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State/Territory Name: North Carolina

State Plan Amendment (SPA) #: NC-22-0034

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



Children and Adults Health Programs Group

January 13, 2023

Mr. Dave Richard
Deputy Secretary for Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

Dear Mr. Richard:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number, NC-22-0034, submitted on December 28, 2022, has been approved. Through this SPA, North Carolina has demonstrated compliance with section 9821 of the American Rescue Plan Act of 2021 (ARP). This SPA has an effective date of March 11, 2021 and extends through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period, as described in section 1135(g)(1)(B) of the Social Security Act (the Act).

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

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

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

This letter approves North Carolina's request for a March 11, 2021 effective date and provides

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the state with the authority to modify the tribal consultation timeline.

Your Project Officer is Joshua Bougie. He is available to answer your questions concerning this amendment and other CHIP-related matters. His 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) 786-8117
E-mail: joshua.bougie@cms.hhs.gov

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

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

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

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: North Carolina
(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)) _____ (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)):

Name: Kody Kinsley	Position/Title: <u>Secretary, NC DHHS</u>
Name: Dave Richard_	Position/Title: <u>Deputy Secretary for Division of Health Benefits</u>
Name: <u>Melanie Bush</u>	Position/Title: <u>Deputy Director-Benefits and Services</u>

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

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))

North Carolina’s Title XXI Plan, North Carolina Health Choice for Children Program (NCHC) is a combination plan consisting of:

a. Medicaid Expansion Group:

-Children ages 0 (newborn) through 12 months with family income greater than 194% and up to 210% of Federal Poverty Level;

-Children ages 13 months through 5 years with family income greater than 141% and up to 210% of the Federal Poverty Level;

-Children ages 6 through 18 years with family income greater than 107% and up to 133% of the Federal Poverty Level

b. Separate Child Health Program:

Uninsured children from ages 6 through 18 years with family income between 133% and

211% of the Federal Poverty Level and who do not qualify for Medicaid.

- 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)

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: October 1, 1998

Implementation Date: October 1, 1998

The chart below incorporates five Modified Adjusted Gross Income (MAGI) CHIP State Plans by reference. The MAGI State Plans are attached to this file as appendices in .PDF format.

SPA #15-0001

Purpose of SPA: The primary purpose of SPA #15-001 is to implement program eligibility changes to reflect Affordable Care Act and State legislative requirements. The North Carolina Legislature has not amended any legislation affecting program benefits or cost sharing since 2011. This SPA also documents the repeal of North Carolina's CHIP buy-in program effective October 1, 2015.

Proposed effective date: October 1, 2015

Proposed implementation date: October 1, 2015

SPA #18-0007

Purpose of SPA: To implement provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor declared or federally declared disaster areas in North Carolina. In the event of a natural disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or FEMA declared disaster areas.

Proposed effective date: September 13, 2018

Proposed implementation date: September 13, 2018

SPA #19-0007

Purpose of SPA: To comply with updated template as well as to demonstrate compliance with Mental Health parity. The North Carolina CHIP program, North Carolina Health Choice (NCHC), is the only North Carolina (NC) benefit plan to which the final rule applies. The North Carolina Division of Medical Assistance (DMA) has completed an analysis of the NCHC benefit package and has determined that NC is compliant with the final rule.

Title XXI (Health Choice) services authorized by this State Plan are reimbursed at the Medicaid established rate for the provided service. Unless otherwise authorized within this section of the State Plan, Title XXI services are prospectively reimbursed and not subject to cost settlement.

Proposed effective date: October 1, 2017

Proposed implementation date: October 1, 2017

SPA #20-0005

Purpose of SPA: To implement provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor or Federally-declared disaster areas in North Carolina. In the event of a natural disaster or public health emergency, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such

adjustments, and the applicable Governor or Federally-declared disaster or public health emergency areas.

Proposed effective date: March 13, 2020

Proposed implementation date: March 13, 2020

SPA # 20-20014

Purpose of SPA: To implement a Health Service Initiative (HSI) that will expand an early literacy program that encourages reading for children age 0-5 years old through the Reach Out and Read initiative.

Proposed effective date: July 01, 2020

Proposed implementation date: July 01, 2020

SPA # 20-0010

Purpose of SPA: To comply with updated template as well as to demonstrate Substance Use-Disorder prevention that promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) requirements for children in CHIP.

Proposed effective date: October 24, 2019

Proposed implementation date: October 24, 2019

SPA # 22-0014

Purpose of SPA: To implement 12-month postpartum option, and to comply with continuous eligibility exception regulations for children in CHIP.

Proposed effective date: April 1, 2022

Proposed implementation date: April 1, 2022

SPA # 22-0034

Purpose of SPA: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

Proposed effective date: March 11, 2021

Proposed implementation date: March 11, 2021

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

The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR section 431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved Medicaid State plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state. The Division of Health Benefits is in constant and almost daily communication with the Eastern Band of Cherokee Indians. **For this SPA submission, the Tribe reviewed and approved this SPA submission as it was written.**

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.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- 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))

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)

North Carolina will expand and improve the delivery of an AAP-endorsed, evidence-based model to promote early literacy, early learning and school readiness as part of routine pediatric primary care visits for children, birth to age 5. This HSI will contribute to transforming the standard of pediatric care for young children in North Carolina to sharpen the focus on activities that support social and emotional development.

Over a three-year period, the initiative will support Reach Out and Read in North Carolina to:

- Expand to about 40 new clinic sites in targeted North Carolina counties, reaching approximately 30,000 children who are currently unserved;
- Increase the number of infants, birth to 6 months, served;
- Train roughly 120 new pediatric primary care providers to deliver the Reach Out and Read model;
- Prepare all providers (new and existing) in the “Back to Birth” component of the intervention, so all clinics can begin at birth, rather than 6 months of age; and
- Boost the percentage of clinics meeting the highest quality standards by providing training and technical assistance.

The state will document the initiative’s progress on performance and outcomes, reporting semi-annually on the following metrics: the number of children served; the number of children in low-income families served; the number of providers completing core training on the Reach Out and Read model; the number of providers trained to deliver the Reach Out and Read model from birth to 6 months of age; the number of new clinic sites launched; and the percentage of clinics achieving the highest quality rating (12/14 quality standards met.)

We project the total cost of the 3-year initiative to be \$3,013,000, of which \$2,400,432.30 will come from the state’s federal CHIP allotment. The state’s share of the cost will amount to \$643,056; the source of the non-federal share will be funding from the NC General Assembly. The state’s preferred effective date for program launch is July 1, 2020.

The Project

In the earliest stages of a child’s life, brain development is occurring at an unprecedented rapid pace, mediated by the nurturing, language-rich interactions that strengthen the parent-child bond and support social and emotional development. Such early responsive caregiving sets the stage for early literacy, early learning, and school readiness. In addition, reading aloud with children eases family stress and fosters feelings of safety and security, building resilience and enabling families and children to cope with social and emotional challenges.

Parents play a vital role in fostering healthy child development and they rely on supportive anticipatory

guidance delivered by their child’s health care provider during routine well-child visits. Recognizing these important factors, in 2014 the American Academy of Pediatrics (AAP) issued a policy statement making clear that literacy promotion is an essential component of pediatric primary care practice.¹

¹ Literacy Promotion: An Essential Component of Primary Care Pediatric Practice, American Academy of Pediatrics Policy

Starting in infancy, the AAP recommends that pediatric providers advise parents about the importance of reading aloud with their children and counseling them on developmentally appropriate shared-reading activities and the value of providing developmentally appropriate books at health supervision visits for children in low-income families.

Reach Out and Read², a clinic-based pediatric primary care intervention, operating in all 50 states and D.C., delivers on the benefits contemplated in the 2014 AAP Policy Statement. Pediatric care providers are trained to recognize and reinforce the strengths parents bring to the relationship with their infants and young children. The provider enters the exam room with a new, developmentally appropriate book which is used as a tool for observing the parent-child relationship and the child’s developmental stage, modeling effective dialogic reading techniques, and providing anticipatory guidance to parents, as referenced in the AAP policy statement.

Reach Out and Read works with a National Book Committee and a variety of large publishing partners, like Scholastic and All About Books, to develop a curated selected of high-quality books to serve the developmental needs of Reach Out and Read’s children/families and providers. They also work to make books available in a variety of languages to serve the cultural needs of families. Publishers create specific catalogs for Reach Out and Read and providers are able to select from the hundreds of vetted titles the books that they would like to utilize with the children/families in their community. In North Carolina, Reach Out and Read currently operates in 340 clinic locations in 88 counties. It is delivered by 1,700 pediatric care providers to roughly 263,000 young children, an estimated 75 percent of whom are in low-income families, and are covered under Medicaid or CHIP. This intervention can be implemented at a cost of \$15/child/year, which covers basic expenses including provider training, technical assistance, books, and evaluation. A component of Reach Out and Read’s engagement with providers also involves connecting providers to community resources such as libraries to train providers on how to connect children with programs and instructions to complete library card applications. NCDHHS considers books to be essential materials to the program. The documented benefits that Reach Out and Read delivers aligns with the goals of the North Carolina Early Childhood Action Plan and NCDHHS’ interests in assuring a robust medical home that not only attends to the medical needs of children and families, but also addresses health-related social needs.

The HSI will enable more of North Carolina’s children and families to benefit from Reach Out and Read by implementing the following project components and objectives:

Expand to all 100 North Carolina Counties. In addition to establishing Reach Out and Read in the 12 North Carolina counties that are unserved³, we will focus expanding to “hard to reach” locations in counties that already host Reach Out and Read. Such counties may include those with rural areas, those with fewer available health care options, or with limited capacity to explore opportunities like Reach Out and Read. We also will focus attention on counties where well-child visit compliance is low.

Statement, 2014 <https://pediatrics.aappublications.org/content/pediatrics/134/2/404.full.pdf>

2 Find information about Reach Out and Read and the evidence supporting its effectiveness.

<https://www.reachoutandread.org/about/> ; <https://www.reachoutandread.org/why-we-matter/the-evidence/>

3 Yancey, Mitchell, Avery, Watauga, Alleghany, Harnett, Sampson, Bladen, Greene, Halifax, Martin, and Tyrrell

By the end of FFY '22, Reach Out and Read will operate in 100% of NC counties, up from 88%. About 40 new clinic sites, will bring the total to 380 clinics statewide. An additional 120 pediatric primary care providers will be trained to deliver the Reach Out and Read model to 30,000 additional children from birth to age 5.

- **Begin at birth in all clinics.** While Reach Out and Read historically launched at the child's 6-month visit, research supports starting Reach Out and Read at the earliest well-child visit after a child is born (generally, the 2-week visit.) Doing so helps to take advantage of every opportunity to influence early brain development and establish nurturing family routines.

By the end of FFY '22, Reach Out and Read will have put in place a plan to increase the number of clinics that implement the intervention from birth from 85 (25%) to 380 clinics (100%), the effort will be complete after three to five years.

- **Improve quality so more clinics attain the highest Reach Out and Read quality rating.** We aim to ensure quality and fidelity to the evidence-based Reach Out and Read model by providing training and technical assistance. Clinics that meet 12 out of 14 quality standards earn the highest quality designation.

By the end of FFY '22, 90% of clinics will have attained the highest quality rating, an increase from 58% of clinics that currently meet that goal.

- **Increase support for robust Medical Engagement and Training.** Activities will focus on facilitating continuous learning and aligning research that supports the pediatric primary care providers' role with children and families. Other activities include developing CME-certified coursework available on the ROR-Carolinas Online Learning Community, partnering with providers on Quality Improvement work and supporting education and training for medical residents. This work is intended to connect with the needs of specific sites and also advance the field of primary care, in general.

By the end of FFY '22, at least one research project launched to evaluate the impact of Reach Out and Read on well-child visit compliance.

Over a three-year period, the HSI will be implemented according to a phased-in approach, as shown in Table 1. A supporting budget for each phase is presented in Table 2. Site quality standards are described in Figure 1. The state intends to use these HSI funds for three years.

- North Carolina provides assurances that the HSI program will only target children under the age of 19.
- North Carolina 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.

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.

The North Carolina Department of Health and Human Services, Division of Health Benefits, follows the same Tribal consultation process for the CHIP Program as it does for the State Medicaid Program. North Carolina received CMS approval on SPA 10-038 on March 17, 2011 to establish the Tribal consultation process which consists of a representative of the Eastern Band of Cherokee Indians sitting on the Medical Care Advisory Committee. The Advisory Committee meets at least quarterly to review activities of the Division of Health Benefits and provide recommendations and advice on current and future policy initiatives and pending changes to the Medicaid and CHIP programs. During the development of this SPA and prior to submission to CMS:

- The State sought the Tribe's advice and input on matters related to the changes to Medicaid and CHIP programs through the MCAC quarterly meeting.
- The State Medicaid Agency also notified the Tribe in writing of these pending CHIP SPA changes via e-mail on April 6, 2015 providing details of the changes.
- The tribe notified the Agency on April 6, 2015 that they were in agreement with the changes.
- Please see attached in the SPA submission packet the CMS standard tribal questions/responses, the notification to the tribes, and the tribal notification back to the State.

TN No: 10-038 Approval Date: 03/17/2011 Effective Date: 01/01/2011

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.

