1/FVC by age: 8–19 years, 85%; 20–39 years, 80%; 40–59 years, 75%; 60–80 years, 70%.

‡ Data are insufficient to link frequencies of exacerbations with different levels of asthma severity. Generally, more frequent and intense exacerbations (e.g., requiring urgent care, hospital or intensive care admission, and/or oral corticosteroids) indicate greater underlying disease severity. For treatment purposes, patients with ≥2 exacerbations may be considered to have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Figure courtesy of the U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute. Asthma Care Quick Reference, Diagnosing and Managing Asthma, Guidelines from the National Asthma Education and Prevention Program, Expert Panel Report 3, 2007. https://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines/quick-reference-html

Program #2: Enrollment Strategies

Referrals to Program #2 for children with *elevated blood lead levels* come from a wide range of sources including:

- Primary care and specialty care providers;
- Managed Care Organizations and inpatient care coordinators
- State and county social services agencies;
- MDE's Childhood Lead Registry;
- Local housing agencies;
- Public health agencies (based on either direct inquiries from the public, or from health care providers following up with children testing at or above BLLs >3.5µg/dL, the current Maryland elevated BLL, or the current CDC BLRV);
- MDE, based on public inquiry, regulatory referrals from their enforcement unit, or notices of defect from renters; or
- Requests from homeowners..

Referrals to Program #2 for children diagnosed with *moderate to severe asthma* come from a wide range of sources including:

- Primary care providers;
- Specialty care providers;
- Managed Care Organizations and inpatient care coordinators;
- School-based health personnel, social services personnel;
- LHDs;
- Emergency departments;
- Emergency services personnel;
- Parents/guardians; or
- Social service agencies.

Program #2: Services

The HSI provides funding for LHDs to hire and train environmental case managers and CHWs to provide educational support and outreach to the parents and guardians of low-income children who have specific health conditions including asthma and lead poisoning, as well as to reduce other hazards to children in homes. Under the Program #2, the environmental case managers and CHWs focus on minimizing poor health outcomes due to indoor air quality, pests, and secondhand smoke, providing individualized referrals and environmental case management and environmental risk reduction through including integrated pest management (IPM) practices.

Program #2 uses evidence-based strategies to reduce environmental hazards in the home that adversely affect health outcomes associated with asthma and exposure to lead. These hazards include:

- Secondhand smoke;

- Allergens associated with mice, cockroaches, dust mites, other animals, and pollen (all of which have been associated with poor asthma outcomes).;
- Lead dust;
- Improperly applied or illegal pesticides used by many families to combat mice/ cockroaches that have been linked to childhood poisonings, as well as teratogenic effects.

Program #2 provides three to six home visits spaced three to six weeks apart, which focus on engaging and supporting families to:

- Identify and reduce environmental asthma triggers; recognize early warning signs of asthma attacks;
- Track respiratory symptoms; and
- Take medications as prescribed with the correct technique; create review, share, and update asthma action plans with other family members and care providers; and improve coordination with medical providers.

The core components of an environmental case management team include an environmental case manager (e.g., community health nurse) and CHWs. The environmental case manager, located in the LHD, manages the needs of the child, coordinates with other medical providers, and oversees the work of the CHWs. The CHWs are trained to perform environmental assessments, as well as provide education and resources to support the family of the affected child. The State coordinates oversight, management, and evaluation to assure that program goals are met and that services covered under Medicaid are not funded under the HSI authority.

The environmental assessments conducted by CHWs examine triggers for asthma and risk for lead poisoning. These assessments align with "healthy homes assessments", which determine hazards in the home as well as provide families and landlords with tangible feedback on how the environment can be improved to reduce triggers and hazards in the home. The assessments also include medication adherence, nutrition, and safe cleaning techniques, which play an essential role in reducing the impact of asthma and lead poisoning.

The environmental assessments performed by CHWs are not considered an "in-home assessment" that is eligible for Medicaid reimbursement. CHWs do not currently have a Medicaid provider category in the state of Maryland and their services cannot be reimbursed for by Medicaid at this time. Additionally, CHWs are trained for clinical assessment, but do not receive compliance training because they do not have regulatory authority. Currently, CHWs are not considered health professionals under Maryland law.

As previously mentioned, the approved SPA 09-05 provides on-site environmental lead inspections for primary residences, limited to Medicaid enrollees under age 19 with confirmed elevated BLL. On-site inspections are not included for asthma.

Program #2: Reducing Lead Dust Hazards

Regarding lead dust, Program #2 reduces lead dust hazards in the home by providing High-Efficiency Particulate Air (HEPA) vacuums, mops, buckets, and other cleaning supplies that, when used regularly, have been shown to reduce the presence of lead dust in the home. Program #2 reduces lead hazards in the home by assisting parents of children with lead poisoning to either enroll in HH4K1, or work with their landlord and MDE to reduce chipping and peeling paint in accordance with Maryland's laws.

As previously mentioned, the approved SPA 09-05 provides on-site environmental lead inspections for primary residences, limited to Medicaid enrollees under age 19 with confirmed elevated BLL. On-site inspections are not included for asthma.

Program #2: Improving Asthma Outcomes

Secondhand smoke has been shown to negatively impact respiratory function and serves as a trigger for asthma episodes. Program #2 reduces this hazard in homes by providing parents and guardians with education regarding how to reduce their child's exposure to secondhand smoke, as well as assistance with enrolling in programs that will support them to quit smoking if that is their desire.

Allergens associated with mice, cockroaches, and dust mites are known triggers for poor asthma outcomes. Asthmatic children who are allergic to these allergens experience additional inflammation and mucus production reducing their capacity to breathe. Program #2 educates parents on the associations between exposure to these allergens and poor asthma outcomes, sources of these allergens, and how to limit exposure to these allergens in their homes. Strategies include the use of HEPA vacuums which have been shown to significantly reduce the level of allergens present in the home and improve asthma outcomes. In addition, families are provided with dust mite covers and educated on their use. Dust mite covers reduce exposure to the allergens present in beds and have been shown to be an effective intervention as well.

Regarding cockroaches and mice, Program #2 provides parents with education regarding the impact of exposure to allergens associated with pests on asthma outcomes. In addition, Program #2 provides parents with education regarding integrated pest management as well as how to use the durables provided to perform integrated pest management.[23] Integrated pest management has been shown to be the most effective manner of reducing cockroach and mouse burden, and has been associated with improved respiratory function among asthmatic children.[24] It has the added benefit of relying sparsely on pesticides. One of the additional benefits of this educational programing is that parents may learn which pesticides to NOT use in their homes. Misapplication of pesticides, and use of illegal pesticides poses a significant poisoning risk for children. Thus, by introducing integrated pest management practices in the home Program #2 does not only reduce the hazards associated with pests, but also some of the hazards that are commonly associated with attempting to control pests through traditional methods.

[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3934496/
[24] http://www.sciencedirect.com/science/article/pii/S0277953606002607

Program #2: Home Visits

LHDs participating in Program #2 share reports with participants' medical providers regarding progress towards the goals, successes, challenges, and needs for additional follow-up, education, or referrals. Similar environmental case management activities and reporting protocols already exist for lead in LHDs and were expanded with this CHIP HSI SPA. Program #2 offers three to six home visits, based on the family's needs and the child's BLL. The number of home visits is a function of the child's underlying condition and severity.

- The literature supports a range of home visits from three to six for children with an asthma diagnosis, depending on the severity of the asthma symptoms.[25]

- Children with a diagnosis of lead exposure may also receive three home visits, but may receive more depending on clinical severity, the need for case management, or other factors.

- Children who are enrolled in Program #2 who have both diagnoses of lead exposure and asthma are assessed and managed for both conditions simultaneously, and receive the same number of visits (three to six) as children with only one diagnosis based on severity.

Typical services that may be provided for asthma home visits are shown below:

Table 3: Program #2 Asthma Home Visit Services

Home Visit 1 Personnel	
● Community Health Worker	Hours
○ Field work to complete HV1: In-home interview, environmental assessment, education	3
○ Office work to complete documentation, encounter form, care coordination	2
○ Transportation time for visit (round trip)	2.0
Total time	6.5 hours
Home Visit 1 Supplies	
● **E**ncasements for mattresses and pillows	
● Spacer	
● Educational binder	
Home Visit 2 Personnel	
● Community Health Worker	Hours
○ Field work to complete HV2: In-home interview, environmental assessment, education	1.5
○ Office work to complete documentation, encounter form, care coordination	1.5

[25] See the *Reducing Asthma Disparities* page for a description of the Baltimore City demonstration project using six visits, accessible at: http://dhmh.maryland.gov/innovations/Pages/reducingasthmadisparities.aspx

○ Transportation time for visit (round trip)	2.0
Total time	4.5 hours
Home Visit 2 Supplies	
● Green Cleaning Kit (bucket, mop, spray bottle, baking soda, vinegar, GreenWorks)	
● Integrated Pest Management supplies	
Home Visit 3 Personnel	
● Community Health Worker	Hours
○ Field work to complete HV3: In-home interview, environmental assessment, education	1
○ Office work to complete documentation, encounter form, care coordination	1.5
○ Transportation time for visit (round trip)	2.0
Total time	4 hours
Home Visit 3 Supplies	
● Doormat	
● HEPA vacuum (10% of clients)	

Under Program #2, CHWs assess what durables a family requires. The listed items under Table 4 are for the families to keep; they are not loaned to the families. Although refills for families may be provided while actively enrolled in the program if needed, families are not enrolled indefinitely in the program. This program assists and educates the families so they can independently maintain their home environment, so asthma triggers and lead levels do not escalate.