Potential new and returning applicants for the NC Health Choice Program are simultaneously screened by a county Department of Social Services (DSS) for eligibility in the State Medicaid Program at the time of application or re-application. This one-stop application process expedites eligibility determination and enrollment in either program. Another parallel between the State Medicaid Program and NC Health Choice is the use of the same claims processing vendor, Computer Sciences Corporation (CSC), as of July 1, 2013. This consolidation of claims processing under one vendor provides a standardized and efficient means of managing health services claims. Finally, beneficiaries in both the State Medicaid Program and NC Health Choice are assigned to a primary care provider medical home via the Community Care of North Carolina (CCNC) network within a primary care case management delivery system. 2011 State legislation mandated standardized requirements for Medicaid and Health Choice Provider applications, screenings, and enrollment.

Methods for Assuring Delivery

Program eligibility is determined through the use of the aforementioned dual Medicaid and Health Choice application by county DSSs. The State transmits new, revised, and cancelled NC Health Choice beneficiary records nightly to the claims processor. Upon determination of an applicant's eligibility and the collection of any applicable enrollment fee, the county eligibility specialist enters the new or renewal applicant's eligibility and demographic information into the State eligibility and enrollment system. The claims processor creates an updated eligibility file with a unique member ID number and generates an annual ID card for each NC Health Choice beneficiary. The card contains the coverage effective date, primary care provider contact information, medical and pharmacy co-payment amounts, and toll-free numbers for providers requesting prior authorization, benefit limits, and claim filing information. The beneficiary must present the ID card when seeking services at a provider office, hospital inpatient or outpatient facilities, or pharmacy. The provider can then verify eligibility via web or phone verification with the claims processor. In the event of an emergency for a beneficiary requiring medication, the claims processor has the authority to update beneficiary eligibility in the claims processing system manually for pharmacy Point-of-Sale verification.

The Division of Health Benefits (DHB) funds and maintains an account to reimburse the claims processor for claim and administrative expenses, in addition to expenses from other contracts established for NC Health Choice program services. Additional vendor contracts include actuarial services, third party recovery and subrogation services, independent auditor services to monitor claims payment accuracy rates, eyewear (glasses & contacts) services, and behavioral health services utilization review.

Choice of Financing

The NC Health Choice for Children Program is funded with federal funds in an enhanced Federal Medical Assistance Percentage ratio pursuant to the allotment to States in 42 USC § 1397dd and State appropriated funds.

Title XXI (Health Choice) services authorized by this State Plan are reimbursed at the Medicaid established rate for the provided service. Unless otherwise authorized within this section of the State Plan, Title XXI services are prospectively reimbursed and not subject to cost settlement.

Managed Care

Health Choice program services are all reimbursed on a Fee-for-Service basis within a primary care case management health service delivery structure (which qualifies as managed care under 42 C.F.R. 457.10). NC Health Choice beneficiaries are linked to a primary care provider in the Community Care of North Carolina (CCNC) primary care case management network. This network ensures cost-effective health care access and utilization. The NC Department of Health and Human Services pays CCNC providers the same per member, per month fees allowed under the State Medicaid Program. Providers are also being reimbursed on a Fee-for-Service basis for services rendered to NC Health Choice beneficiaries.

Health Choice beneficiaries select or are assigned to a CCNC Medical Home primary care provider (PCP). That provider's contact information appears on the beneficiary's health insurance ID card. Beneficiaries are encouraged to make an appointment to get a medical history established with their PCP; beneficiaries must see the PCP for most health care services and obtain referrals to see other providers.

Pursuant to 42 U.S.C. 1397cc(f)(3) and 42 U.S.C. 1396u-2(1)(c), enrollment in CCNC is optional for federally recognized American Indian Medicaid and NC Health Choice beneficiaries whether or not they receive services through tribal facilities.

Beneficiaries may change primary care providers by contacting the Department of Social Services. Beneficiary rights and procedures for changing providers are the same as those for the State Medicaid Program. Beneficiaries may change providers during a review process, when the currently authorized provider goes out of business, and when the beneficiary is changing providers for another service with an authorization period of six months or more. The current authorization for services will transfer to the new provider within five (5) business days of notification by the new provider to the Division of Medical Assistance Fiscal Agent and upon submission of written attestation that provision of the service meets NC Health Choice policy and the beneficiary's condition meets coverage criteria and acceptance of all associated responsibility; and *either*: a) Written permission of beneficiary or legal guardian for transfer; *or* b) a copy of a discharge from the previous provider. Authorization will be effective on the date that the new provider submits a copy of the written attestation. Prior to the end of the current authorization period, the new provider must submit a request for reauthorization of the service in accordance with the clinical coverage policy requirements and these procedures. Beneficiaries may change providers at any other time. However, the discharging provider and the new provider must follow all policy requirements and these procedures.

Effective October 1, 2015, North Carolina Health Choice hospital outpatient services, excluding laboratory services, for in-state hospitals shall be reimbursed at 70 percent (70%) of their allowable outpatient costs. North Carolina Health Choice allowable outpatient costs shall be determined using the CMS 2552 cost report, 42 CFR § 413, and the CMS Provider Reimbursement Manual. If a hospital's interim NC Health Choice payments exceed the allowable outpatient cost for NC Health Choice services, the provider shall remit the difference at the time the cost report is filed. The Division shall return the federal share of the difference via the CMS 64 Report. If a hospital's allowable outpatient cost for NC Health Choice services exceeds the NC Health Choice interim payments on the filed and accepted cost report, and subject to the availability of federal funds in the NC Health Choice allotment, the Division shall pay the difference to the provider and submit claims to the CMS for reimbursement of the federal share of that payment in the federal fiscal quarter following payment to the provider. No cost settlement payment shall be paid to the provider if funds in the NC Health Choice allotment are unavailable or insufficient to cover the federal share of the cost settlement.

Effective July 1, 2016, Local Health Departments shall be reimbursed their allowable costs for covered services, which are rendered to North Carolina Health Choice recipients. North Carolina Health Choice allowable costs for covered services shall be determined using the CMS approved cost report methodology in the Medicaid (Title XIX) State Plan, 42 CFR § 413, and the CMS Provider Reimbursement Manual. If a local health department's interim NC Health Choice payments exceed the provider's certified cost for NC Health Choice services, the provider shall remit the excess federal share of the overpayment at the time the cost report is filed. The Division shall return the federal share of the difference via the CMS 64 Report. If a local health department's certified cost for NC Health Choice services exceeds the NC Health Choice interim payments on the filed and accepted cost report, and subject to the availability of funds in the NC Health Choice allotment, the Division shall pay the federal share of the difference to the provider and submit claims to the CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider. No cost settlement payment shall be paid to the provider if funds in the NC Health Choice allotment are unavailable or insufficient to cover the federal share of the cost settlement.

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.

All Health Choice enrollees who receives Primary Care Case Management (PCCM) are fee-for-service.

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

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

Managed care organization (MCO) (42 CFR 457.10)
 Capitation payment
 Describe population served:

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.

PIHP does not require a rebate if the 85% benchmark has not been met. The State does require our PAHP to pay a remittance through the contract for not meeting

the required minimum MLR. The State will require MCOs to pay a remittance through their contracts for not meeting their required minimum MLRs.

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

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

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

3.4 Enrollment

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

3.4.1 Enrollment Process

- 3.4.1.1 The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in

42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

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

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))
 Yes
 No

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

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

3.4.2 Disenrollment

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

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

3.4.2.3 If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll

in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)

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

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

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

3.4.2.5 Enrollee Requests for Disenrollment.

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

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

- Yes
- No

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

- The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))
- The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))
- The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:
 - During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
 - At least once every 12 months thereafter;
 - If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
 - When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))
- 3.4.2.6 The State assures that the State ensures timely access to a State review for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(2))

3.5 Information Requirements for Enrollees and Potential Enrollees

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

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

PCCM entity to notify its enrollees:

- That oral interpretation is available for any language and written translation is available in prevalent languages;
- That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
- How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

3.5.7 ☒

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

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

PIHP, PAHP and PCCM entity, including enrollee satisfaction.

- 3.5.8** The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.
- 3.5.9** The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
 - The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).
- 3.5.10** The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:
- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
 - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
 - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
 - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
 - The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
 - Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
 - The extent to which, and how, after-hours and emergency coverage are

provided, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.6 Benefits and Services

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

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

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

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

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

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

3.6.11

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

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

3.6.12

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

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

3.6.13

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

3.6.14

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

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

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

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

Guidance: For assurances 3.6.17 through 3.6.20, applicability to PIHPs and PAHPs is based on 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 438.408(b) and (c))

3.9.16

The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the

MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b) and (c), and 42 CFR 438.410(a))

- 3.9.17** The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))
- 3.9.18** The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:
- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
 - Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
 - Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))
- 3.9.19** The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))
- 3.9.20** The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))
- 3.9.21** For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:
- The results of the resolution process and the date it was completed; and
 - For appeals not resolved wholly in favor of the enrollees:
 - The right to request a State review, and how to do so.
 - The right to request and receive benefits while the hearing is pending, and how to make the request.

- That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

- 3.9.22** For notice of an expedited resolution, the State assures that each contracted MCO, PIHP, or PAHP makes reasonable efforts to provide oral notice, in addition to the written notice of resolution. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(ii))
- 3.9.23** The State assures that if it offers an external medical review:
- The review is at the enrollee's option and is not required before or used as a deterrent to proceeding to the State review;
 - The review is independent of both the State and MCO, PIHP, or PAHP; and
 - The review is offered without any cost to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(f))
- 3.9.24** The State assures that MCOs, PIHPs, and PAHPs do not take punitive action against providers who request an expedited resolution or support an enrollee's appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(b))
- 3.9.25** The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:
- The right to file grievances and appeals;
 - The requirements and timeframes for filing a grievance or appeal;
 - The availability of assistance in the filing process;
 - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
 - The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)
- 3.9.26** The State assures that it requires MCOs, PIHPs, and PAHPs to maintain records of grievances and appeals and reviews the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy. The record must be accurately maintained in a manner accessible to the state and available upon request to CMS. (42 CFR 457.1260, cross-referencing to 42 CFR 438.416)

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

3.10 Program Integrity

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

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

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

PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility;
- Provision for notification to the State when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCO, PIHP or PAHP;
- Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis;
- In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least \$5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers;
- Provision for the prompt referral of any potential fraud, waste, or abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and
- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

3.10.5

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

- 3.10.6** The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))
- 3.10.7** The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))
- 3.10.8** The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))
- 3.10.9** The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))
- 3.10.10** The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))
- 3.10.11** The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)
- 3.10.12** The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:
- Encounter data in the form and manner described in 42 CFR 438.818.
 - Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.

- Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.
- Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.
- Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.
- The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13

The State assures that:

- It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))
- It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and
- It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

3.10.14

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

3.10.15

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

3.10.16

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

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

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

3.11 Sanctions

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

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

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

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

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

- Yes
- No

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

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

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

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

3.12 Quality Measurement and Improvement; External Quality Review

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

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

3.12.1 Quality Strategy

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

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

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
- A description of:
 - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
 - The performance improvement projects to be implemented in

accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;

- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a “significant change” for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

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

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

- 3.12.1.4 The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))
- 3.12.1.5 The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii).
- 3.12.1.6 The State assures that it will submit to CMS:
- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
 - A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))
- 3.12.1.7 Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:
- Make the strategy available for public comment; and
 - If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))
- 3.12.1.8 The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

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

- 3.12.2.1.1 The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR

438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The elements of the assessment and program include at least:

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

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

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

Guidance: Only states with a PCCM entity whose contract with the State provides for shared savings, incentive payments or other financial

reward for improved quality outcomes need to, complete the next assurance (3.12.2.1.3).

- 3.12.2.1.3** The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:
- Standard performance measures specified by the State;
 - Mechanisms to detect both underutilization and overutilization of services; and
 - Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

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

- 3.12.2.2.1** The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))
- 3.12.2.2.2** The State assures that it annually requires each MCO, PIHP, and PAHP to:
- 1) Measure and report to the State on its performance using the standard measures required by the State;
 - 2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
 - 3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))
- 3.12.2.2.3** The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:
- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and

- The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

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

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

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

3.12.4 Quality Rating

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

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

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

3.12.5 Quality Review

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

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

3.12.5.1 External Quality Review Organization

- 3.12.5.1.1** The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))
- 3.12.5.1.2** The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

3.12.5.2 External Quality Review-Related Activities

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

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

- 3.12.5.2.2** The State assures that if it elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will document the use of nonduplication in the State’s quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)
- 3.12.5.2.3** The State assures that if the State elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will ensure that all information from a Medicare or private accreditation review for an MCO, PIHP, or PAHP will be furnished to the EQRO for analysis and inclusion in the EQR technical report described in 42 CFR 438.364. ((42 CFR 457.1250(a), cross referencing to 42 CFR 438.360(b))

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

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

3.12.5.3 External Quality Review Report

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

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

(iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))

- 3.12.5.3.2** The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).
- 3.12.5.3.3** The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:
- The EQRO has sufficient information to use in performing the review;
 - The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;
 - For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
 - The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))
- 3.12.5.3.4** The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:
- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));
 - For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
 - Objectives;
 - Technical methods of data collection and analysis;
 - Description of data obtained, including validated

performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and

○ Conclusions drawn from the data;

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

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

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

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

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

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

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

Section 4. Eligibility Standards and Methodology

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:

NC uses Title XXI funding to expand Medicaid benefits to the following assistance categories based on family income in relation to the Federal Poverty Level:

1. Children 0 – 12 months of age with family income from 194% up to and including 210% of the federal poverty income level;
2. Children 13 months – 5 years of age with family income from 141% up to and including 210% of the federal poverty income level; and
3. Children 6-18 years of age with family income from 107% up to and including 133% of the federal poverty income level.

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.

North Carolina has been conducting a daily, automated match with social security numbers provided on joint Medicaid and NC Health Choice eligibility applications since January of 2010. If an applicant claims to be a U.S. citizen, the DSS sends the Social Security number to the Social Security Administration (SSA) for a citizenship match. The average response time for a match through the SSA 22 is 24 to 48 hours.

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

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

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

Pursuant to N.C. GEN. STAT. § 108A 70.21(a)(1), all beneficiaries in the separate CHIP Program (NC Health Choice) must be 6 through and including 18 years of age.

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 % of the FPL (SHO #02-004, issued November 12, 2002)

N.C. Health Choice beneficiaries receive benefits in the following assistance categories based on family income in relation to the Federal Poverty Level.

- Income of above 133% up to and including 159% of the Federal Poverty Income Level; and
- Income in excess of 159% up to 211% of the Federal Poverty Income Level.

Household income must be above Medicaid income guidelines and from above 133% and up to and including 211% of the federal poverty level (FPL). Countable household monthly income is determined using the same Modified Adjusted Gross Income (MAGI) guidelines as for Title XIX. Earned income is determined by review of provided pay stubs, copies of checks, business records for self-employment, or other written proof of income as requested. New applications require proof of income for the month prior to application. Renewal eligibility determinations require proof of income for the month prior to renewal review. Self-employment income is determined using a base period of 12 months immediately prior to application. Exceptions to the 12-month period use the same guidelines as Title XIX. Unearned income is determined using the same guidelines as Title XIX. The monthly income base period is the month prior to application or renewal review. The child support base period is six (6) months.

Family size is determined by the tax household under the MAGI rules for both Medicaid and NC Health Choice. Under MAGI rules, there is a 5% income disregard if an applicant lives in a household with an income too high to qualify for Medicaid eligibility. (Per CMS guidance and

instructions, North Carolina applies the 5% disregard if income exceeds the NC Health Choice limit. The 5% disregard would have already been applied to the highest income limit Medicaid program available prior to evaluating for NC Health Choice).

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

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

Beneficiaries must be residents of North Carolina pursuant to N.C.

GEN. STAT. § 108A 70.21(a)(1). State residency verification is controlled by N.C. GEN. STAT. § 108A-55.3.

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:

Pursuant to N.C. GEN. STAT. § 108A 70.21(a)(1), an applicant is ineligible for the NC Health Choice program if he or she is insured or is eligible for Medicaid, Medicare, or other federal government sponsored insurance.

A child must be uninsured to be eligible for NC Health Choice. Uninsured means the applicant is not covered under any private or employer-sponsored creditable health insurance plan on the date of enrollment into the program and is ineligible for Medicaid, Medicare or other federal government sponsored insurance.

4.1.8 Duration of eligibility, not to exceed 12 months:

Pursuant to N.C. GEN. STAT. § 108A 70.21(a)(4), enrollment is continuous for one year. However, due to the addition of the 12-months postpartum continuous eligibility period for pregnant children under North Carolina Health Choice, individuals who, while pregnant, were eligible and received services under the state child health plan or waiver shall remain eligible throughout the duration of the pregnancy (including any period of retroactive eligibility) and the 12-month postpartum period, beginning on the day the pregnancy ends and ending on the last day of the 12th month consistent with paragraphs (5) and (16) of section 1902(e) of the SSA. However, pursuant to N.C. GEN. STAT. § 108A 70.21(a)(3), if a beneficiary acquires health insurance other than (in addition to) the NC Health Choice Program after enrollment and prior to the expiration of the eligibility period of one year, then the beneficiary will be deemed to be insured and ineligible for continued coverage under the Program.

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:

- Pursuant to 42 USC 1397jj(b)(2), targeted low-income children do not include inmates in a public institution and patients in an institution for mental diseases, as defined in 42 C.F.R. 435.1010, at the time of initial application for the Program or at the time of eligibility redetermination.
- Applicants ineligible for the Medicaid Program solely because of a failure to comply with procedural requirements (e.g., proving required eligibility determination information) are not eligible for the Title XXI NC Health Choice Program.

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 a 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.

Program eligibility is determined through the use of a dual Medicaid and NC Health Choice application by a county DSS. Applications require a Social Security number for each child applying for health insurance coverage.

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

- 4.1.9.2** Continuous eligibility

The period of enrollment is twelve (12) continuous months from the date of initial enrollment. An increase in household income during the continuous enrollment period does not affect current enrollment. The eligibility worker only reviews household income during the annual renewal review to determine eligibility for a new 12-month enrollment period. However, if family income decreases during the continuous enrollment period, a family may request to apply for Medicaid eligibility. Also, individuals who, while pregnant, were eligible and received services under the state child health plan or waiver shall remain eligible throughout the duration of the pregnancy (including any period of retroactive eligibility) and the 12-month postpartum period, beginning on the day the pregnancy ends and ending on the last day of the 12th month consistent with paragraphs (5) and (16) of section 1902(e) of the SSA

Exceptions to the 12-month continuous enrollment period that will result in coverage cancellation include:

- Child moves out of state
- Child turns age 19

- Child dies
- Child's family submits a voluntary request for termination
- County case workers are unable to locate the child

On September 18, 2015, Session Law 2015-241, Appropriations Act of 2015 (State budget) was signed into law. As a result, Section 12H.14. (c) of the Act repealed N.C. General Statute §108A-70.21(g), which authorized the purchase of Extended Coverage or buy-in for NC Health Choice beneficiaries who had become ineligible for insurance because of a family income increase. Due to the repeal of the Extended Coverage General Statute, effective October 1, 2015, the program was terminated.

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 least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;
- (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
- (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
- (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

Elected for pregnant women.

Elected for children under age 19

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

4.1-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)

A. Application Availability:

Joint application forms for Medicaid and NC Health Choice for Children are available at community government offices including local health departments, county DSS offices, and unemployment offices. Special displays and application forms are also available at community locations frequented by potential applicants. These include: Human Resource departments of local employers; public school administration and school nurse areas; neighborhood churches; non-profit food distribution centers; subsidized and church-based day care; and Mother's Day Out locations. In addition, outreach workers regularly visit and maintain outstations within safety net hospital Emergency Departments, Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), migrant health centers, and Indian health centers.

English and Spanish versions of application forms and educational materials are available for on-line completion and printing from the NC DHHS Health Choice Program Web pages. Assistance in filling out the forms is available through county DSS and any of the specially designated outstations.

Eligibility Determination:

NC Health Choice provides 12 months of continuous coverage for eligible children. The 12-month certification period for siblings within the same household can differ if the siblings apply for and are approved for coverage in different months.

All new and renewal applications are processed within the CMS standard of 45 calendar days from the received date of the signed application. The receipt date (Processing Day One) is the calendar day on which the county social services office receives the signed application. Mail picked up from the post office for processing on a non-State business day is determined as officially received on the next State business day. Applicants may apply via telephone with a DSS and the date of the application will be the call date. However, applicants must follow up with a signature page within the application processing time frame. Any unsigned application is not a valid application and does not preserve the potential effective date even if the child is ultimately approved for coverage.

CHIP Disaster Relief:

- At State's discretion, the State will extend the redetermination timelines for current CHIP

enrollees living and/or working in Governor or Federally-declared disaster areas or other areas as determined by the North Carolina Department of Health and Human Services. (42 CFR 457.340)

- At State's discretion, the State may also waive: (1) the annual enrollment fee and co-payments; and (2) unpaid enrollment fee balances for applicants and/or current enrollees who are living and/or working in Governor or Federally-declared disaster areas or public health emergency areas or other areas as determined by the North Carolina Department of Health and Human Services.
- At State's discretion, requirements related to timely processing of applications may be temporarily waived for a state that has CHIP applicants who reside and/or work in state or Federally-declared disaster area.
- At State's discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP beneficiaries who reside and/or work in state or Federally-declared disaster area.
- At State's discretion, the State may delay acting on changes in circumstances for CHIP beneficiaries other than the required changes in circumstances described in 42 CFR 457.342(a) cross-referencing 42 CFR 435.926(d).

Enrollment Fee:

Counties collect an annual enrollment fee when family income is between 159% and 211% of FPL. The annual fee is \$50 per child, with a \$100 maximum per family for two or more children. The county DSS retains each enrollment fee to help offset application processing administrative costs. Applicants who are members of a federally recognized American Indian tribe and Alaskan Natives are exempt from the enrollment fee and are identified by a unique race code and enrollment category.

Enrollment Method:

County DSS caseworkers enter new enrollments into NC FAST, a statewide eligibility information system. NC FAST also generates an automated Notice of Eligibility or denial of approval for benefits for each applicant. The notice is mailed to the applicant within one (1) business day of the decision.

Once an applicant is deemed eligible, coverage is retroactively effective as of the first day of the month in which the applicant submitted a signed application. There are, however, two exceptions to the availability of a retroactive effective date since Health Choice beneficiaries cannot have any other form of comprehensive health insurance:

1. If the child has active Medicaid in the month of a Health Choice application, NC Health Choice coverage begins the first day of the month *following* Medicaid termination.

2. If the child has active comprehensive insurance in the month of application, NC Health Choice coverage begins the first day of the month *following* other insurance termination. The State requires written proof of the other insurance termination date and cannot accept verbal confirmation from the applicant.

New Enrollments:

The experience of the typical enrollee will be as follows:

The family learns about the NC Health Choice program, completes the joint Medicaid – Health Choice application form online on the Federally Facilitated Marketplace, via mail, or in person at the county DSS. The local DSS assesses the application and makes one of three possible determinations within 45 days:

1. The child is eligible for Medicaid

The caseworker enters application and enrollment information into NC FAST, including the Medicaid coverage effective date.

2. The child is eligible for NC Health Choice

The caseworker enters application and enrollment information into NC FAST with three possible outcomes:

a. No Annual Enrollment Fee Required:

The caseworker creates the new enrollment with the coverage effective date in NC FAST.

b. Annual Enrollment Fee Required:

The annual enrollment fee must be paid in full prior to enrollment and coverage activation for eligible children in a family with an annual income level requiring the fee. The child is enrolled in the Title XXI program *after* receipt of the appropriate enrollment fee for families between 159-211% FPL. American Indian and Alaskan Native children are exempt from this requirement regardless of family income.

The enrollment fee is \$50 for one child and \$100 for two or more children in the same family.

The family has twelve (12) calendar days from the date on the county DSS Notice of Eligibility to pay the enrollment fee. During the initial 12-day period, applicants may ask for an additional twelve (12) days to pay the enrollment fee. If the fee remains unpaid as of the 13th calendar day of the extension period DSS will mail a denial / termination notice to the applicant.

c. Enrollment Freeze

The child is eligible for NC Health Choice. However, he or she cannot be enrolled because the State's NC Health Choice budget is insufficient to cover additional enrollees (Title XXI is not an entitlement program). New eligible applications are frozen and the child's name is added to the statewide "wait list." The enrollment fee (if required) is not billed or requested until an enrollment opening becomes available for the child. Section 4.3.1 contains additional information about the Enrollment Freeze policy and procedures.

3. Applicant is Ineligible for both Medicaid and NC Health Choice

The child fails to meet one or more eligibility requirements for both programs and is ineligible for both Medicaid and NC Health Choice.

B. Renewal Review/ Enrollment:

NC Health Choice provides 12 months of continuous enrollment without regard to changes in income.

An *increase* in family income during the enrollment period has no impact on NC Health Choice eligibility, even if the new household income is above 211% FPL. Enrollees are not required to notify the DSS caseworker regarding income changes during the continuous enrollment period. If the family notifies the caseworker of increased household income, the file will be annotated and reviewed at renewal through current income verification requirements.

A *decrease* in family income below the NC Health Choice minimum income requirement also does not affect eligibility during the continuous enrollment period. However, a parent or guardian may request an eligibility re-evaluation to determine Medicaid eligibility. Upon Medicaid approval, NCHC coverage is terminated and Medicaid enrollment created with no gap in coverage.

North Carolina DSS offices implement an *ex parte* process to facilitate re-enrollment for CHIP beneficiaries.

If an enrollment fee is due, the family has 12 calendar days from the date on the county DSS Notice of Enrollment Fee to pay the fee. If the fee remains unpaid as of the 13th calendar day following the notice date, the case is terminated for non-payment of the enrollment fee.

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.

The North Carolina DHHS Secretary may choose to freeze new NC Health Choice enrollments if State-appropriated funds are depleted prior to the end of the State fiscal year. This process is referred to as a “freeze.” Current beneficiaries who remain eligible at renewal receive another 12-month continuous eligibility period; however newly eligible applicants are placed on a waiting list. The State notifies CMS prior to initiation of an enrollment freeze and associated

wait list. The general public, potential beneficiaries, and enrolled children receive notification through public media (newspaper and website) of the new enrollment suspension and wait list process.