Table 4: Program #2 Required Durables

Asthma Durables	Lead Durables
HEPA Vacuum	HEPA Vacuum
Bucket	Bucket
Mop	Mop
Sponges	Sponges
Mouse traps	Microfiber cleaning cloths
Cockroach traps / baits	Soap
Dust mite covers for mattress	
Medication storage containers	
Spacers (for inhalers)	
Caulk	
Copper Mesh	
Sticky Traps	
Soap	

Program #2: Staffing

The core components of an environmental case management team includes an environmental case manager (e.g., community health nurse) and CHWs. The environmental case manager, located in the LHD, manages the needs of the child, coordinates with other medical providers, and oversees the work of the CHWs.

As part Program #2, CHWs are identified and recruited in targeted communities in part with the assistance of the MDH Office Minority Health and Health Disparity's Minority Outreach and Technical Assistance program. Training of the environmental case managers and CHWs is described below. The State uses the current training vendor to train additional environmental case managers and community health workers. Funding from the HSI ensures coordination between HH4K and #2, analysis, and reporting to MDH regarding project outcomes focusing specifically on health disparities that have been identified as priorities.

The current training vendor, a non-governmental non-profit organization, is supported by Program 2to provide education, outreach, and training to LHDs, community-based organizations, and communities affected by lead poisoning. These ongoing efforts are augmented with funding under the HSI to provide healthy homes training to LHD environmental caseworkers and CHWs. Under Program #2, LHDs leverage current staff to assist with program implementation; however, in many instances the State expects that LHDs to hire new staff that will be paid for by HSI funds. These new staff would be employed by the LHD.

The supported organization has extensive experience training personnel. The healthy homes curriculum includes training on how to reduce environmental hazards related to both asthma and lead poisoning, as well as how to perform in-home environmental hazards assessments. There are other organizations that have the potential to deliver training to the environmental case managers and CHWs, and MDH may evaluate the suitability of these trainings and organizations for the purposes in the future and utilize these additional organizations as appropriate.

Program #2: Monitoring Performance, Measuring Progress: Quality Metrics/Reporting Requirements

The State ensures that Program #2 is meeting performance goals and providing quality services using a set of core reporting metrics that are reported to CMS quarterly or at another agreed upon schedule. These metrics include:

1) Number of children enrolled in Program #2;
2) Number of children enrolled in Program #2 who received at least three home visits;
3) Of the children served by Program #2 who have been diagnosed with asthma, the proportion who report an improvement in asthma symptom management;
4) Of the children served by Program #2 who have been diagnosed with asthma, the proportion who report having an up-to-date asthma action plan

5) Of the children served by Program #2 who have elevated BLL, the proportion who received a follow-up blood lead test during the program timeframe; and
6) Of the children served by Program #2 who have an elevated BLL, the proportion whose follow up blood lead test was below the elevated BLL standard , that is, the Maryland elevated BLL, or the current CDC BLRV.

Other metrics may be added at the agreement of the state and CMS during implementation of the HSI.

The estimated costs per child (which include core services, administration, training of new personnel, as well as direct services) served by Program #2 are between $1,500 - $2,500 per child/per year. Therefore, Program #2 provides services to approximately 1,200-2,000 children annually. These costs will vary based on the number of home visits that are required (3–6) to optimally support the family, and the complexity of the environmental case management efforts required based on the individual family/child's needs. Ultimately, the number of children to be served by Program #2 depends on the cost per unit per year.

SPA #MD-17-0001-Poison Control

Program 3: Maryland Poison Control Center (MPCC)

The MPCC, a unit of the University of Maryland School of Pharmacy, responds to approximately 35,000 human exposure calls each year. These are calls to the MPCC where an individual has been exposed to potentially toxic substance and the caller is seeking medical advice/treatment from the MPCC. Each year, the majority of those calls involve exposures that occur in children. Below are the numbers of pediatric human exposure cases reported to the MPCC over the past two full calendar years broken down by quarter.

Year	Quarter	Total Pediatric	Total Human	% Pediatric
2010	1	5,282	8,554	61.75
2010	2	5,572	9,218	60.45
2010	3	5,465	9,363	58.37
2010	4	5,323	8,761	60.76
2011	1	5,113	8,662	59.03
2011	2	5,310	8,962	59.25
2011	3	5,257	9,284	56.62
2011	4	5,145	8,836	58.23

NOTE: For this summary, pediatric calls are defined as those that occur in children age <19 years.

The percentage of pediatric cases reported to the MPCC changes a bit over time (range of 56.62% - 61.75%). In the schedule of projected costs and allocation method submitted with the amendment to the Cost Allocation Plan, the allocation of MPCC costs to the under-19 years (child) population uses an overall percentage of 59.31%, which is the simple average of the above 8 quarters of data. The percentage of quarterly allocations to CHIP, going forward, would be made based on the most recent call data, gathered for the quarter being claimed.

Cost. A revision of the Maryland CHIP Cost Allocation Plan has been submitted separately. In brief, the projected costs of this program are approximately $4.1 million, of which roughly 59.31% or $2.4 million are attributable to pediatric services to individuals under 19 years old. At Maryland's CHIP rate of 65%, this would result in a federal expenditure of approximately $1.5 million. MPCC, a previously state-funded program, will continue to track total calls and calls respecting children to supply accurate statistics for cost allocation.

Conformity with 42 CFR 457.1005. The services of the MPCC conform to the requirements of CHIP regulations. Specifically, they are not prohibited by any provision of Subpart D. As a unit of the University of Maryland School of Pharmacy, the activities of the MPCC are subject to stringent controls for quality. MPCC services are offered at no cost to individuals who call to request them, so the provisions of Subpart E limiting enrollee financial responsibility are satisfied.

HSI Assurances

1. Maryland provides assurances that the HSI program will only target children under the age of 19.
2. Maryland provides further assurances that funds under this HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.
3. Maryland provides further assurances that the State will report on agreed upon metrics at regular intervals to CMS on the progress of the HSI.

2.3-TC **Tribal Consultation Requirements**- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

Section 3. Methods of Delivery and Utilization Controls

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

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid

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

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

3.1.1 Choice of Delivery System

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

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

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

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

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

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child

health assistance using Title XXI funds to targeted low-income children. Include a description of:

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

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

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

☐ No
☐ Yes

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

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:

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
  ☐ Capitation payment
  ☐ Other (please explain)
  Describe population served:

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

- ☐ Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
  - ☐ Capitation payment
  - ☐ Other (please explain)

    Describe population served:

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

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

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

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

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

3.1.3 Nonemergency Medical Transportation PAHPs

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

☐ The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

3.2.1 ☐ The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the

procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

3.2.2 ☐ The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

3.2.3 ☐ The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

3.2.4 ☐ The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

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

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

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

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

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

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

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

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

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

☐ The State assures that it if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

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

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

3.4 Enrollment

☐ The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

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

3.4.1 Enrollment Process

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

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

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

☐ Yes
☐ No

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

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

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

3.4.2 Disenrollment

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

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

3.4.2.3 ☐ If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

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

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

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

3.4.2.5 Enrollee Requests for Disenrollment.

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

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

☐ Yes
☐ No

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

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

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

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

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

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

3.5 Information Requirements for Enrollees and Potential Enrollees

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

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

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

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

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and

- Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

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

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

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

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

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

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

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

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

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

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

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
  - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
  - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
  - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
  - What constitutes an emergency medical condition and emergency services;
  - The fact that prior authorization is not required for emergency services; and
  - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;

- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
  - The right to file grievances and appeals;
  - The requirements and timeframes for filing a grievance or appeal;
  - The availability of assistance in the filing process; and
  - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

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

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

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

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

- Which medications are covered (both generic and name brand); and

- What tier each medication is on.