The freeze remains in place indefinitely until the NC DHHS Secretary determines that enrollment levels are within budgeted and legislated parameters. However, a freeze period can be no less than two consecutive months. The chart below identifies Enrollment Freeze Notice Requirements.

<i># Days Prior to Freeze Effective Date:</i>	<i>Contact</i>	<i>Notification Method</i>
45 calendar days	US DHHS CMS	Phone call to CMS Regional Coordinator Written notice to same
60 calendar days	Current Enrollees	Written notice to currently enrolled beneficiaries NC DHHS website alert
30 calendar days	Public – Providers	DMA NC Medicaid Provider Bulletin Recorded notice on Automated Verification Response System (AVRS) Posted notice on web-based eligibility system, NC FAST
<i># Days Prior to Freeze Effective Date:</i>	<i>Contact</i>	<i>Notification Method</i>
30 calendar days	Public – DSS Offices	“Dear County Director” notification letter Notice of enrollment freeze posted on DSS intranet.
30 calendar days	Public Outreach Groups Other State Agencies NCHC Contractors	Notification Letter to existing advocacy, outreach, and key stakeholder entities Mass internal email notice to all state agency management personnel
20 calendar days	Media	NC DHHS Press Release

Notice will be provided to the Centers for Medicaid and Medicare Services (CMS) 45 days in advance of the implementation of any enrollment freeze. Written notification will be announced to the current enrollees via letter 60 days prior to the imposition of an enrollment freeze and to the news media no later than 20 days before a new enrollment freeze is to be implemented. The

purpose of the plan is two-fold:

- Limit enrollment in a manner that does not impose an extra burden on families to file multiple repeat applications; and
- Allow children to enroll as slots become available rather than waiting for a pre-established date.

The initial closure will last a minimum of two consecutive months to allow children with renewals in the first month of the freeze period adequate time to submit their renewal application, including the grace period, and to begin to build an inventory of open enrollment slots.

New Application Processing:

The NC Health Choice freeze has no impact on the Medicaid program. Medicaid is an entitlement program in which the State enrolls all qualified beneficiaries. As a Title XXI program, NC Health Choice is not an entitlement program. Enrollment is dependent upon available State funding to cover plan medical and administrative expenses for current enrollees in addition to new applicants. However, families may continue to file applications and counties will determine eligibility as usual. In addition, Medicaid is always evaluated first before applying the NC Health Choice freeze

Medicaid Eligible:

Children determined eligible for Medicaid will be approved and enrolled.

- NC Health Choice Eligible (during new enrollment freeze)

Children determined newly eligible for NC Health Choice will be denied enrollment and provided with information that the child qualifies for the program, yet cannot be enrolled due to a freeze. The child will be added to the statewide wait list for later notification by the DSS caseworker when a new enrollment slot becomes available or the freeze is lifted. The State establishes an automated wait list within NC FAST and adds the child to the end of the waiting list. Children eligible for NC Health Choice on the inactive wait list are not included in the nightly updates sent to the Claims Processing Contractor until they are enrolled in an available program slot or the new enrollment freeze is lifted.

- Ineligible for Medicaid and NC Health Choice If the child is determined to be ineligible for either program, the application will be denied with no further action. However, the family may choose to re-apply at any time.

Renewal Enrollments: Children currently enrolled in NC Health Choice receive a new 12-month continuous eligibility period with no break in coverage if the signed renewal application is received within the ten-day grace period. The signed application must be received by the county DSS office within ten (10) calendar days of the renewal date. An unsigned application is not a

valid application and does not preserve the renewal enrollment exception permitted during the freeze. Renewal applications received by the county DSS after the ten-day grace period are handled as new applications and processed accordingly.

New Application Wait List Procedures:

- At the time of application, a registration number is created so the wait list applications can be sequenced chronologically according to the date of application stored in NC FAST.
- The State reactivates applications on a first in – first out method based on the registration number. When a child’s application is re-activated for enrollment, the child is removed from the waiting list and the number of NC Health Choice children on the application reduces available enrollment slots.
- When the NC DHHS Department of Health Benefits (DHB) determines that there are available program openings to allow for new enrollments, it will notify the Division of Information Resources Management (DIRM) of the specific number of open slots. The notification can occur during the freeze if it is determined enough children have dropped off of NC Health Choice (due to ineligibility or becoming eligible for Medicaid. The waiting list can be reduced in increments as determined by DHB Management until the freeze is lifted. The waiting list is reduced in date order.
- The 45-calendar day application processing timeline begins the day the case is re-activated. NC FAST generates notification to the family that the application has been re-opened and asks that the family confirm their current residence address and the child’s current insurance status. The family has 12 calendar days to provide the requested information. Day One is the date of re-activation notice issuance as recorded in the NC FAST case history data.
- If the family does not return the reactivation notice within 12 calendar days from the letter production date, the county caseworker checks agency records to see whether an address change has occurred and will mail a second notice. The family has 12 calendar days from the date of the EIS re-activation notice to respond to the 2nd request for current information.
- Incomplete or unsigned information forms received by the DSS or result in a new letter to the family requesting the missing information. The family has 12 calendar days from the date of the letter to respond. A 2nd letter is sent on the 13th calendar day and gives the family another 12 calendar days to respond.
- The application is denied on the 46th calendar day after reactivation if there is no response or it remains incomplete. The county DSS takes no action on the re-activated application pending return of the completed and signed information update. Should a family not reply within 45 days, the application is denied and the number of enrollment positions allotted for the children in the family are released to the children next in line on the wait list. The family has the right to submit a new application at any time, and is subject to all new application requirements and/or restrictions in place at that time.
- If required information is completed and the child remains eligible and approved for NC Health Choice, the caseworker mails a notice within 45 days of the decision. The notice includes the amount of any enrollment fee due with the statement that full payment is required prior to the child’s enrollment and NC Health Choice coverage activation.
- NC Health Choice benefits begin the first day of the application re-activation month and will

continue for 12 consecutive months from that date.

Ending the Enrollment Freeze

If the State budget shortfall and enrollment cap are resolved, all children on the wait list receive enrollment review priority. Wait list children must have the first opportunity to enroll in the program before enrollment opens to new applicants in general. The NC DHHS immediately notifies CMS in writing of the freeze end date and the number of children on the wait list. Wait listed applications will be reviewed in chronological order based on the date that they were added to the wait list. If an application on the wait list is re-activated within three months (90 calendar days) of the date the child was initially placed on the wait list, the family must confirm the child's current insurance status. The State will use the verified income from when the applicant first applied to determine eligibility. If an applicant is on the wait list for longer than three months, caseworkers will re-verify insurance and income at the time of re-activation.

Based upon family income, some children must pay annual enrollment fees in order to re-enroll. Children who have applied and been determined eligible for NC Health Choice with an enrollment fee requirement do not pay the enrollment fee until they are off of the waiting list and ready to enroll in the program. However, if the required annual enrollment fee is not paid, the wait listed applicant will be denied re-enrollment.

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.

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

agencies.

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.

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

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.

Pursuant to N.C. GEN. STAT. § 108A 70.21(a)(1), an applicant is ineligible for the NC Health Choice program if he or she is insured or is eligible for Medicaid, Medicare, or other federal government sponsored insurance. A child must be uninsured to be eligible for NC Health Choice. Uninsured means the applicant is not covered under any private or employer sponsored creditable health insurance plan on the date of enrollment into the program and is ineligible for Medicaid, Medicare or other federal government sponsored insurance.

- 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))

Medicaid and NC Health Choice use the same application form to ease the administrative burden on families applying for benefits. County caseworkers initially screen all applications for Medicaid eligibility. If the child is not eligible for Medicaid, the review progresses with an evaluation of NC Health Choice eligibility. The review includes a search of the NC FAST database for existing Title XIX or Title XXI enrollment or the presence of other creditable insurance. Citizenship and identity status for each applicant is validated through automated queries and responses between the SS Bendex database and the DSS county office or tribal office. DSS workers obtain income verification, and request any additional information necessary. If family income is within Title XIX limits and the child meets all other Medicaid eligibility requirements, Medicaid enrollment occurs.

- 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))

During the application process described in 4.4.2 above, if family income exceeds the Medicaid income limit and is at or below 211% of FPL, the child will be enrolled in the NC Health Choice Program if all other Program eligibility requirements set forth in G.S. 108A-70.21(a) are met.

- 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)

A child must be uninsured to be eligible for NC Health Choice. As defined in G.S. 108A-70.18(8), “uninsured” means the applicant is not covered under any private or employer-sponsored comprehensive health insurance plan on the date of enrollment. Comprehensive coverage is health insurance that provides basic medical care and hospitalization, whether group, private plan, HMO, or other managed care plan. It also includes Medicare, TRICARE, State health insurance risk pools and other public health plans. Comprehensive insurance does not include policies that pay for specific illnesses or pay a daily amount while a person is

hospitalized.

A child is also considered uninsured if:

- The non-custodial parent with a court order for medical support is providing coverage through a medical insurance plan (e.g., a managed care plan with a limited network of providers) that is located outside of the child's state of residence.
- The non-custodial parent with a court order for medical support is not providing coverage under a medical insurance policy even if he or she has been ordered to make direct payment for medical care.
- He or she is covered by a full service Health Maintenance Organization (HMO) which does not have a network of medical providers in the child's county of residence (and therefore the child does not have "reasonable geographic access to care" pursuant to 42. C.F.R. § 457.310(b)(2)(ii).

State employees must pay 100% of the monthly health insurance premium costs for any dependents covered under the State Employees' health insurance plan. There is no "more than nominal" amount contributed by the State. Therefore, pursuant to 42 C.F.R. § 457.310(c)(1), children of State employees and teachers are eligible for coverage under Title XXI in North Carolina.

If an otherwise eligible child has active comprehensive health insurance as of the date of application, NC Health Choice enrollment will begin on the first day of the month following proof of a termination date for other coverage. Beneficiaries enrolled following voluntarily termination of private or employer-sponsored comprehensive health insurance are assigned a specific enrollment code to permit the State to determine whether the crowd out rate is negatively impacted.

- 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))

American Indian and Alaska Native children who self-identify at the time of application are exempt from all enrollment fees and co-payments associated with the Program. Eligibility categories and cost-sharing requirements are outlined in Section 8.

American Indian and Alaska Native beneficiaries in the NC Health Choice Program are also

subject to other exceptions pursuant to federal regulations. For example, these beneficiaries are eligible for the federal Vaccines for Children Program, and the Division of Medical Assistance notifies providers that they are to administer vaccines accordingly. All other beneficiaries in North Carolina's separate CHIP Program are deemed "insured" and therefore ineligible for the Vaccines for Children Program. For American Indian and Alaska Native beneficiaries, the assignment of a primary care provider medical home within the Community Care of North Carolina (CCNC) primary care case management delivery system is optional; the assignment is mandatory for all other NC Health Choice Program beneficiaries.

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))

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):

North Carolina employs a combined marketing approach for the State Title XIX and XXI Programs. Outreach approaches employ social marketing principles and consider the needs of diverse populations (e.g., preferred languages, ethnic and cultural social norms, the specific concerns for parents/guardians of children with special health care needs, and materials targeted for low literacy populations). The Division of Public Health in the NC Department of Health and Human Services has a staff position focusing specifically on minority outreach for Health Check (Medicaid for Children) and NC Health Choice. Establishing trust within the minority communities opens new doors for outreach and education. The DPH Minority Outreach Consultant works through minority-led State and Community-Based Organizations (CBOs) to reach African American, American Indian, Latino, and other Immigrant/Refugee communities.

Education is carried out in venues such as mobile consulate visits, Latino heritage festivals, Hmong cultural celebrations, American Indian pow wows and the Commission on Indian Affairs, African American sororities/fraternities, and other social/cultural events. Minority-owned businesses (e.g., grocery stores, beauty salons, media, and restaurants) are often willing to share child health insurance information with their customers. Another outreach opportunity has been through faith-based services and family events within the Catholic (Latino, Vietnamese, and Congolese), Baptist (Korean) and Muslim (Arabic) traditions. Through the statewide Refugee Advisory Council, these relationships enable the State to focus-test professionally translated outreach materials in seven languages. The Refugee Advisory Council also keeps DHB abreast of the most rapidly growing refugee populations (currently Burmese, Bhutanese/Nepali, Vietnamese, Iraqi, Cuban and Somalian).

The NC Division of Public Health (DPH) leads outreach and marketing efforts in collaboration with a host of State, regional and local public and private partners. DPH publishes a one-page, bi-lingual (English and Spanish) fact sheet as part of its marketing efforts. Hard copies are mailed out with other consumer information about federal poverty guidelines, and DPH maintains electronic copies of the fact sheet on its Women’s and Children’s Health Web page. The Division of Medical Assistance also provides links to the electronic version of the fact sheet on its website. The fact sheet highlights income eligibility guidelines, health benefits available, and how to apply for both Medicaid and NC Health Choice.

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:

As the Title XXI program has matured since its inception in 1998, NC has re-focused outreach efforts on infrastructure development by working with partners to integrate outreach for child health insurance programs into the ongoing work of their State and local organizations. State and local partners engaged in child health insurance outreach include:

Early Childhood Organizations: Smart Start, More-at-Four, Head Start & Pre-Kindergarten Programs; Child Care Resource and Referral Agencies; Child Care Health Consultants; NC Association for the Education of Young Children; NC Division of Child Development; and various Child Care Provider Associations are all invaluable partners. The preschool age programs in particular educate parents before their children reach the Health Choice eligibility age of six years.

Schools: The NC Department of Public Instruction (DPI) collaborates through its NC Healthy Schools and Child Nutrition Sections (Free/Reduced Price School Meals). Other related collaborators include the School Nurses Association of North Carolina; the School Health Advisory Councils; the School Support Services Staff (Psychologists, Social Workers, Counselors); Coaches; School-Based and School Linked Health Centers; and the NC Parent Teacher's Association. The NC Community Colleges' Basic Skills and Literacy staff have also been partners in assisting with outreach efforts with their GED, Adult High School, and English-as-a-Second-Language classrooms (faculty and students).

Health Care Providers: Collaborators include the NC Pediatric Society; the NC Academy of Family Physicians; Local Medical Societies; Associations representing Physician Assistants and Nurse Practitioners; Safety Net Providers (Health Departments; Community, Rural, Indian and Migrant Health Centers; Free Clinics); the NC Hospital Association; and Hospital Finance and Emergency Department Staff.

Governmental Partners: Several Department of Health and Human Services divisions (Social Services, Medical Assistance, and Public Health) partner through their respective programs. Other governmental partners include the NC Office of Minority Health and Health Disparities; the Department of Public Instruction; the Employment Security Commission; the Department of Juvenile Justice and Delinquency Prevention; the Housing Authority; NC Community College System; Cooperative Extension Agencies; Parks and Recreation Departments; Vocational Rehabilitation agencies; the NC Commission of Indian Affairs; the Refugee Health Program; and the Division of Motor Vehicles. Pursuant to G.S. 143-682, a nine-member Commission appointed by the Governor is charged with monitoring and evaluating the provision of services to Children with Special Health Care Needs.

Private Not-for-Profits: These collaborators include Community Action Agencies; Domestic Violence Shelters; United Way / 2-1-1; Homeless Shelters; Food Banks; Advocacy Groups; Communities in

Schools; Legal Services; Libraries; Faith-Based Organizations; and the Salvation Army.

Businesses: Collaborators include the NC Association of Health Insurance Underwriters; the NC Hotel / Motel Association; Community College Small Business Centers; Banks; Local Chambers of Commerce, including the NC Hispanic and Black Chambers of Commerce; and Tax Preparers—particularly VITA centers across the State.

Media: The DPH consultant partners with minority media outlets whenever possible, including an annual appearance on the Univision talk show.

The focus of statewide activities is ultimately on local efforts through all of DHB’s partners, including Community Care of North Carolina (CCNC). Fourteen CCNC networks coordinate DHB Health Check Coordinators (HCCs). HCCs are available to assist parents and providers. The HCCs promote initial enrollment in Title XIX and XXI services, retention in the health insurance programs, access to a quality medical home, and the importance of preventive services and appropriate service utilization. Because the NC Health Choice Program has limited State appropriations for medical and administrative costs, it is critical to educate NC Health Choice members’ parents to use the health care system in the most appropriate way to keep their children healthy. The Program undertakes ongoing efforts to identify children with asthma, diabetes, behavioral-mental health, and other chronic diagnoses. The goal is to assure that children with chronic conditions are receiving all of the help they need to prevent emergency episodes. A major focus is medical management with the goal of providing health information and case management services for families with frequent visits or high cost episodes.

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.

The Division of Health Benefits (DHB) in the NC Department of Health and Human Services has overall responsibility for the administration of Title XIX and XXI and assists outreach partners, providers and other stakeholders involved in seeking, identifying and enrolling uninsured children by providing county-level data. DHB also provides oversight of the eligibility determination and enrollment process implemented by local Departments of Social Services. The NC Health Choice Program works with the Division of Public Health to increase general public awareness and targets special populations

(low income, minority, and children with special health care needs) to assure that they know about both of the State’s publicly-funded child health insurance programs.

Applicants for both Medicaid and NC Health Choice complete a joint application online via the Federally Facilitated Marketplace, in person at a county Department of Social Services or via U.S. Mail. Applicants are screened first for Title XIX eligibility, and then for Title XXI eligibility. The “assets test” is not applicable to the NC Health Choice Program; children qualify for 12 months of continuous eligibility without regard to changes in family income during the enrollment period. To assist with renewal retention, the State mails ex parte renewal applications during the 10th month of continuous enrollment with a cover letter that advises beneficiaries to notify case workers if anything material that would affect program eligibility (such as health insurance status in the case of NC Health Choice) has changed. Otherwise, the beneficiaries do not have to return the form and renewal is automatic for an additional 12 consecutive months.

The efficient application process provides a number of program benefits:

- It assures that children who are eligible for either Title XIX or Title XXI are enrolled in the most appropriate program based on the applicant’s eligibility;
- It provides one standardized and consolidated source of enrollment data, which can be analyzed for the purpose of further refining outreach efforts; and
- It avoids duplicative eligibility and enrollment infrastructures for the Title XIX and Title XXI programs.

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)

Outreach efforts include all uninsured low-income North Carolina children potentially eligible for Title

XIX or Title XXI coverage. Tribal organizations collaborate with State and local outreach staff to assist with educating tribal members about the North Carolina Medicaid and NC Health Choice programs. Education includes how to apply, eligibility criteria, covered benefits, how to access healthcare services, and appropriate use of the Emergency Room. Representatives from the NC Commission of Indian Affairs, will craft best practice strategies to reach the State's American Indian communities and assure that all families with potentially eligible children are contacted and informed about this program and the health care benefits available to low-income children.

The North Carolina Division of Public Health runs a State-supported toll-free specialized resource line focused specifically on the needs, questions, benefits, and resources available to families of children with special needs in both the Health Check and NC Health Choice programs. The helpline provides telephone assistance for families with children with special needs and providers regarding health insurance and healthcare needs. The toll-free number is available to callers from 8 a.m. until 5 p.m. Monday through Friday at 1-800-737-3028. Additional outreach to families of children with special health care needs is done via health care providers and community-based organizations; NC Children's Developmental Services Agencies; Family Support Networks; the Exceptional Children's Assistance Center; and various diagnosis-specific groups such as the United Cerebral Palsy Association and the NC Autism Society.

A claims analysis for the 2014 State Fiscal Year revealed that out of the 20,016 NC Health Choice claims for Emergency Department visits, the top three reasons for the visits were: 1) asthma; 2) long-term use of medication; and 3) fever. In an effort to promote the most appropriate utilization of primary care and emergency room care, the NC Health Choice Program implements targeted efforts to promote wellness and disease management strategies. Related outreach materials have been developed in both English and Spanish.

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)

The Division of Health Benefits administers NC Health Choice benefits equivalent to those of the NC Medicaid Program, with four exceptions:

1. No services for long-term care;
2. No non-emergency medical transportation;
3. No EPSDT; and
4. Dental services on a restricted basis in accordance with the criteria adopted by the Department.

Session Law 2011-145 directed the Department of Health and Human Services to transition health benefit changes in the NC Health Choice Program to provide coverage equivalent to benefits provided for Medicaid beneficiaries, with the exceptions noted above.

In July 2013, the NC Health Choice Program transitioned the administration of medical and pharmacy claims to CSC, the third party administrator for the Medicaid program operated under Title XIX of the Social Security Act. NC Division of Medical Assistance administrators believe that this transition will be the most cost-effective approach to administration of the NC Health Choice program. Having the NC Health Choice program clinical coverage policies, prior approval processes, utilization review, and claims systems administration parallel the NC Medicaid Program processes will reduce the cost of running the program.

NC Health Choice Program administration will parallel Medicaid administration only to the extent allowable by Title XXI, the code of federal regulations, and State statutes. NC Health Choice beneficiaries will therefore continue to be subject to unique eligibility, cost sharing requirements, and review process rights.

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)

The state may waive the prior authorization requirements for services listed in Section 6 of the CHIP state plan for enrollees who are living and/or working in Governor or Federally-declared disaster or public health emergency areas or other areas as determined by the North Carolina Department of Health and Human Services.

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

The NC Health Choice Program will not cover any long-term care services. See Section 8 for co-payment requirements associated with this benefit. Utilization review and prior authorization for services may be required.

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

See Section 8 for co-payment requirements associated with this benefit. Utilization review and prior authorization for services may be required.

6.2.3. Physician services (Section 2110(a)(3))**6.2.4.** Surgical services (Section 2110(a)(4))

The NC Health Choice Program will cover medically necessary surgical services under inpatient and outpatient services covered in Sections 6.2.1 and 6.2.2.

6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

NC Health Choice will not include Early and Periodic Screening, Detection, and Treatment (EPSDT) services. However, pursuant to 42 CFR § 457.410(b)(1), NC Health Choice will cover annual office visits for preventive services (well-child visits) for children ages 6 through 18 and age appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices. Pursuant to 42 CFR § 457.520, NC Health Choice Program beneficiaries receive well-child visits and age-appropriate immunizations at no cost to their families (an exception to the co-payment requirements outlined in Section 8). The following are considered well-child care services:

- Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) “Guidelines for Health Supervision III” and described in “Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.”;
- Laboratory tests associated with well-child routine physical examinations;
- Immunizations and related office visits as recommended and updated by the Advisory Committee on Immunization Practices (ACIP); and
- Routine preventive and diagnostic dental services (such as oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described in the most recent guidelines issued by the American Academy of Pediatric Dentistry (AAPD).

6.2.6. Prescription drugs (Section 2110(a)(6))

The Department may establish authorizations, limitations, and reviews for specific drugs, drug classes, brands, or quantities in order to effectively manage the NC Health Choice pharmacy program. Prior authorization must be obtained from the NC Health Choice Pharmacy Benefit Management Coordinator or its authorized agent for any drug on the prior authorization list before reimbursement will be available. The NC Health Choice Preferred Drug List is identical to the Medicaid Program Preferred Drug List. There is no limit to the number of prescriptions covered. See Section 8 for co-payment requirements associated with this benefit.

6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))

The Department may establish authorizations, limitations, and reviews for specific drugs, drug classes, brands, or quantities. Prior authorization may be required based on criteria as published in the NC Division of Medical Assistance's NC Health Choice Clinical Coverage Policies. See Section 8 for co-payment requirements associated with this benefit.

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

Utilization review and prior authorization for services may be required.

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

Family planning services and supplies are covered benefits. However, contraceptives that can be purchased without a prescription or do not require the services of a physician for fitting or insertion are not covered. In addition, Health Choice does not cover sterilizations; neither the Health Choice nor Medicaid Program covers sterilization reversals.

Prenatal care and childbirth are not covered benefits under the NC Health Choice Program. However, if an NC Health Choice beneficiary becomes pregnant, she will be enrolled in the NC Medicaid for Pregnant Women program if her income is less than 196% of the Federal Poverty Level (FPL). The Medicaid for Pregnant Women program provides:

- prenatal care, delivery, and care 60 days postpartum;
- Services to treat medical conditions which may complicate the pregnancy (*some services require prior approval*);
- Childbirth classes; and
- Family planning services.

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))

Personal Care Services (PCS) are not a covered benefit in the NC Health Choice Program.

Home and community-based covered benefits for beneficiaries are:

Home Health: Skilled Nursing
Specialized Therapies
Home Health Aide
Services Medical
Supplies

Hospice: Physician Services
Nursing Services
Medical Social Services
Counseling Services
Hospice Aide and Homemaker Services
Volunteer Services
Medical Appliances and Supplies
Drugs and Biologicals
Therapy Services
Short-Term Inpatient Care
Ambulance Services
Nursing Facility and ICF/MR Room and Board

Home
Infusion Therapy: Total Parenteral Nutrition (TPN)
Enteral Nutrition (EN)
Intravenous Chemotherapy
Intravenous Antibiotic Therapy
Pain Management Therapy

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))

Utilization review and prior authorization for services may be required.

- 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))

Non-emergency medical transportation is not a covered benefit in the NC Health Choice Program. Ambulance transportation via air or ground for a state-to-state placement requires prior authorization.

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))

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

COVID-19 Vaccine:

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

COVID-19 Testing:

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

COVID-19 Treatment:

- The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
 - The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
 - The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and
 - The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

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

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without amount, duration, or scope limitations, during the period when a

beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

6.2-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.

The State requires practitioners to follow the Bright Futures/APA recommendations. Training is provided and technical assistance is available if needed. The State reimburses for the completion of the screenings. The state publishes yearly and updates as necessary its *Early, Periodic Screening Program Guide*. The Guide is a complete document for pediatricians and family practice practitioners providing preventive care to Medicaid and Health Choice-enrolled children and youth. Frequently used brief screening tools are listed. It is the responsibility of the PCCM to provide best practice guidance and training to their network providers on a broad range of clinical and pediatric topics, including effective use of brief screening tools during the preventive service visit. NC Medicaid and Health Choice reimburses for screens in addition to the base preventive service visit rate (CPT9938x-9939x).

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

Outpatient behavioral health services determine beneficiary's treatment needs and provide the necessary treatment. Services focus on reducing psychiatric and behavioral symptoms in order to improve the beneficiary's functioning in familial, social, educational, or occupational life domains. Medicaid and NCHC shall require prior approval for Psychotherapy for Crisis and Psychological Testing beyond the unmanaged visit limit.