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

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

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

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

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

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

3.5.18 ☐ The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

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

3.6.1 ☐ The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)

3.6.2 ☐ The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.3 ☐ The State assures that it:

- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
- Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

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

3.6.4 ☐ The State assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.5 ☐ The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:

- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
- Women's health specialists to provide direct access to covered care necessary to provide women's routine and preventative health care services for female enrollees; and
- Family planning providers to ensure timely access to covered services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)

3.6.6 ☐ The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))

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

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

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less

than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

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

3.6.10 ☐ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:
- Offers an appropriate range of preventative, primary care and specialty services; and
- Maintains a provider network that is sufficient in number, mix, and geographic distribution. (42 CFR 457.1230, cross-referencing to 42 CFR 438.207(b))

3.6.11 ☐ Except that 42 CFR 438.210(a)(5) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the coverage of services requirements under 42 CFR 438.210, including:
- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and
- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

3.6.12 ☐ Except that 438.210(b)(2)(iii) does not apply to CHIP, the State assures that its contracts with each MCO, PIHP, or PAHP comply with the authorization of services requirements under 42 CFR 438.210, including that:
- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures;
- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and

- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual with appropriate expertise in addressing the enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

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

3.6.14 ☐ The State assures that its contracts with each MCO, PIHP, or PAHP provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(e))

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

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

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services;
- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;
- Ensure that each provider furnishing services to enrollees maintains and

shares, as appropriate, an enrollee health record in accordance with professional standards; and

- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

Guidance: For assurances 3.6.17 through 3.6.20, applicability to PIHPs and PAHPs is based a determination by the State in relation to the scope of the entity's services and on the way the State has organized its delivery of managed care services, whether a particular PIHP or PAHP is required to implement the mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(a)(2))

3.6.17 ☐ The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.

3.6.18 ☐ The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))

3.6.19 ☐ The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:

- Is in accordance with applicable State quality assurance and utilization review standards;
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))

3.6.20 ☐ The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

3.7 Operations

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

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

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

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

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

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

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

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

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

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

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

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

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

3.8 Beneficiary Protections

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

3.8.2 ☐ The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))

3.8.3 ☐ The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:

- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))

- Covered services provided to the enrollee for which the State does not pay the MCO, PIHP or PAHP or for which the State, MCO, PIHP, or PAHP does not pay the individual or the health care provider that furnished the services under a contractual, referral or other arrangement. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(b))
- Payments for covered services furnished under a contract, referral or other arrangement that are in excess of the amount the enrollee would owe if the MCO, PIHP or PAHP covered the services directly. (42 CFR 457.1226, cross-referencing to 42 CFR 438.106(c))

3.9 Grievances and Appeals

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

3.9.1 ☐ The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 ☐ The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 ☐ The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?

☐ Yes
☐ No

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

3.9.5 ☐ The State assures that the external medical review is:

- At the enrollee's option and not required before or used as a deterrent to proceeding to the State review;
- Independent of both the State and MCO, PIHP, or PAHP;
- Offered without any cost to the enrollee; and
- Not extending any of the timeframes specified in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(1)(i))

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

3.9.7 ☐ The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))

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

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

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

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

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

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

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

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

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

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

☐ All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to

whether such information was submitted or considered in the initial adverse benefit determination.

- ☐ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
- ☐ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
- ☐ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14 ☐ The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

3.9.15 ☐ The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

3.9.16 ☐ The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

3.9.17 ☐ The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))

3.9.18 ☐ The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a

grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

3.9.19 ☐ The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))

3.9.20 ☐ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 ☐ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:
- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:
  - The right to request a State review, and how to do so.
  - The right to request and receive benefits while the hearing is pending, and how to make the request.
  - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

3.9.22 ☐ For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))

3.9.23 ☐ The State assures that if it offers an external medical review:
- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
- The review is independent of both the State and MCO, PIHP, or PAHP; and
- The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))

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

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

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

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

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

3.10 Program Integrity

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

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

3.10.1 The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:

- ☐ Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;
- ☐ Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and
- ☐ Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280)

3.10.2 ☐ The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)

3.10.3 ☐ The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))

3.10.4 ☐ The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that includes all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP;
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation

of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

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

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

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

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

3.10.9 ☐ The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

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

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

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

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

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

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

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

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

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

3.10.13 The State assures that:

☐ It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))

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

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

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

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

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

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services;

- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

3.11 Sanctions

Guidance: Only States with MCOs need to answer the next three assurances (3.11.1 through 3.11.3). Intermediate sanctions are defined at 42 CFR 438.702(a)(4) as: (1) Civil money penalties; (2) Appointment of temporary management (for an MCO); (3) Granting enrollees the right to terminate enrollment without cause; (4) Suspension of all new enrollment; and (5) Suspension of payment for beneficiaries.

3.11.1 ☐ The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

3.11.2 ☐ The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.3 ☐ The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

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

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

☐ Yes
☐ No

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

3.11.5 ☐ The State assures that before it imposes intermediate sanctions, it gives the affected entity timely written notice. (42 CFR 457.1270, cross referencing 42 CFR 438.710(a))

3.11.6 ☐ The State assures that if it intends to terminate an MCO, PCCM, or PCCM entity, it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b). If the decision to terminate is affirmed, the State assures that it gives enrollees of the MCO, PCCM or PCCM entity notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving CHIP services following the effective date of termination. (42 CFR 457.1270, cross referencing 42 CFR 438.710(b))

3.11.7 ☐ The State assures that it will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700. (42 CFR 457.1270, cross referencing 42 CFR 438.724)

3.12 Quality Measurement and Improvement; External Quality Review

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

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

3.12.1 Quality Strategy

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

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

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
- A description of:
  - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
  - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent

practicable, health disparities based on age, race, ethnicity, sex, and primary language;

- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a "significant change" for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

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

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

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

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

3.12.1.6 ☐ The State assures that it will submit to CMS:

- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
- A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required

every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

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

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

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

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

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

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

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

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

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

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

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

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

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

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

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

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

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

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

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

3.12.3 Accreditation

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

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

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

information at least annually. (42 CFR 457.1240(c), cross referencing to 42 CFR 438.332(c))

3.12.4 Quality Rating

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

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

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

3.12.5 Quality Review

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

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

3.12.5.1 External Quality Review Organization

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

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

3.12.5.2 External Quality Review-Related Activities

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

(relating to the validation of performance improvement projects, validation of performance measures, and compliance review).

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

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

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

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

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

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
- A review, conducted within the previous 3-year period, to determine the PCCM entity's compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

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

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

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

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

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

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

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR

438.310(c)(2));

- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
  - Objectives;
  - Technical methods of data collection and analysis;
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
  - Conclusions drawn from the data;
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

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

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

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

3.12.5.3.8 ☐ The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential

enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

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

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

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. ☒ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group: Superseded by Title XXI amendment CS3.

4.1. ☐ **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 ☐ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

Citizenship is verified via a system check establishing that an applicant is known to another federally funded benefit program which requires citizenship, such as Maryland's Temporary Cash Assistance (i.e., TANF), Medicare, Social Security Disability Insurance, or Supplemental Security Income. Applicants who were born in Maryland to a mother eligible for Medical Assistance are citizens. Children receiving assistance under Section IV-B and IV-E of the Social Security Act are not required to prove citizenship. For children not previously determined to be citizens by a program to which Maryland has access, citizenship can be determined by showing a birth certificate or other document or combination of documents specified in 42 CFR 435.407.

4.1.1 ☐ Geographic area served by the Plan if less than Statewide:

MCHP and MCHP Premium are available on a Statewide basis.

4.1.2 ☐ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

For MCHP and MCHP Premium, children must be under 19 years old.

4.1.2.1-PC ☐ Age: through birth (SHO #02-004, issued November 12, 2002)

4.1.3 ☐ Income of each separate eligibility group (if applicable):

4.1.3.1-PC ☐ 0% of the FPL (and not eligible for Medicaid) through 317% of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 ☐ Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

The eligibility determination for MCHP and MCHP Premium considers only the applicant's family income; assets are not considered.

4.1.5 ☐ Residency (so long as residency requirement is not based on length of time in state):

Current residency in the State is required.
A resident must have an address in the State and intend to remain.

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

4.1.7 ☐ Access to or coverage under other health coverage:

A child must not have existing full-benefit coverage that is affordable to the child's parents in order to qualify for CHIP in Maryland.

4.1.8 ☐ Duration of eligibility, not to exceed 12 months:

Once an applicant is determined eligible for MCHP Premium and enrolled in the program, eligibility will be redetermined annually. If there is any change in income, employment or insurance status, the parent or guardian must notify the State.

4.1.9 ☐ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not

addressed above. For instance:

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing an SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☐ States should specify whether Social Security Numbers (SSN) are required.

Maryland requires the SSN of a child applying for Medicaid/CHIP except for the deemed newborn of a Medicaid mother and an individual subject to one of the exceptions set forth at 42 CFR 435.910(h).