- **Psychological Testing-** involves the culturally and linguistically appropriate administration of standardized tests to assess a beneficiary's psychological or cognitive functioning.
- **Psychotherapy for Crisis-** is stabilization, mobilization of resources, and minimization of further psychological trauma. Psychotherapy for crisis services are restricted to outpatient crisis assessment, stabilization, and disposition for acute, life-threatening situations

North Carolina allows 16 unmanaged visits per State Fiscal Year, which are inclusive of assessments and psychological testing codes. Once the 16 visits are exhausted, the state requires a prior approval.

6.3.2.2- BH Tobacco cessation
 Provided for: Substance Use Disorder

Tobacco cessation products are listed on the Preferred NCDHHS Drug List. Most rebatable generic drugs that offer rebates and the preferred drugs are covered without a prior approval. Outpatient treatment may also be provided for SUD.

Authorization or a “must try 2 Preferred drugs and fail” before being covered. Currently, the only Non-Preferred options left that could be covered are Nicotrol Inhaler and Nicotrol Nasal Spray. The Behavioral Health Outpatient Benefit includes both individual and group therapy/counseling.

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

Medicaid and NCHC shall cover OBOT services for a beneficiary when **all** the following components are met diagnosis and initial evaluation, initial laboratory testing, psychosocial treatment modalities, informed consent, treatment plan, treatment contract, and prescription drug monitoring. For office-based opioid treatment, an eligible NCHC beneficiary who is a minor, 16 through 17 years of age, shall have a documented history of at least two prior unsuccessful withdrawal management attempts. Refer to NCGS § 90-21.5. *Minor's consent sufficient for certain medical health services.*

Office Based Opioid Treatment (OBOT) has the same criteria for Medicaid and NCHC beneficiaries, which is inclusive of a documented history of at least two prior unsuccessful withdrawal management

attempts. Based on SAMHSA guidance from 3/2020, the State updated the OBOT policy on 07/01/2021 to remove this requirement for two prior unsuccessful withdrawal management attempts. NCHC beneficiaries have access to inpatient treatment for SUD. Our Opioid Treatment Program (OTP) only services adults.

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

Peer Support Services (PSS) PSS provides structured, scheduled services that promote recovery, self-determination, self-advocacy, engagement in self-care and wellness and enhancement of community living skills of beneficiaries. PSS services are directly provided by Certified Peer Support Specialists (CPSS) who have self-identified as a person(s) in recovery from a mental health or substance use disorder. NCHC shall cover Peer Support Services for an eligible beneficiary who is 18 years of age until he or she reaches his or her 19th birthday.

This age limit does apply to Medicaid eligible beneficiaries. In the SMD letter that CMS issued August 15, 2007, the background speaks to peer support delivered to Medicaid eligible adults.

6.3.2.5- BH Caregiver Support
 Provided for: Mental Health Substance Use Disorder

Caregiver Support is not a service that is provided to NCHC beneficiaries.

6.3.2.6- BH Respite Care
 Provided for: Mental Health Substance Use Disorder

Respite is not a service that is provided to NCHC beneficiaries.

6.3.2.7- BH Intensive in-home services
 Provided for: Mental Health Substance Use Disorder

Intensive In-Home (IIH) service directly addresses the beneficiary's mental health or substance use disorder diagnostic and clinical needs. The needs are evidenced by the presence of a diagnosable mental, behavioral, or emotional disturbance (as defined by DSM-5, or any subsequent editions of this reference material), with documentation of symptoms and effects reflected in the Comprehensive Clinical Assessment and the Person-Centered Plan (PCP). This (3) person team provides a variety of clinical rehabilitative interventions available 24 hours per day, 7 days per week, 365 days per year. This service

is billed per diem, with a 2-hour minimum. That is, when the total contact time per date of service meets or exceeds 2 hours, it is a billable event. Prior authorization is required on the first day of this service.

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

Substance Abuse Intensive Outpatient Program (SAIOP) means structured individual and group addiction activities and services that are provided at an outpatient program designed to assist adult and adolescent beneficiaries to begin recovery and learn skills for recovery maintenance. The program is offered at least 3 hours a day, at least 3 days a week, with no more than 2 consecutive days between offered services and distinguishes between those beneficiaries needing no more than 19 hours of structured services per week (ASAM Level 2.1). The beneficiary must be in attendance for a minimum of 3 hours a day in order to bill this service.

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

Day Treatment interventions are designed to reduce symptoms, improve behavioral functioning, increase the individual's ability to cope with and relate to others, promote recovery, and enhance the beneficiary's capacity to function in an educational setting, or to be maintained in community-based services. Evidence-Based Practices (EBPs) must address the clinical needs of each beneficiary, and those needs shall be identified in the comprehensive clinical assessment and documented in the PCP. Interventions include, but are not limited to, the development of skills and replacement behaviors in a therapeutic and educational environment; monitoring of psychiatric symptoms; development or improvement of social and relational skills; enhancement of communication and problem-solving skills; individual, group and family counseling; and psycho-education and training of family, unpaid caregivers, or others who have a legitimate role in addressing the needs identified in the PCP. It is available for children 5 to 17 years of age (20 or younger for those who are eligible for Medicaid and age 6-18 for those eligible for NCHC).

6.3.3.1- BH Partial Hospitalization
 Provided for: Mental Health Substance Use Disorder

Partial Hospitalization (PH) is designed to prevent hospitalization or to serve as an interim step for those leaving an inpatient facility. A physician shall participate in diagnosis, treatment planning, and admission or discharge decisions. Physician involvement is one factor that distinguishes Partial Hospitalization from Day Treatment Services. Partial Hospitalization is provided in a licensed facility that offers a structured, therapeutic program under the direction of a physician that may or may not be hospital based. physician, doctoral level licensed psychologist, psychiatric nurse practitioners, psychiatric clinical nurse specialist within their scope of practice can order this service.

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

Provided for: Mental Health Substance Use Disorder

Inpatient Behavioral Health Services is provided through a 24 hours hospital treatment facility. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service provides continuous treatment for beneficiaries with acute psychiatric or substance use problems. Medicaid criteria for the admission of a beneficiary less than 21 years of age to psychiatric hospitals or psychiatric units of general hospitals as well as criteria for the admission of an NCHC beneficiary age 6 through 18 to psychiatric hospitals or psychiatric units of general hospitals. After an initial admission period for Inpatient Behavioral Health Services of up to three calendar days, the Medicaid or NCHC beneficiary shall meet the criteria outlined in Clinical Coverage Policy 8B.

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

Residential treatment is a structured, therapeutic, and supervised environment to improve the level of functioning for beneficiaries. This level of care responds to beneficiaries needs for more active treatment and interventions. The NCHC utilization review contractor evaluates and authorizes requests for out-of-state placement for residential facilities. Medicaid and NCHC allow up to 15 days of therapeutic leave per quarter, not to exceed 45 days in a calendar year, regardless of the number of facilities used for the service. Unused days do not carry over to the next quarter.

6.3.4.2- BH Detoxification

Provided for: Substance Use Disorder

NC Medicaid has reviewed the SUD continuum and has determined that Ambulatory Detox is not a necessary benefit in the NCHC package. This service was removed from NCHC effective 03/01/2019. If a child needed detox, it would be provided in the inpatient setting.

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

Emergency Services may include several crisis interventions Care may include identifying and implementing best known strategies for crisis care while reducing avoidable visits to the emergency departments. This may include mobile crisis, emergency facility-based programs, and/emergency foster care placement.

6.3.5.1- BH Crisis Intervention and Stabilization
 Provided for: Mental Health Substance Use Disorder

Mobile Crisis Management involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. Mobile Crisis Management services are available at all times, 24-hours-a-day, 7-days-a-week, 365-days-a-year. Crisis response provides an immediate evaluation, triage and access to acute mental health, intellectual/developmental disabilities, or substance abuse services, treatment, and supports to effect symptom reduction, harm reduction, or to safely transition persons in acute crises to appropriate crisis stabilization and detoxification supports or services. These services include immediate telephonic response to assess the crisis and determine the risk, mental status, medical stability, and appropriate response.

Facility-Based Crisis Service for children and adolescents is a service that provides an alternative to hospitalization for an eligible beneficiary who presents with escalated behavior due to a mental health, intellectual or development disability or substance use disorder and requires treatment in a 24-hour residential facility with 16 beds or less. Facility-Based Crisis Service is a direct and indirect, intensive short term, medically supervised service provided in a physically secure setting, that is available 24 hours a day, seven days a week, 365 days a year. Under the direction of a psychiatrist, this service provides assessment and short-term therapeutic interventions designed to prevent hospitalization by de-escalating and stabilizing acute responses to crisis situations.

6.3.6- BH Continuing care services
 Provided for: Mental Health Substance Use Disorder

Continuing Care Services are provided through our Outpatient services as well as our enhanced services such as Intensive In-Home or MST.

6.3.7- BH Care Coordination
 Provided for: Mental Health Substance Use Disorder

North Carolina Medicaid has a designated contractor to provide Care Coordination to NCHC and Medicaid beneficiaries. Care Coordination objectives are to collaborate between healthcare teams, providers, families and patients to reach optimal health and wellness. Additionally, this service benefits multiple uncontrolled chronic conditions, social or economic conditions, disparities, any beneficiary that may have multiple hospital stays due to worsening or uncontrolled chronic condition.

6.3.7.1- BH Intensive wraparound
 Provided for: Mental Health Substance Use Disorder

NCHC beneficiaries have access to State Plan Intensive In-Home and Multi-systemic Therapy (MST) which we would consider to be intensive wrap around services. These services are not provided through our PCCM.

6.3.7.2- BH Care transition services
 Provided for: Mental Health Substance Use Disorder

Care Transition Functions can be facilitated with Case Management services or by Care Coordination by the State's NCHC UM Vendor.

6.3.8- BH Case Management
 Provided for: Mental Health Substance Use Disorder

Mental Health/Substance Abuse Targeted Case Management (MH/SA TCM) is a service for a NC Medicaid (Medicaid) beneficiary or Health Choice (NCHC) beneficiary who has either a serious emotional disturbance, mental illness or a substance related disorder. Prior authorization is required on the first day of this service. Reimbursement for case management is limited to 1 unit per calendar (Sunday-Saturday) week.

The MH/SA case manager coordinate and communicate with Community Care of North Carolina (CCNC) (if Medicaid or NCHC beneficiary is enrolled in CCNC), the beneficiary's primary care physician, and the Medicaid beneficiary's obstetrician and gynecologist (OBGYN), when applicable. CCNC and the primary care physician are responsible for coordination of the beneficiary's overall health care. A comprehensive and culturally appropriate case management assessment is required to ensure beneficiary's service needs, strengths, resources, preferences, and goals are documented through a Person-Centered Plan (PCP).

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

The CALOCUS are required in the contract with the PIHPs and outlined in their provider manuals so it is likely that agency and licensed professionals that are providing services to both Medicaid and NCHC beneficiaries would be more likely to use these tools for both groups.

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 Disorder

- 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.

The State requires the use of the LOCUS/CALOCUS in the PHP contract for Medicaid and as such most providers use these tools. The ASAM is required for SUD treatment in policy. The State is currently funding ASAM trainings to allow for a reduced cost to clinicians. The administering of the assessments is reimbursable.

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 (CDT⁴) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)

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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 CDT⁵ codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

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

6.2-DS **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section

2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

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

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

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

The State used the following standard definitions to determine classification (services that can be provided in both inpatient and outpatient settings were classified as both): Inpatient: Benefits that are ordered by a doctor to formally admit an enrollee to a hospital or other facility that provides treatment 24 hours per day. Room and board are included in the cost for inpatient. Outpatient:

Benefits that do not require a doctor’s order for formal hospital admission. Outpatient benefits can include services delivered in a hospital setting, including outpatient surgery, lab tests, x-rays, etc. Emergency Care: Benefits provided evaluate and/or treat a medical, mental health or substance use disorder condition that requires immediate, unscheduled medical care. Prescription Drugs: Pharmaceuticals that legally require a medical prescription to be dispensed.

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)). N/A

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 least 1/3 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: Outpatient, Emergency Care))

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 (Outpatient and Emergency Services)

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

The recommended services for children with special health care needs are set forth by the nine-member Commission for Children with Special Needs, established in 1998 per NC General Statute Chapter 143-682. The focus is on children with high cost and/or high incidence conditions such as: • Asthma; • Diabetes; and • Emotional Behavioral Conditions. Measures for these children may include: • The proportion of children who have hospital stays; • The average length of hospital stays; • The proportion of beneficiaries requesting durable medical equipment; • The proportion of beneficiaries receiving durable medical equipment; • Types of mental health / behavioral health services received, by age; • The average number of mental health / behavioral health outpatient treatments per beneficiary; • The average number of mental health / behavioral health home health visits per beneficiary; • Quantitative and/or qualitative summaries of information from periodic surveys of parents of children with special health care needs; and • The average number of emergency room visits per beneficiary. Notable gaps in service will act as trigger points for the Commission to develop recommendations to improve access to and quality of care for children with special health care needs. These recommendations are then

submitted to the Secretary of DHHS and the NC General Assembly for consideration on an annual basis.

7.1.2. Performance measurement

7.1.2 (a) CHIPRA Quality Core Set

7.1.2 (b) Other

The NC Health Choice Program will monitor progress using several of the CHIPRA 2014 Core Performance Measures:

- Childhood Immunizations
- Immunization Status for Adolescents
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for /Children/Adolescents
- Developmental Screening in the First Three Years of Life
- Chlamydia Screening in Women
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visit
- Child and Adolescent Access to Primary Care Practitioners
- Ambulatory Care – Emergency Department (ED) Visits
- Consumer Assessment for Healthcare Providers and Systems® (CAHPS) 5.0H Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items
- Human Papillomavirus (HPV) Vaccine for Female Adolescents

These data are available for tracking within claims data. DHB has IT staff and the capacity to use software to conduct database queries and generate reports on the measures. DHB also receives annual measures reporting from the PCCM contractor, Community Care of North Carolina (CCNC).

NC Health Choice beneficiaries' use of preventive health services will be evaluated through the following measures:

- The immunization rate per (1000) beneficiaries*
- The well-child screening rate per (1000) beneficiaries, by age.
 - o ages 6-10 (middle childhood)**
 - o ages 11-18 (adolescence)**

*The immunization rate among NC Health Choice Program participants will be compared with the immunization rate at the State and national levels.

** Age categories are in line with the American Academy of Pediatrics' Recommendations for Preventive Pediatric Health Care.

The rate of use of acute care services will be evaluated via the following measures:

- Average number of ambulatory visits per month (in a State fiscal year), by age;
- Number and rate of ambulatory visits per 1000 member months, by age
- Number and rate of emergency room visits per 1000 member months
- Number and rate of hospital stays per 1000 member months, by age Average length of hospital stay per beneficiary, by age

7.1.3. Information strategies

Application, enrollment, and claims data reporting are completed on a monthly basis. Periodic ad hoc queries to evaluate claims for specific conditions and payment scenarios are also done. The regular reporting and periodic queries allow NC Health Choice Program administrators to monitor program cost efficiency, claims processing accuracy, and service utilization patterns.

7.1.4. Quality improvement strategies

Data collection and analysis will yield insight into Health Choice Program beneficiaries' health service utilization and the subsequent health status outcomes among the target population. Furthermore, the data will provide a feedback loop for outreach and education efforts relevant to Program enrollees. As needed, program staff may develop supplemental notices to participants or modify the beneficiary Handbook content from year-to-year.

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))

NC Health Choice Program staff review paid claims data, independent studies by researchers and State immunization registry data to monitor access to well-child care and age-appropriate immunizations. Furthermore, the Health Choice Program excludes these covered benefits from the cost sharing component of Program enrollment, as required by federal regulations.

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))

NC Health Choice Program staff review paid claims data to monitor access to covered services, including emergency services. NC Health Choice Program beneficiaries have access to emergency services in out-of-state settings also. Only non-emergency, out-of-state services require prior approval. At the time of enrollment in NC Health Choice, each beneficiary selects or is assigned to a primary care provider within the CCNC network. As of October 2014, there were 78,718 NC Health Choice providers across all 100 NC counties available to serve approximately 80,000 NC Health Choice beneficiaries.

- 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))

All NC Health Choice Program providers are required to enroll as Medicaid-enrolled providers with the NC Medicaid program and go through the credentialing process. DHB periodically conducts focused studies on high cost or high incidence conditions or provider practice patterns. If the investigation results indicate provider and/or member education is appropriate, DHB develops a collaborative multi-strategy to contact, educate, and monitor for expected changes. In 2011, North Carolina legislation mandated that the NC Health Choice Program provides health benefits coverage equivalent to coverage provided for Medicaid beneficiaries, with some exceptions. One of the exceptions is no EPSDT services in the Health Choice Program. However, the Health Choice Program covers all well-child visits and immunizations, inpatient and outpatient mental health services, and the provision of durable medical equipment. Home and community based health care services are also covered. Prior approval based on the medical necessity of services is required for all specialized therapies.

- 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.

Pursuant to 42 CFR 457.495(d)(1), Prior authorization decisions are made in accordance with the medical needs of the patient within 5 days after receipt of a request for medical services and within 24 hours after receipt of a request for pharmacy services, unless the utilization review contractor needs additional information from the requesting provider. Compliance is verified through spotchecking, provider feedback, and reports from the Claims Processing Contractor

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:

The State imposes different co-payments on families in two different income categories: families 78 with annual income from above 133% FPL up to and including 159% FPL, and families with annual income FPL above 159% up to and including 211% FPL have co-payment requirements set forth in N.C.G.S. 108A-70.21(d) and (e). Those requirements are outlined in the table below. Providers collect copayments for services, and then claim payments for covered benefits are reimbursed net of the applicable co-payment.

Health Choice Cost Sharing

<u>Income Level</u>		<u>Cost Sharing</u>
<u>Family income is < 159% FPL and Native American Tribe or Alaskan Native</u>		<ul style="list-style-type: none"> • <u>No annual enrollment fee</u> • <u>No cost sharing</u>
<u>Family income is < 159% FPL</u>	•	<ul style="list-style-type: none"> • <u>No annual enrollment fee</u> • <u>No copayments for office visits</u> • <u>Generic Prescription copay: \$1</u> • <u>Brand Prescription when no generic available copay: \$1</u> • <u>Brand prescription when generic available copay: \$3</u> • <u>Over-the-counter copay: \$1</u> • <u>\$10 non-emergency emergency room visits</u>
<u>Income > 159% and < 211% FPL and Native American Tribe or Alaskan Native.</u>		<ul style="list-style-type: none"> • <u>No annual enrollment fee</u> • <u>No cost sharing</u>
<u>Income > 159% and < 211% FPL</u>		<ul style="list-style-type: none"> • <u>Annual enrollment fee: \$50 per child or \$100 maximum for two or more.</u> • <u>Office visit copay: \$5</u> • <u>Outpatient hospital: \$5</u> • <u>Generic Prescription copay: \$1</u> • <u>Brand Prescription when no generic available copay: \$1</u> • <u>Brand prescription when generic available copay: \$10</u> • <u>Over-the-counter copay: \$1</u> • <u>\$25 non-emergency emergency room visits</u>

For all members of federally recognized Native American tribes and Alaska Natives, there is no cost-sharing imposed. A \$0 copayment is printed on each qualified beneficiary's health insurance card. Pursuant to 42 C.F.R. § 457.505(d)(1), all beneficiaries receive well-child visits and age-appropriate immunizations at no cost to their families. NC law (N.C. GEN. STAT. § 108A-70.21(e) restricts the total annual aggregate (12 months, continuous coverage as opposed to a calendar or fiscal year) cost-sharing for beneficiaries' subject to co-payments to 5% of the family's income.

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

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration without cost sharing, in accordance with the requirements of section 2103(c)(11)(A) and 2103(e)(2) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

COVID-19 Treatment:

- The state provides coverage of COVID-19-related treatments without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

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

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without cost sharing, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. This coverage includes items and services, including drugs, that were covered by the state as of March 11, 2021.

8.2.4. Other:

For children in families living above 159% and up to 211% of the federal poverty level, there is also an annual enrollment fee of \$50 per child, with a \$100 maximum for two (2) or more children in the same family. Families are required to pay the annual enrollment fee both at the time of initial enrollment and upon each annual renewal, as appropriate based on family income level. The State activates initial enrollment and renewal eligibility periods following full payment of the enrollment fee. The county social service departments retain the enrollment fee to assist with defraying administrative expenses.

- For all members of federally recognized Native American tribes and Alaska Natives, there is no enrollment fee imposed.
- North Carolina will waive the annual enrollment fee for applicants and/or current enrollees who are living and/or working in Governor declared or federally declared disaster areas or other areas as determined by the North Carolina Department of Health and Human Services.
- At State discretion, copay requirements may be temporarily waived for CHIP beneficiaries who are living and/or working in Governor declared or Federally-declared areas or other areas as determined by the North Carolina Department of Health and Human Services.

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))

Beneficiary cost sharing charges are prominently posted in the beneficiary Handbook, on membership ID 81 cards, and on the Health Choice Program Web pages. Cost sharing requirements, including co-payments and enrollment fees, are legislated through the NC General Assembly and set forth in N.C.G.S. 108A70.21(d) and (e). The public has the opportunity for input through healthcare advocacy groups and direct communication with their elected representatives. Media coverage in print, radio, and television keeps the general public informed regarding public policy changes, including those to federal and state Title XIX and Title XXI programs. Pending legislation is available for public review on the NC legislative website. In the event of a cost sharing change, DHB mails letters to each beneficiary head of household at least 15 calendar days in advance of the change effective date. Each beneficiary also receives a new ID card with updated co-payment information.

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 N/A 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: The State applies co-payments to services based on type of service and family income, rather than the type of condition the service is intended to treat. There is no difference between the financial requirements of mental health and substance use disorder benefits and medical/surgical benefits. Please see Attachment B for NC Health Choice financial requirements analysis.)

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.

N/A - The State applies financial requirements (co-payments and annual enrollment fees) to services based on type of service and family income, rather than the type of condition the service is intended to treat. There is no difference between the financial requirements of mental health and substance use disorder benefits and medical/surgical benefits. Please see Attachment B for NC Health Choice financial requirements analysis. All medical and surgical benefits are subject to this 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))

The NC Health Choice program annual maximum cost sharing requirements are legislatively set at the federal annual limit of 5% of the countable family income. To date, no families have incurred annual cost sharing expenses that met the annual maximum. The Division of Health Benefits eligibility database includes the family countable net income for each NC Health Choice beneficiary. The claims processing contractor calculates the annual cost-sharing maximum by multiplying the monthly income by 12 months and multiplying the result by five percent. For example, countable household income of \$2500-month x 12 months = \$30,000 countable annual income. The annual family cost sharing maximum is \$1500 ($\$30,000 \times .05 = \$1,500$). Cost sharing contributions, including the annual enrollment fee (if applicable) are accumulated for all enrolled children in the family towards the maximum annual limit. NC Health Choice children in the same family accumulate cost sharing expenses in a combined tracking tool aggregated under the case head/ head of household. The claims processor generates a monthly report to monitor the total cost sharing expenses for each family and ensure that the total is below the annual maximum. In the event the cost-sharing ceiling is reached during the annual enrollment period, the beneficiary's family will be notified that copayments are suspended for the remainder of the annual enrollment period. Each beneficiary will then receive a new ID card with \$0 co-payment amounts. Beneficiaries will be instructed to provide the notice and new ID card to providers and pharmacists as evidence that no co-payment is due. During the remainder of the 12-month continuous enrollment period, provider claims for covered services will be reimbursed without the applicable co-pay deduction from provider proceeds. As a precaution, the claims processor generates an annual report grouping all enrollees under the same case. Total cost sharing expenses (including those from Pharmacy claims) will be listed with the cost sharing maximum to ensure that all cases have multiple review checkpoints.

- 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)

NC Health Choice and Medicaid share a joint application. The application requests self-reported, demographic data including race and ethnicity. American Indian and Alaska Native children identification is Race Code "I," a specific classification that excludes them from cost-sharing requirements. Applicants declaring US citizenship and American Indian status are asked to provide evidence (such as a Tribal Membership Card) of membership in a federally recognized Native American tribe. Verification of race exempts American Indian and Alaska native children from all program cost-sharing requirements including the enrollment fee (if applicable) and co-payments. The beneficiary's health insurance ID card also shows \$0 co-payment amounts for pharmacy and medical services, so the exclusion from cost-sharing is clearly communicated to providers each time a qualifying beneficiary accesses medical services.

- 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))

As described in Section 8.6, American Indian and Alaska Native children are exempt from paying an annual enrollment fee. For all other eligible children in a family with an annual income level between 159-211% FPL, the annual enrollment fee must be paid in full prior to enrollment and coverage activation. The annual enrollment fee is \$50 for one child and \$100 for two or more children in the same family. The family has 12 calendar days from the date on the county Department of Social Services Notice of Eligibility to pay the enrollment fee. If the fee remains unpaid as of the 13th calendar day following the Notice date, the application will be denied for nonpayment. Regarding any applicable cost sharing payment at the time of service, the beneficiary handbook states, "If a NC Health Choice for children recipient is not able to pay the co-payment, a provider may permit the patient to be billed for the co-payment after the service is provided or refuse treatment to the patient." North Carolina will waive unpaid enrollment fee balances if the child's family is determined to have been living and/or working in Governor declared or federally declared disaster areas or other areas as determined by the North Carolina Department of Health and Human Services.

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))

Active beneficiaries are disenrolled from the NC Health Choice Program during their 12-month continuous enrollment period for the following reasons:

- The beneficiary reaches the age of 19 (disenrolled on the last day of the month in which their 19th birthday occurs);
- The beneficiary requests voluntary disenrollment;
- The beneficiary no longer resides in North Carolina (moves out of state);
- The beneficiary dies; or

Active beneficiaries are disenrolled from NC Health Choice at the annual redetermination review for the following reasons:

- The beneficiary's family income exceeds program income limits (211% FPL);
- The beneficiary no longer resides in North Carolina (moves out of state);
- The beneficiary cannot be located (returned mail with no forwarding address);
- The beneficiary has become eligible for Medicaid;
- The beneficiary has requested voluntary disenrollment;
- The beneficiary has comprehensive health insurance in effect on the renewal date;
- The beneficiary has not paid the annual enrollment fee (if required);
- The beneficiary resides in a public institution; or
- The beneficiary has submitted an incomplete renewal application when material changes in, e.g., health insurance status must be reported.