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☐ Continuous eligibility

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1) "lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☐ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

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

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
(4) An alien who belongs to one of the following classes:
    (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
    (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
    (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
    (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
    (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
    (vi) Aliens currently in deferred action status; or
    (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;
(6) An alien who has been granted withholding of removal under the Convention Against Torture;
(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☒ Elected for children under age 19

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

4.1-DS ☐ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

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

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

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

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

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

4.3. **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

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

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. ☐ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility ☒ Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

Our express-line program was hindered by the conclusion of the State Comptroller that tax information could not be shared by this office with another state entity. We relied on the Comptroller's office to identify and provide a list of families whose income fell within bounds of CHIP eligibility, to which we sent a simplified application form. A large number of Express Lane applications were from families already enrolled, who did not recognize the outreach package as a benefit already received.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

Office of the Comptroller of Maryland.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

The data we sought to confirm was limited to income as reported for State tax purposes.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

Family income is the only component addressed under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.
The normal application processing requirements are applied to families that respond to Express Lane outreach

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its

Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

4.4.1. ☐ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

See Section 4.4.4.3 below for prevention of substitution of coverage.

4.4.2. ☐ children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))

4.4.3. ☐ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

4.4.4. ☐ the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)

4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

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))

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

☒ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

MARYLAND CHILDREN'S HEALTH PROGRAM OUTREACH STRATEGY

The effective date for MCHP outreach was July 1, 1998. The effective date for MCHP Premium outreach was July 1, 2001. The outreach strategy for the Maryland Children's Health Program is guided by the following goals:

- Design a program that is easy for the general public to understand and access;
- Conduct a culturally sensitive public information campaign, targeted to those individuals and organizations that have the most direct contact with the low-income uninsured population;
- Identify, inform, and enroll the low-income uninsured population into either the State's Medicaid program, MCHP or MCHP Premium, as appropriate; and
- Coordinate enrollment into these programs with other public or private health insurance.

To effectively achieve the goals of enrolling the targeted uninsured population into the Maryland Children's Health Program, Maryland uses a multifaceted strategy. In order to target families, Maryland will continue with a grassroots information dissemination campaign involving collaboration with the following entities:

- State agencies;
- Advocacy and community-based groups; and
- Provider organizations.

This grassroots approach complements Maryland's comprehensive HealthChoice education and outreach campaigns targeted at low income pregnant women and children. Maryland has conducted public media and advertising campaigns using some of the same strategies which have been effective during the implementation of HealthChoice.

Grassroots Information Dissemination Campaign

The primary objective of the grassroots public information campaign is to educate families of the eligibility provisions and benefits under the Maryland Children's Health Program. State agencies as well as local community-based organizations, advocacy groups, and providers serve as information links to low-income working families. Each of these groups is asked to distribute brochures and other forms of information, assist with mail-in applications, use their own newsletter for communication, and host meetings for others to be educated on the outreach process. In all of these activities, the State serves as a central contact and clearinghouse, as well as providing technical assistance.

The State coordinates its outreach efforts closely with Local Health Departments, Community Health Centers, Managed Care Organizations, (MCOs) and other public and private providers with historic experience in providing information, services, and referrals for low income uninsured populations. The State also works through children's services providers such as schools, licensed day care providers, and Head Start programs. Each of the grassroots outreach entities are outlined below with a description of their major area of responsibility.

STATE AGENCIES

Maryland Department of Health

MDH is responsible for strategic planning of Statewide outreach. MDH efforts include the

following:

- *Consultation with the Maryland Medicaid Advisory Committee.* MDH, in consultation with the Maryland Medicaid Advisory Committee, refines mechanisms for outreach with a special emphasis on identifying children who may be eligible for program benefits under the Maryland Children's Health Program.
- *Toll Free Information Line*. MDH operates a toll-free information line to field questions about the program and take requests for enrollment applications. DHMH's toll free line is linked to the national 1-877-KIDSNOW hotline.
- *Printed Materials*. The following materials are distributed to those groups who have the most direct contact with the uninsured population such as Community Health Centers, Local Health Departments, the Department of Social Services offices, advocacy groups for children, school systems, community outreach organizations, and churches:

    - Mail-in applications
    - Brochures, posters, and flyers
    - Question and answer information packets for enrollees
    - Question and answer information packets for professionals
    - Training materials for Local Health Departments
    - Training materials for public speaking engagements
    - Scripts for newsletters and newsprint.

□ *Web based materials. Materials are posted on a public-access agency website, to include applications, general information, eligibility updates and topic specific information.*

The largest percentage of non-English speaking populations in the State speak Spanish and Vietnamese. Outreach for HealthChoice and MCHP included specific efforts to reach these populations. Other identified languages spoken frequently in the State include Russian, Korean and Chinese. Maryland provides application forms and brochures in English and Spanish, and will evaluate whether to translate additional outreach brochures and posters into other languages for jurisdictions with large non-English speaking populations.

Local Health Departments

Public health services in Maryland are provided through a network of 24 LHDS that have a longstanding history of service delivery to maternal and child health populations through the following programs: Family Planning Services (Title X); preventive health care and specialty care to low income children and prenatal care to low-income pregnant women (Title V); WIC; and immunization programs.

Through funding from the HealthChoice program, each LHD has created a care coordination unit responsible for outreach to low-income families, as well as follow-up of certain hard-to-reach and special needs populations enrolled in HealthChoice who fail to keep appointments. These Statewide networks of Medicaid supported outreach units have the knowledge, skills, and tools to conduct outreach activities to identify, track, enroll, and educate the low-income

uninsured population into the Maryland Children's Health Program. LHDs perform community outreach through collaborative efforts with schools, family and center-based day care centers, family support centers, churches, medical and mental health providers, work site wellness programs, business and service organizations (e.g., Chamber of Commerce), non-profit organizations (e.g., March of Dimes), youth activity, and sports programs.

Department staff meet regularly with LHD outreach staff to keep them abreast of changes in the Maryland Children's Health Program, to ensure that all grantees understand outreach goals, and to provide information on statewide outreach strategies. MDH will also seek input from grantees regarding the development of performance measures for these activities. Local health department outreach staff will also be asked to evaluate local strategies.

Department of Human Services
DHS works closely with MDH to coordinate eligibility issues especially for those who fall between200 and 300 percent of FPL. The introduction of the family contribution requirement and Maryland's efforts to assure that Maryland Children's Health Program enrollees do not have any other creditable coverage present challenges for the eligibility process. MDH and DHS (which does CARES eligibility processing for MCHP and MCHP Premium) work closely to identify and resolve any issues relating to eligibility determination for the Maryland Children's Health Program.

Maryland State Department of Education
MSDE plays a key role in encouraging low-income families to apply for insurance coverage for their children by developing and implementing a school based outreach program. Examples of cooperative efforts with MDH include:

- *Boards of Education*. MDH may enter into contracts with county boards of education to provide information at public schools on the Maryland Children's Health Program.
  - *National Free and Reduced Price School Lunch Program*. The Maryland State Department of Education (MSDE) maintains information concerning public school children who participate in the National Free and Reduced Price School Lunch program for children in families with income below 185 percent of the Federal poverty line (FPL). MDH and MSDE have developed a two-part targeted outreach strategy that permissively uses the National Free and Reduced Price School Lunch Program to direct outreach information to children who are likely to be eligible for public health insurance coverage under either Medicaid or the Maryland Children's Health Program. This strategy will concentrate on schools that (based on their relatively high proportion of children who qualify for the National Free and Reduced Price Lunch Program) are likely to enroll a relatively high number of children who are eligible for Medicaid or the Maryland Children's Health Program. When a child applies for the National Free and Reduced Price School Lunch Program and is determined to be eligible, the school will send a notice of eligibility to the child's parents; outreach information about the Maryland Children's Health Program will be

included with the notice; and

- For school years 2000 and 2002, a Maryland Children's Health Program application was sent home with every child. For school year 2001, new entrants in prekindergarten, kindergarten and first grade received applications.

- *School-Based Health Centers*. School-based health centers are located in schools in Maryland which serve large numbers of children in low-income families. SBHCs will encourage families of uninsured children to apply for Maryland Children's Health Program coverage.

- *Licensed Day Care Centers*. The Child Care Administration (CCA) is responsible for licensing and monitoring day care centers and family day care programs in Maryland. In addition, it administers the childcare subsidy payment program for eligible families. CCA will provide general information about the Maryland Children's Health Program through education articles in a quarterly newsletter and by distributing outreach materials to 2,200 day care centers and 14,400 family day care providers.

Head Start

Head Start programs serve over 7,200 children in Maryland. The program predominantly serves four year old children with some available space for younger children. One component of Head Start is to promote access to health care for the children and families served in each program. Ten percent of the children served must have documented disabilities and ten percent of the children enrolled may come from families whose income exceeds the Head Start income guidelines, which are at the Federal poverty line. The Maryland Head Start Collaboration Network project was established to facilitate coordination of services between Head Start and Health care providers, education agencies, child care programs, employment projects, and other community organizations. It provides an open access arena for communication to the 31 Head Start programs in every county in the State. The project collaborates with the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program to improve access to health care services and to make sure that children enrolled in Head Start receive EPSDT screening and treatment services. Local Head Start programs provide Medicaid and Maryland Children's Health Program eligibility information and explain the importance of obtaining an EPSDT screen and immunizations during their annual spring recruitment phase.