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 the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4.** Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5.** No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

- 8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

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))

1. To reduce the overall number of uninsured children in NC living in families with incomes below 200% of the federal poverty guidelines.
2. To identify and decrease disparities by race and ethnicity for the number of program applications received relative to the number of uninsured children.

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))

Strategic Objective 1: To reduce the number of uninsured children living in families with incomes below 200% of the federal poverty guidelines.

Performance goal 1: Increase the number of eligible applicants accepted into the NC Health Choice Program by 3%.

Strategic Objective 2: To identify and decrease disparities by race and ethnicity for the number of applications received relative to the total population of uninsured children by race and ethnicity.

Performance goal 1: Use U.S. Census and other available data to identify the number of uninsured children in the State living below 200% FPL, by race and ethnicity.

Performance goal 2: Identify the number of uninsured children by county, living below 200% FPL, by race and ethnicity.

Performance goal 3: Work with the subcontractor to provide supplemental outreach and education to the top 2 races with the identified disparity.

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.

The Title XIX's Medically Indigent Children program has measured the annual increase of children enrolled by parents seeking health insurance only since the inception of the CHIP program in 1998.

- 9.3.2.** The reduction in the percentage of uninsured children.

The reduction, as a percent, of uninsured children statewide with family income that would qualify them for Medicaid or NC Health Choice, using U.S. Census and NC Families Accessing Services through Technology (NC FAST) data.

- 9.3.3.** The increase in the percentage of children with a usual source of care.

NC Health Choice children are required to enroll in the Community Care of North Carolina

(CCNC) primary care medical home and be linked to a primary care provider. Prior to Oct 1, 2011, the process was not mandatory. DHB will measure any increase in the percentage of children with a usual source of care with NC FAST data.

- 9.3.4.** The extent to which outcome measures show progress on one or more of the health problems identified by the state.

North Carolina is already a leader in the implementation of new models of care with Community Care North Carolina (CCNC), in which Health Choice beneficiaries are linked to a primary care provider. Continued monitoring of CCNC patient enrollment, satisfaction, and health outcomes statistics will be one means of quantifying the extent of progress made within the NC Health Choice program. Each year, the NC Institute of Medicine also publishes a Child Health Report Card which tracks health insurance coverage, health services utilization, and health status indicators that are relevant to the Health Choice Program. Health Choice will put corresponding measures in place for outcomes monitoring as DHB continues to manage and administer the Program.

- 9.3.5.** HEDIS Measurement Set relevant to children and adolescents younger than 19.

NC Health Choice will use nine (9) HEDIS style measures adopted by CMS (See 9.3.7).

- 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:

- HEDIS Immunization for Adolescents
- HEDIS Children and Adolescents' Access to a Primary Care Provider

- 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)

Upon receipt of the Annual CARTS Template from CMS, the Division of Medical Assistance sends appropriate template sections to agency IT staff and contractors and coordinates the requests for the required data. DHB staff gather all of the information and populates the report template. DHB submits the CHIP Annual Report for review and edits to all parties who provide data and substantive updates. Following edit incorporation and approval from the Division Director, staff submit the final report to CMS.

- 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))

NC state law mandates that the Department may not amend the State Plan unless the General Assembly or the federal government change a law that requires a State Plan Amendment (N.C. GEN. STAT. § 108A54.1A). Although the same statute requires the 10-day posting of the State Plan Amendment to the Department's Web page prior to CMS submission, there is no public notice and comment period. However, during General Assembly general sessions, consumers and advocates have opportunities to sign up and speak at hearings, and they always have the opportunity to provide input about NC Health Choice Program implementation via mail, email, or telephone calls to Legislators and the Department.

- 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))

Division of Medical Assistance, submitted a letter to confirm that the State will follow the same Tribal consultation process for the CHIP Program as it does for the State Medicaid Program.

North Carolina received CMS approval on March 17, 2011 to establish the Tribal consultation process which consists of a representative of the Eastern Band of Cherokee Indians sitting on the Medical Care Advisory Committee. The Advisory Committee meets at least quarterly to review activities of the Division of Medical Assistance and provide recommendations and advice on current and future policy initiatives and pending changes to the Medicaid and CHIP programs.

- 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).

Benefits may be amended via either legislation or individual clinical coverage policies which may require a State Plan Amendment. Eligibility requirements may be amended via legislation. During General Assembly legislative sessions, consumers and advocates have opportunities to sign up and speak at hearings, and always have the opportunity to provide input about the NC Health Choice Program implementation via mail, email, or telephone calls to Legislators. Once new legislation becomes effective, the Division of Health Benefits (DHB) notifies potential applicants and current beneficiaries via Consumer Notices on the DHB Web Page and via mailed letters to currently enrolled beneficiaries. Beneficiaries also receive Handbooks which are revised annually to reflect any eligibility or benefits changes. The process for notification regarding new or amended clinical coverage policies is described below, and the process for notification regarding a State Plan Amendment is described in Section 9.9 above. Once a State Plan Amendment is approved by CMS, it is posted on the Division's Web page. The process for any adoption of or amendment to medical policy is also mandated by State law (N.C. GEN. STAT. § 108A-54.2). The Department must consult with and seek the advice of the

Physician Advisory Group and other organizations that the Secretary deems appropriate. The Secretary must also consult with officials of professional societies or associations representing providers who would be affected by the new or amended medical policy. At least 45 days prior to the adoption of a new or amended policy, the Department must publish the policy on the Department's Web site and notify all NC Health Choice providers. During a 45-day period after publishing the proposed new or amended policy, the Department must accept oral and written [public] comments. If the proposed new or amended policy is modified after the comment period, then the Department must notify all NC Health Choice providers and upon request, provide persons notice of amendments to the proposed policy, for at least 15 days prior to posting the new or amended policy. Effective 2013, NC State Law requires posting for 30 and 10 day periods, respectively, if the adoption of new or amended medical coverage policy is necessitated by an act of the General Assembly or a change in federal law. In addition to the public notice and comment period for any proposed new or amended policies, the NC Health Choice program includes information about any Health Choice policy changes that impact beneficiaries in Medicaid Notification documentation to all Department of Social Services case heads.

- 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.

North Carolina does not implement the Express Lane eligibility option

- 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

North Carolina anticipates a notable impact on the budget.

CHIP Budget

STATE:	FFY Budget
Federal Fiscal Year	2022
State's enhanced FMAP rate	81.70%
Benefit Costs	
Insurance payments	\$ 0
Managed care	\$ 236,879,198
<u>per member/per month rate</u>	\$ 152
Fee for Service	\$ 436,349,487
Total Benefit Costs	\$ 673,228,685
(Offsetting beneficiary cost sharing payments)	\$ 0
Net Benefit Costs	\$ 673,228,685
Cost of Proposed SPA Changes – Benefit	\$ 7,745
Administration Costs	
Personnel	\$ 6,063,607
General administration	\$ 9,202,142
Contractors/Brokers	\$ 0
Claims Processing	\$ 981,309
Outreach/marketing costs	\$ 0
Health Services Initiatives	\$ 1,101,000
Other	\$ 0
Total Administration Costs	\$ 17,348,058
10% Administrative Cap	\$ 74,803,187
Cost of Proposed SPA Changes	\$ 7,745
Federal Share	\$ 564,201,199
State Share	\$ 126,375,544

STATE:	FFY Budget
Total Costs of Approved CHIP Plan	\$690,576,743

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds:

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed 7745 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

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.

The North Carolina Health Choice Program for Children has a program-specific review process that is compliant with 42 CFR 457.1120 – 1180. Although county Departments of Social Services use one application form to assess eligibility for the State Medicaid Program and NC Health Choice, the eligibility criteria and enrollment processes for each program differs. Pursuant to N.C. GEN. STAT. § 108A-70.21(a), NC Health Choice Program applicants must: • Be between the ages of 6 through 18 • Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance; • Be uninsured; • Be in a family whose family income is above 133% of the FPL and does not exceed 200% of the FPL; • Be a resident of the State and eligible under federal law; and • Have paid the Program enrollment fee. The enrollment fee is collected and retained by county Departments of Social Services; each Department establishes its own procedures for collection. Pursuant to N.C. GEN. STAT. § 108A-70.26(c), N.C. GEN. STAT. § 108A-70.29(a), and N.C. GEN. STAT. § 108A-79, applicants have an opportunity to appeal a denial of eligibility for either an initial or re-application. Each applicant or

beneficiary shall be notified in writing of his right to appeal upon denial of his application for assistance and at the time of any subsequent action on his or her case. Active Program beneficiaries remain enrolled during the review of a decision to terminate or suspend enrollment.

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.

Pursuant to N.C. GEN. STAT. § 108A-70.29 and applicable federal regulations, NC Health Choice Program beneficiaries may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review process.

Beneficiaries have the right to request an internal first level review of the decision with the North Carolina Department of Health and Human Services (DHHS) followed by an external second level review with the DHHS Hearing Office. Both levels of review must be completed within 90 calendar days of the date of receipt of the internal first level review request.

To Request a Review:

Beneficiaries and/or legal guardians or authorized representatives may request an internal first level review of an adverse prior approval decision or a claims denial within 30 calendar days of the date on the adverse notice or the date the claim was adjudicated. If the beneficiary and/or legal guardian are not satisfied with the outcome of the internal first level review decision, they may request a second level review within 15 calendar days of the internal first level review decision date. An authorized representative may submit completed request forms for an internal first level review or external second level reviews, or submit a letter of request. If a letter of request is submitted, each item of information specified below must be included with the request.

- A. Child’s name
- B. Child’s NCHC identification number
- C. Telephone number
- D. Address
- E. Date the service was provided
- F. Name(s) of the provider(s) of the service
- G. Reason for review request
- H. The letter about the benefit decision
- I. Name of the representative in Customer Service who handled the inquiry if applicable
- J. Completed NCHC Authorized Representative Form if an attorney or other representative is assisting the beneficiary or authorized representative in the review process.
- K. Authorized representative’s signature and date on the review request form or letter requesting a

review

L. Both the review request form and the authorized representative form are available at: <http://www.ncdhhs.gov/dma/healthchoice/revrequest.htm#nchr>. Hard copy forms will be included with the adverse decision letter that is mailed to the beneficiary.

Additional or supplemental information (such as medical records, letters from a doctor, etc.) may be included with the request for review.

Internal first level review requests (completed form or letter requesting a review and a completed NCHC Authorized Representative Form, if applicable) shall be mailed or faxed to NCHC.

NCHC Review Coordinator
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: (919) 733-6608

Internal First Level Review: Beneficiaries have the right to an internal first level review by the Clinical Medical Director of the Division of Medical Assistance or clinical designee, who will review the determination and any other information submitted.

- The beneficiary must submit the request for an internal first level review within 30 days of the date of the adverse decision notice.
- The beneficiary will receive a written decision by certified mail.
- The internal decision notice will provide further information about how the beneficiary may request a second level review.

If beneficiaries disagree with the internal first level review decision, they may request an external second level review with the DHHS Hearing Office by writing a letter or filling out an External Second Level Review Request Form. External second level review requests (completed form or letter requesting a review and a completed NCHC Authorized Representative Form, if applicable), shall be mailed or faxed to the Department of Health and Human Services (DHHS) Hearing Office.

DHHS Hearing Office
2501 Mail Service Center
Raleigh, NC 27699-2501
Telephone: 919-814-0090
FAX: (919) 814-0032

External Second Level Review: If a beneficiary is not satisfied with the internal first level review decision, he or she may request an external second level review by the DHHS Hearing Office.

- The beneficiary must request this review within 15 days of the date of the first level review decision.
- The DHHS Hearing Office will conduct a hearing in Raleigh, which the beneficiary

may attend in person or by telephone.

- At the hearing, the beneficiary may represent him/herself or have a representative, including an attorney at the beneficiary's expense.
- The beneficiary will receive a written decision by certified mail.
- As required in N.C.G.S. 108A-70.29(b)(3), the hearing officer must render a written decision within 90 calendar days of the date the beneficiary requested the first level review.

Expedited Review: If a Health Choice beneficiary's physician determines that the standard 90-day time frame could seriously jeopardize the child's life or health or ability to attain, maintain, or regain maximum function, the beneficiary may request that the review be completed within an expedited time frame. Under the expedited time frame, each level of review must be completed within 72 hours unless the beneficiary requests additional time (no more than 14 days may be allowed).

Review Decisions: All review decisions are based on coverage noted in the North Carolina General Statutes and in the NC Health Choice clinical coverage policies.

When a Review Will Not Be Held: A review will not be held if the sole basis of the decision is a provision in the State Plan or in a Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

Services Provided During the Review Process: Maintenance of service is not provided during the review process. When the decision is a reduction, suspension, termination, or denied request for increase of existing services, the services shall be covered in accordance with the decision under review. Services which are terminated or suspended shall not be covered, unless and until the decision is overturned on review.

Enrollment: A Health Choice beneficiary will remain enrolled in the Health Choice program during the review process as long as he or she is eligible.

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.

North Carolina does not implement a Premium Assistance Program

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.mcgregal@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 4 th 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 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
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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 pre-pregnancy 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(1)(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.