Governor's Office on Children, Youth and Families
MDH coordinates with this agency, as appropriate to assist in its outreach efforts.

Office of the State Comptroller
MDH coordinates with this agency, as appropriate, to assist in its outreach efforts. Effective April, 2010, MDH uses this agency as an Express Lane agency that uses income information from State tax records to identify children financially eligible for CHIP.

ADVOCACY AND COMMUNITY BASED ORGANIZATIONS

HealthChoice Linkages

Maryland has been highly successful in working in partnership with advocacy organizations for HealthChoice outreach and education activities. These partnerships will be strengthened to enhance outreach efforts as we move forward with the Maryland Children's Health Program. These advocacy organizations represent children and pregnant women of varying health status, geographic location and ethnic backgrounds. The advocacy organizations have a vested interest in child health and have grounded experience in overcoming the barriers that keep children and pregnant women from getting care.

During the planning stages for MCHP, regional meetings were conducted to seek input from the public. Numerous advocacy organizations participated in these regional meetings and expressed their willingness to assist in outreach efforts. A few examples of these established groups that have proven their commitment to reach the uninsured include:

- The Maryland Committee on Children
- Advocates for Children and Youth
- The Maryland Developmental Disabilities Council
- The Maryland Association of Resources for Families and Youth
- Workgroup on Managed Care for Children in State-Supervised Care
- The Lutheran Office on Public Policy
- The United Baptist Missionary Convention and Auxiliaries, Inc.
- Collington Life Center (Senior Center)
- The Mid-Atlantic Association of Community Health Centers

MDH works closely with these and other groups to implement an outreach plan that complements other simultaneous outreach efforts and that specifically attempts to identify potential eligibles who are in rural areas, who are homeless, or who are members of special needs populations. Such activities as creating meeting participant lists, providing input on brochures and applications, distributing materials through churches and libraries, and speaking to parent groups are requested of these organizations.

Linkage with Robert Wood Johnson Outreach Grant - Covering Kids and Families - Maryland

Discontinued/Grant Period Ended June 30, 2006**.**

Linkage with Insurance Brokers

When issuing or renewing group health insurance policies with an employer that does not include dependent coverage, insurers and non-profit health service plans (those that issue or deliver group health insurance policies in the State) provide enrollment information to insured employees regarding methods for enrolling dependents of the insured employee.

PROVIDER OUTREACH

Primary and Specialty Care Providers

Health care providers are an invaluable resource in providing information concerning Medicaid coverage for low income children, children with special health care needs, and families. Primary care and specialty providers are encouraged by DHMH to identify individuals, especially pregnant women and children, in need of health care coverage and to make appropriate referral to local and State agencies for assistance.

Professional Medical Organizations

MDH coordinates with recognized medical organizations such as the American College of Obstetrics and Gynecology (ACOG), the American Academy of Pediatrics (AAP) and the Maryland Association of Family Practitioners to promote access to Medicaid coverage. These organizations provide information to their providers through their professional meetings and newsletters. The EPSDT program supplies primary care physician's offices with outreach materials such as flyers and brochures to inform patients about Medicaid and the Maryland Children's Health Program.

Managed Care Organizations (MCOs)

Through a variety of existing communication forums including biweekly information sharing meetings, MDH works closely with its HealthChoice MCOs to request assistance in the distribution of applications and information to its community networks.

Community Based Diagnostic and Treatment Centers

Maryland has a number of community-based diagnostic and treatment centers such as the Diagnostic and Evaluation Service Centers for individuals with HIV/AIDS and Planned Parenthood offering women's health services, where the most current information on the Maryland Children's Health Program will be disseminated.

Community Based Providers

As discussed in Section II of this application, Maryland has a number of locally operated programs (e.g., Montgomery County Care For Kids Program) as well as community health centers that already serve the uninsured. These programs provide direct information to the families that they serve so that children who receive partial benefits under these programs can receive comprehensive medical coverage.

GENERAL OUTREACH

Public Information Campaign-Media Relations and Advertising

Maryland has conducted three grassroots public information dissemination campaigns intended to target those families of the working uninsured who might have children eligible for the Maryland Children's Health Program. Designed to complement the outreach activities described above, the Statewide media campaigns have been successful in reaching individuals and families

who were not contacted through these other mechanisms or who may have been ineligible at the time they received the information and had a change in their financial situation.

Mass Media
Prior to implementation of MCHP Premium, MDH mounted an initial kick-off campaign to encourage media interest in MCHP Premium. The kick-off consisted of a combination of information dissemination activities, which included press releases, press conferences, and television and radio interviews of State officials. MDH also used public service announcements to inform potential program eligible about the Maryland Children's Health Program, and radio ads, billboards, and mass transit posters.

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

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

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

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

Maryland uses a variety of methods to identify and enroll all eligible children in Maryland for Medicaid and the Children's Health Program. We have implemented a broad-based and diverse outreach program. Some of our activities include:

- Brochures, flyers and posters;
- Radio and TV public service announcements;
- Outreach through primary care provider offices and pediatric specialty providers;
- Outreach and information and enrollment at the Local Health Departments and the Local Departments of Social Services;
- Direct mailings to individuals receiving unemployment checks;
- Outreach through schools, licensed child care providers, the Maryland Infants and Toddler's Program and Head Start;
- Outreach by established advocacy groups such as the Maryland Committee for Children and the Advocates for Children, Youth and Families; and

- Public presentations by members of the MDH speakers bureau.
- Web-based materials provided to inform the public of new issues and requirements.

In addition, Maryland has taken the following actions to streamline the eligibility process:

- Adoption of a shortened, simplified application form (3 pages);
- Allowing applicants two new application options—applying by mail or face-to-face at local health departments (instead of the still-available alternative of applying at local departments of social services);
- Allowing self-declaration of income;
- Elimination of the mandatory face-to-face interview; and
- Establishing a "1-800" number for anyone who has questions or wants an application form.

As demonstrated by the higher than anticipated enrollment levels during MCHP Phase I, Maryland's outreach efforts have been quite successful. These efforts, as well as Maryland's plans for additional outreach consistent with the goals of MCHP Phase II, are discussed in detail in Section 5 of this application.

Maryland uses a combined application for Medicaid, MCHP and MCHP Premium. Applicants determined eligible to participate in Medicaid or MCHP who subsequently have a change in circumstances which qualifies them for the other program are reassigned without requirement for completion of another application and without any impact on their HealthChoice enrollment. MCHP Premium applicants who become ineligible for MCHP Premium due to a reduction in income which would qualify them for Medicaid or MCHP must complete the brief application form to move from MCHP Premium into the appropriate program.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

There are currently no public-private partnerships in Maryland that provide creditable health insurance coverage.

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health

insurance programs, other sources of health benefits coverage for children, other 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. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

5.3. **Strategies** 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)

Section 6. Coverage Requirements for Children's Health Insurance

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

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

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

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

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

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

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

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

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

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

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

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;

- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has

the largest insured commercial enrollment in the state); and

- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
    - coverage of prescription drugs,
    - mental health services,
    - vision services and
    - hearing services.

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

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

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

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures

for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

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

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

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

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

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

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

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

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

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

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

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

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

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

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

6.1.4.7. ☐ Other (Describe)

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

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

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

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 pre-pregnancy 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))

6.2.11. ☐ Disposable medical supplies (Section 2110(a)(13))

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

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

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

6.2.13. ☐ Nursing care services (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 (Section 2110(a)(16)

6.2.15. ☐ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

6.2.16. ☐ Vision screenings and services (Section 2110(a)(24))

6.2.17. ☐ Hearing screenings and services (Section 2110(a)(24))

6.2.18. ☐ Case management services (Section 2110(a)(20))

6.2.19. ☐ Care coordination services (Section 2110(a)(21))

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

6.2.21. ☐ Hospice care (Section 2110(a)(23))

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

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

6.2.22.1 ☐ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

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

6.2.23. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

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

6.2.25. ☐ Medical transportation (Section 2110(a)(26))

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

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

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

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.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

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, as described at Section 6.2.22 and 6.2.22.1, 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.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

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.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

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.

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

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH ☐ Psychosocial treatment
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.2.2- BH ☐ Tobacco cessation
Provided for: ☐ Substance Use Disorder

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

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

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

6.3.2.8- BH ☐ Intensive outpatient
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.2.9- BH ☐ Psychosocial rehabilitation
Provided for: ☐ Mental Health ☐ Substance Use Disorder

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

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

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

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH ☐ Residential Treatment
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.4.2- BH ☐ Detoxification
Provided for: ☐ Substance Use Disorder

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

6.3.5- BH ☐ Emergency services
Provided for: ☐ Mental Health ☐ Substance Use Disorder

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
Provided for: ☐ Mental Health ☐ Substance Use Disorder

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

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

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.

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-DC Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will

provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☐ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[26]) codes are included in the dental benefits:

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

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

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

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

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[27] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

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

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

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

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

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

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

☐ Yes
☐ No
Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((§457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Act provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

☐ Yes
☐ No
Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of §457.496(b) related to deemed compliance.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐ All children covered under the State child health plan
☐ A subset of children covered under the State child health plan.
Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, §457.496(b)(3) limits deemed compliance to those children only and you must complete Section 6.2.3- MHPAEA to complete the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (§457.496(b)(2)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

☐ All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions (Section 1905(r)).

☐ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan (Section 1905(r)).

☐ All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan (Section 1905(r)(5)).

☐ Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness (Section 1905(r)(5)).

☐ Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness (Section 1905(r)(5)).

☐ EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis (Section 1905(r)(5)).

☐ The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary (Section 1902(a)(43)).

☐ All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them (Section 1902(a)(43)(A)).

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3- MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements §457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

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 (§§457.496(d)(2)(ii); 457.496(d)(3)(ii)(B)).

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

6.2.3.1.1 MHPAEA The state assures that:

☐ The State has classified all benefits covered under the State plan into one of the four classifications.

☐ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

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

☐ Yes

☐ No

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

☐ The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).
Guidance: For purposes of this section, any reference to "classification(s)" includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

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

Guidance: States are not required to cover mental health or substance use disorder benefits. However if a state does provide any mental health or substance use disorders, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan.

Annual and Aggregate Lifetime Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan (§457.496(c)).

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied
☐ Aggregate annual dollar limit is applied
☐ No dollar limit is applied
Guidance: If there are no aggregate lifetime or annual dollar limit on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☐ Yes (Type(s) of limit:)
☐ No
Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental

health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits (§457.496(c)(1)).

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (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 (457.496(c)(3)).

☐ The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.
Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable, as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3
☐ At least 1/3 and less than 2/3
☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3
☐ At least 1/3 and less than 2/3
☐ At least 2/3
Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (§457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide

the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (§§457.496(c)(4)(i)(B); 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with §§457.496(c)(4)(i)(B) and 457.496(c)(4)(ii). Please include the state's methodology as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (§457.496(c)(2)(i); (§457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes (Specify:)
☐ No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply financial requirements to any mental

health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

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

☐ Yes
☐ No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class 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 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. (§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. (§457.496(d)(3)(i)(E))
Guidance: Please include the state's methodology as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to "substantially all" (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (§457.496(d)(3)(i)(A))

☐ Yes
☐ No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose that type of QTL on mental health or substance use disorder benefits in that classification. (§457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use

disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in §§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 §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. (§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 predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominate level is the least restrictive level of the levels combined to meet the one-half threshold (§457.496(d)(3)(i)(B)(2)).

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements (§§457.496(d)(4); 457.496(d)(5)).

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☐ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of

benefits, provider reimbursement rates and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in §457.496(d)(4)(ii).

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 services provided by out of network providers?

☐ Yes
☐ No

6.2.6.2.2- MHPAEA If yes, please assure the following:

☐ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services.

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

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

6.3. The State assures that, with respect to pre-existing medical conditions, one of the

following two statements applies to its plan: (42CFR 457.480)

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

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

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

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

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

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

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

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section

2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

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

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

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

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

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

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

6.4.2.2. 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))

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

☐ Yes
☐ No

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

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

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

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

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such

coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

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

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

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

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

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

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

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

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

☐ Yes

☐ No

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

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

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

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

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

Section 7. Quality and Appropriateness of Care

Guidance: **Methods for Evaluating and Monitoring Quality**- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National

Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

☒ 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.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☐ Quality standards

7.1.2. ☐ Performance measurement

7.1.2 (a) ☐ CHIPRA Quality Core Set

7.1.2 (b) ☐ Other

7.1.3. ☐ Information strategies

7.1.4. ☐ Quality improvement strategies

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 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))

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))

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))

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)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Section 8. Cost-Sharing and Payment

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

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

8.1.1. ☐ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☐ No, skip to question 8.8.

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

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

8.2.1. ☐ Premiums:

8.2.2. ☐ Deductibles:

8.2.3. ☐ Coinsurance or copayments:

8.2.4. ☐ Other:

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and

dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

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

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

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

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

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

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

8.4.1- MHPAEA ☐ There is no separate accumulation of cumulative financial requirements, as defined in §457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits (§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 (§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 §457.560 (§457.496(d)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance

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

☐ Yes (Specify:)
☐ No
Guidance: If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

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

☐ Yes
☐ No
Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the proportion 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) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits (§457.496(d)(3)(i)(E)).
Guidance: Please include the state's methodology as an attachment to the State child health plan.

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

☐ Yes
☐ No
Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (§457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in §457.496(d)(3)(i)(B)(1)) 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. (§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 predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominate level is the least restrictive level of the levels combined to meet the one-half threshold (§457.496(d)(3)(i)(B)(2)).

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

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

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

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

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

Guidance: Provide a description below of the State's premium grace period process and how

the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

8.7.1.2. ☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

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

8.7.1.4 ☐ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (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, copayments, 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 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

Guidance: States should consider aligning its strategic objectives with those discussed in Section II

of the CHIP Annual Report.

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))

MCHP Premium features four complementary objectives for increasing the number of low and moderate income children with creditable health insurance. Those objectives are:

- Develop and implement a multi-faceted ***outreach strategy*** that targets the eligible population for the program, including low and moderate income families.
- Reduce the percentage of uninsured children in Maryland.
- Increase access to health care services for enrollees in low and moderate income populations.
- Increase the use of appropriate preventive services by enrollees

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

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

Maryland measures outreach efforts by:

- The number of Medicaid-eligibles enrolled in the Maryland Children's Health Program as compared to projections; and
- Reduction in the percentage non-covered children.

Maryland will increase access to health care services for low-income populations as measured by:

- Increase in provider network capacity in areas where capacity is lowest;
- Increase in the number of primary care and dental providers participating in HealthChoice;
- Increase in the number of enrollees who indicate that they have improved access to the health care delivery system through satisfaction survey reports; and
- Increase in the number of participating specialty health care resources.

MCHP Premium

Maryland uses the following performance goals to evaluate its success in meeting each of its strategic objectives.

- Provide appropriate preventive care to enrollees.
- Reduce the percentage of uninsured children under 300 percent FPL.
- Meet or exceed the number of MCHP Premium enrollees as compared to projections.
- Increase in the number of enrollees who indicate that they have improved access to the health care delivery system. This will be measured through satisfaction survey reports.
- Increase in the number of enrollees who indicate that they are satisfied with specialty care resources.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

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))

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, 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)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

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

The Maryland HealthChoice Quality Improvement Program (QIP) outlines the monitoring, evaluation and reporting methodologies the State will use to oversee the quality of health care services delivered to enrollees in the Maryland Children's Health Program.

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 or audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

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)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

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 ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

MCHP:

In 1997, Governor Parris N. Glendening and the Secretary of the Department of Health and Mental Hygiene Martin P. Wasserman engaged in an extensive public process to obtain input on the design and implementation of the Maryland Children's Health Program. To ensure broad public input, the process began with four public hearings throughout the State and culminated with Governor's Round Table on Children's Health Insurance, which Governor Glendening personally chaired. The hearings and Round Table were followed by four regional briefings. Finally, there was an extensive legislative process which resulted in the Children and Families First Health Care Act of 1998. The Department of Health and Mental Hygiene will assure ongoing public involvement in the Maryland Children's Health Program through consultation with the Maryland Medicaid Advisory Committee and through monthly communication with the Local Health Department's health officers. The strategies used by the Department in this public involvement process are described below.

Public Input—Design and Implementation

- **Public Hearings**
  The four public hearings were publicized through appropriate advocacy and provider groups

as well as direct mailings to over 200 representatives of consumers, providers and advocacy groups. The first public hearing, for Western Maryland, was held in Hagerstown on October 28, 1997; the second public hearing, for Central Maryland, was held in College Park on October 30, 1997. The third public hearing, for the Eastern Shore, was held in Wye Mills on November 3, 1997; the fourth public hearing, for Baltimore City, was held in Baltimore on November 6, 1997. All hearings were held at 7 p.m. to assure maximum public participation. Each hearing began with the Governor's representative explaining the provisions of the Children's Health Insurance Program under Title XXI and the options available for implementing the program in Maryland. Individuals were then given an opportunity to offer their views. A total of 193 individuals attended the four hearings and 94 testified. Of those individuals who addressed the issue, 60 recommended implementing Title XXI by expanding the current Medicaid program. Only five individuals recommended establishing a new program rather than expanding Medicaid.

- **Governor's Round Table on Children's Health Insurance**
  Governor Glendening chaired the Governor's Round Table on Children's Health Insurance in Baltimore on November 18, 1997. There were approximately 20 participants in the Round Table, including several key members of the Maryland General Assembly, representatives of provider and advocacy groups, community leaders, and a representative from the Children's Defense Fund and the National Governor's Association. The representative of the National Governor's Association explained the provisions of the Federal law and the Secretary of Health and Mental Hygiene explained the current situation in Maryland and options for implementing the new program. The Governor then chaired a discussion focusing on the expansion population, the benefit package, options for implementation, and whether there should be co-payments and premiums for enrollees. The discussion included all of the Round Table participants. Of those Round Table members who expressed a preference, all recommended implementing Title XXI through expanding the current Medicaid program. In addition to the participants, there were approximately 250 people in the audience observing the proceedings of the Round Table. Approximately 15 members of the audience made comments or raised questions during a question-and-answer session; only one person expressed opposition to implementing the program by expanding the Medicaid program.

- **Regional Briefings on Maryland Children's Health Program**
  Subsequent to the four regional Public Hearings and the Governor's Round Table Discussion, the Department and the Governor's Office conducted four regional briefings. These briefings were held in eastern, central, southern, and western regions of Maryland. This provided an opportunity for the public, consumers, advocates, Local Health Departments, and service providers to learn about the legislative proposal submitted by the Governor to the Maryland General Assembly. The briefings offered an additional opportunity for local and regional recommendations regarding the design and implementation of the Maryland Children's Health Program. The regional briefings were conducted by the Secretary or Deputy Secretary of the Department of Health and Mental Hygiene and a member of the Governor's executive staff. Interested parties, including State Legislators and Local Health Departments, were notified about the briefings through mailings and press

releases.

The dates and locations of the briefings were as follows:

- Eastern Maryland—Salisbury, MD, January 22, 1998
- Central Maryland—Baltimore, MD, January 28, 1998
- Southern Maryland—Rockville, MD, February 2, 1998
- Western Maryland—Cumberland, MD, February 2, 1998

- **Maryland Legislature 1998**
  The expansion of coverage to uninsured children was one of the major policy initiatives of Governor Glendening and the 1998 Maryland legislative session. Prior to the start of the session the Governor proposed legislation to address the needs of uninsured children. The legislature then engaged in an extensive debate on proposals regarding uninsured children. The legislative process included the formation of a work group of key legislative leaders who met regularly throughout the session. The work group invited representatives from the insurance industry, hospital, physician, provider and child advocacy groups to attend and participate in their work sessions. April 11, 1998, legislation entitled The Children and Families First Health Care Act of 1998, authorizing the Maryland Children's Health Program passed with overwhelming bipartisan support. This legislation closely follows the legislation originally proposed by Governor Glendening.

Ongoing Public Involvement

- **Maryland Medicaid Advisory Committee**
  The Maryland Medicaid Advisory Committee reviewed and discussed the provisions of Title XXI and the options available to the State at its meetings of October 23 and November 24, 1997. The Committee recommended expanding the existing Medicaid program to implement the new program.

  In order to assure on-going public involvement and input in program implementation and continuing administration, the State uses the Maryland Medicaid Advisory Committee, established under the Section 1115 Maryland Medicaid waiver for the HealthChoice program.[28] The Maryland Medicaid Advisory Committee consists of 27 members including State legislators, consumers, and providers. The Committee is currently charged with advising the Department of Health and Mental Hygiene on the implementation, operation and evaluation of the Medicaid program, including the following activities: reviewing and making recommendations on regulations; reviewing and making recommendations on standards used in contracts with Managed Care Organizations; reviewing and making recommendations on the Department's oversight of quality assurance standards; reviewing data collected from Managed Care Organizations and data collected by the Maryland Health

[28]. The role of the Medicaid Advisory Committee is explicitly outlined in the "Children and Families First Health Care Act of 1998."

Care Access and Cost Commission; promoting the dissemination of Managed Care Organization performance information; assisting the Department in the evaluation of the enrollment process; reviewing reports of the Ombudsman; and publishing an annual report to the Governor and Maryland General Assembly. The Committee has added the Title XXI program to each of these areas of its responsibility, as appropriate. The Committee meets monthly and periodically conducts regional public hearings.

- **Monthly Meetings with the Local Health Departments**
  On a monthly basis, local health officers representing the 24 LHDs have a round table discussion on issues affecting the implementation of the HealthChoice program.

MCHP Premium

The Maryland General Assembly, in its 1999 session, enacted Senate Bill 738, requiring the Department of Health (the Department or MHD) to study how to expand eligibility for the Maryland Children's Health Program by using private market insurance (private option) coverage. SB 738 directed the Department to:

> Study and make recommendations regarding the ability of the State to expand the Children and Families Health Care Program beyond the current income eligibility level to individuals who would qualify for the enhanced federal match provided for under Title XXI of the Social Security Act as part of the program established under §15-301 of this subtitle through private market, employer-sponsored health benefits plans and private market, individual health benefit plans.

To fulfill this legislative mandate, the Department formed a Technical Advisory Committee (TAC) composed of representatives of the Department, the Maryland Insurance Administration, the Maryland Health Care Foundation, the Maryland Health Care Commission, the business community, the health care insurance industry, and State employees. In the interest of gaining as broad and informed a perspective as possible, the Department expanded the membership of the TAC to also include advocates representing additional relevant interest groups.
The University of Maryland, Baltimore County (UMBC), Center for Health Program Development and Management (CHPDM), conducted all relevant research and provided staff to support the TAC. The Department and the TAC pursued an open and inclusive approach to soliciting information and assuring that complex (and potentially contentious) design issues were thoroughly reviewed and discussed. Two methods were used:

- *Full meetings of the TAC.* The full TAC met on five separate occasions from June to October 1999. Each of these meetings lasted for roughly three hours and, in the aggregate, touched on all aspects of the private option. At its initial meetings, the TAC reviewed proposed approaches to the private option, adopted a workplan, and addressed basic issues, such as benefit design. At later meetings, staff recommendations were presented, discussed, and modified.
- *Issue-specific workgroups.* Five workgroups supplemented the deliberations of the full TAC. The workgroups were composed primarily of TAC members, but also included additional

individuals with relevant expertise or experience (e.g., employers). The workgroups explored the following issues: benefit design, administrative concerns for employers and insurers, outreach processes, and cost sharing requirements. At the recommendation of the TAC, a sixth workgroup of consumers met in November, 1999 and discussed the program's overall design and implementation. The consumer focus group paid particular attention to the potential effects of various cost sharing mechanisms.

In addition to discussions designed to capture input from the TAC and the workgroups, staff researched and analyzed a number of topics necessary to inform these groups' deliberations. Staff prepared the following:

- *Discussion papers.* Staff produced a series of papers presenting pertinent research and analysis of key issues that are central to the design and development of a private option program under Title XXI. Discussion papers on the following topics were distributed to workgroup participants and the TAC as a whole:
    - Benefit Design Options;
    - Estimating the Target Population; and
    - Cost Sharing Issues.

- *Employer survey*. Maryland has always been concerned that the HCFA guidance calling for an employer contribution of at least 60 percent of the cost of family coverage for employer-sponsored coverage under Title XXI, represented a significant barrier to employer participation in a private option program. Therefore, Maryland was very interested in collecting Maryland-specific data on this issue. In cooperation with TAC members, staff developed a brief employer contribution survey to gather information on employee health insurance contribution patterns among Maryland employers. The survey was mailed to over 23,000 Maryland employers and responses were received from over 2,600 employers. The results of the survey provide a strong basis for Maryland seeking a lower employer contribution threshold of 50 percent for the private option. Based on final federal regulations and Maryland's experience since July, 2001 in implementing and operating the private option program, Maryland reduced the required employer contribution threshold to 30 percent. This allowed the State to provide access to the MCHP Premium through employer-sponsored insurance for children in families where the family size was large enough to meet the cost-effectiveness test.

- *Research of approaches being used by other states.* A very limited number of other states have either developed or attempted to develop employer-sponsored approaches to providing health insurance coverage for children through a separate state plan under Title XXI. To understand how they designed and implemented their Title XXI employer-sponsored insurance programs, and to assess their current status, staff contacted each of the states (Massachusetts, Wisconsin, Mississippi, and Oregon) that have either been approved by, or submitted a proposal to, HCFA to use an employer-based approach to Title XXI.

- *Interim Report.* As required by SB 738, the Department prepared an interim report recounting the TAC process and progress. The interim report (submitted September 15, 1999) did the following. It:
    - Presented TAC discussions of major policy issues, especially benefit design;
    - Outlined the remaining issues to be addressed;
    - Described a strategy for completing the Committee's efforts; and,
    - Included copies of all issue papers.

The process outlined above was invaluable in the development of workable recommendations for a Maryland Children's Health Program private option that adhered to the goals and requirements detailed in SB 738. The Department especially benefited from the active participation of the membership of the TAC, in particular from the TAC's willingness to openly discuss issues and consider opposing viewpoints. The TAC's spirited and insightful discussions were indispensable to understanding the complexities of the private option.

Using the final December 3, 1999 report of the TAC as a starting point, the Maryland legislature passed the HB2, the Maryland Health Programs Expansion Act of 2000. Thus, this state plan amendment is the culmination of an extensive public process.

Since enactment of the legislation in April of 2000, MDH has reconvened the TAC to discuss its implementation plans. MDH will continue to hold regular meetings with the TAC and arrange meetings with technical experts as needed.

Legislative Adjustments to MCHP and MCHP Premium effective July 1, 2003

In the 2003 session of the Maryland General Assembly, changes were made to MCHP and MCHP Premium pursuant to House Bill 40 of 2003 (the Budget Bill 2003) and House Bill 935 of 2003 (the Budget Reconciliation and Financing Act of 2003).

House Bill 40 and House Bill 935 froze enrollment in MCHP Premium for children in families with incomes above 200 percent FPL but at or below 300 percent FPL, eliminated ESI enrollment for MCHP Premium children, and required MCHP children above 185 percent FPL to pay a premium for continued coverage. The legislation set the premium for children above 185 percent FPL at 2 percent FPL for a family of two at 185 percent FPL. All changes are effective July 1, 2003, per the legislation. (NOTE: Implementation of changes to MCHP Premium occurs effective July 1, 2003. Imposition of a premium on children in families with incomes above 185 percent FPL but at or below 200 percent FPL will occur effective September 1, 2003.)

Maryland agency regulations for MCHP and MCHP Premium are amended effective July 1, 2003, to implement the changes mandated by the legislation.

The Medicaid Advisory Committee was advised of all changes in May and June 2003.

Legislative Adjustments to MCHP and MCHP Premium effective July 1, 2004

The changes made to MCHP and MCHP Premium effective July 1, 2003 pursuant to House Bill 40 of 2003 and House Bill 935 of 2003 are applicable to state fiscal year 2004 only. These changes expire at the end of the state fiscal year, on June 30, 2004. The sole exception is the elimination of the ESI program, which the Maryland General Assembly terminated July 1, 2003 by amendment to the Annotated Code of Maryland.

Effective July 1, 2004, children in families with income above 185 percent FPL but at or below 200 percent FPL will not be required to pay a premium for coverage. The upper income limit for MCHP (the free Medicaid expansion program) and the lower income standard for MCHP Premium (the contributory separate child health program) will change from above 185 percent FPL to above 200 percent FPL.

Also, effective July 1, 2004, the freeze on new enrollment in MCHP Premium for children in families with income above 200 percent FPL but not greater than 300 percent FPL will be removed.

Maryland agency regulations for MCHP and MCHP Premium will be amended effective July 1, 2004, to implement these changes.

The Medicaid Advisory Committee was advised of these changes in May, 2004.

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. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

Maryland has no federally recognized Indian tribes, however, Maryland has multiple State-recognized Indian tribes. This includes the following groups:

- The Piscataway Indian Nation (Executive Order 01.01.2012.02)
- The Piscataway Conoy Tribe and sub-tribes (Executive Order 01.01.2012.01)
- Accohannock Tribe (Executive Order 01.01.2017.31).

Any Maryland resident, including those who are American Indians or Alaska natives, may participate in the review of amendments to State law or regulation and may offer comments on all Program policies, including those relating to provision of child health assistance to American Indian or Alaska native children. The process for review and comment is outlined in 9.9.2 below.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

Prior to 2009, Maryland was under the impression that it had no urban Indian health organizations that met federal requirements. Pursuant to CMS guidance, related to SMDL 10-001 of January 22, 2010 regarding § 5006 of the American Recovery and Reinvestment Act of 2009 (ARRA), CMS acquainted us with an organization devoted to behavioral health and substance abuse prevention and services, supported by funding from IHS Region IV (Nashville). Native American Lifelines of Baltimore constitutes an outreach and referral urban Indian health organization. Effective March 2010, Maryland Medicaid (including CHIP) provides notice of proposed state plan or waiver changes prior to submission for CMS approval to Ms. Jessica Dickerson, Medical Case Manager, Appointed Committee Member on the Maryland Medicaid Advisory Committee (MMAC) of Native American Lifelines of Baltimore. We benefit from Ms. Dickerson's willingness to consult on proposed policy changes.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

The Express Lane option was designed prior to implementation of the Express Lane eligibility option. Because our EL was based on income taxes, it did not reach the majority of the AI/AN population interacting with Native American Lifelines of Baltimore.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
    - Projected amount to be spent on health services;
    - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
    - Assumptions on which the budget is based, including cost per child and expected enrollment.
    - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
    - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.

- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
    - Total 1-year cost of adding prenatal coverage
    - Estimate of unborn children covered in year 1

Program Budget
We provided the overall program budget with the recently approved HSI initiatives for combating lead poisoning and addressing environmental contamination—see chart below.

Both of the HSI Program Initiatives expand the current resources available in Maryland to identify and abate lead-related health hazards for low-income children. Maryland assures that CHIP funding for the HSI Lead Initiative will not be claimed as a match for federal funds under any existing county, municipal, State or federal program.

Program #1: Healthy Homes for Healthy Kids
The Healthy Homes for Healthy Kids Program proposes to expand upon the DHCD's existing lead abatement activities statewide to serve low-income children in eligible properties with lead contamination using $907,001.55 in State funding and $1,684,431.45$ in CHIP federal matching funds. The State's share will be funded through existing State General Funds.

Program #2: Childhood Lead Poisoning &Asthma Prevention and Environmental Case Management Program
The Childhood Lead Poisoning & Asthma Prevention and Environmental Case Management program will use $1,110,675 of State General Funds and $2,511,879 in CHIP federal matching funds to expand capacity to build environmental case management and CHW capacity in LHDs.
State matching funds will be drawn down by Maryland Medicaid as well as funds from other MDH agencies. Funding from the Department's sister agency, the Health Service Cost Review Committee, will be used by leveraging the hospital global budget revenue system to support population health priorities as identified under the Total Cost of Care model.

These initiatives will expand the current resources available in Maryland to identify and abate lead-related health hazards for low-income children. Maryland assures that CHIP funding for the HSI Lead Initiative will not be claimed as a match for federal funds under any existing county, municipal, State or federal program.

COST OF PROPOSED [S]CHIP PLAN

Enhanced FMAP Rate	**FFY 20**22 69.34**% FMAP**
Benefit Costs	
Insurance payments	
Managed Care	$285,564,784
per member/per month rate	$150
Fee for Service	$135,951,447
Total Benefit Costs	$421,516,231
(Offsetting beneficiary cost sharing payments)	$(3,039)
Net Benefit Costs	$421,513,192
Cost of Proposed SPA Changes - Benefit	$0
Administrative Costs	$28,972,591
Personnel	$2,054,608
General Admin	$14,867,4679
Contractors	$1,520,449
Claims Processing	$ 0
Outreach / Marketing Costs	$1,398,118
Health Services Initiative Costs	
HSI – Program 3	$2,917,961
HSI – Program 1	$2,591,433
HSI - Program 2	$3,622,555
Total Administrative Costs	$28,972,591
10% Administrative Cost Ceiling	$46,835,137

Costs of Proposed SPA Changes	($952,679)
Federal Share	$309,246,382
State Share	$136,739,170
TOTAL PROGRAM COSTS	$445,985,5520

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

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 uninsured 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

Maryland has filed Annual Reports for MCHP (effective July 1, 1998) for fiscal years 1998—2011. According to SHADAC, Maryland's uninsured children fell from 5.3% in 2010 to 3.6% in 2014.

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

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

10.3-DC ☐ The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

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 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-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. **Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.

12.3. **Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, 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.

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices				
CMS Regional Offices	**States**		**Associate Regional Administrator**	**Regional Office Address**
Region 1-Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2-New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3-Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4-Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5-Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6-Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7-Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8-Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9-San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103

Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
23. Hospice care.

24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
    a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
    b. performed under the general supervision or at the direction of a physician, or
    c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. IN GENERAL- Subject to paragraph (2), the term 'targeted low-income child' means a child--
    a. who has been determined eligible by the State for child health assistance under the State plan;
    b. (i) who is a low-income child, or
    (ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
    c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. CHILDREN EXCLUDED- Such term does not include--
    a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
    b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. MEDICAID APPLICABLE INCOME LEVEL- The term 'Medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under Section 1902(l)(2) for the age of such child.
5. TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant

woman' means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. CHILD- The term 'child' means an individual under 19 years of age.
2. CREDITABLE HEALTH COVERAGE- The term 'creditable health coverage' has the meaning given the term 'creditable coverage' under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. LOW-INCOME CHILD - The term 'low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. POVERTY LINE DEFINED- The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. PREEXISTING CONDITION EXCLUSION- The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms 'State child health plan' and 'plan' mean a State child health plan approved under Section 2106.
8. UNINSURED CHILD- The term 'uninsured child' means a child that does not have creditable health coverage.