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State/Territory Name: Idaho

State Plan Amendment (SPA) #: ID-19-0019

This file contains the following documents in the order listed:

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

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

Children and Adults Health Programs Group

AUG 0 8 2019

Matt Wimmer
Administrator
Idaho Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0036

Dear Mr. Wimmer:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), ID-19-0019, has been approved. ID-19-0019 demonstrates compliance with the CHIP managed care regulations at 42 CFR 457, Subpart L for utilization of a managed care delivery system. The SPA also makes changes to the state's benefits to align with changes to its Medicaid Alternative Benefit Plans, as recently approved in Medicaid SPAs ID-18-0006 and ID-19-0007. SPA ID-19-0019 has an effective date of July 1, 2018.

Sections 2101(a), 2103(f)(3), 2107(b), and 2107(e) of the Social Security Act, as implemented through regulations at 42 CFR 457 Subpart L, describe the application of managed care requirements to CHIP. Idaho has provided the necessary assurances indicating that the state complies with the managed care requirements in the delivery of CHIP services and benefits covered under the state's separate child health plan as of July 1, 2018.

This SPA approval does not substitute for CMS review of any contracts between the state and managed care entities that serve the state's CHIP populations. All managed care contracts for CHIP populations in effect as of the state fiscal year beginning on or after July 1, 2018 must comply with the CHIP managed care regulations and be submitted for CMS review.

Your title XXI project officer is Ms. Janice Adams. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
701 Fifth Avenue, Suite 1600, Mail Stop: RX-200
Seattle, WA 98104
Telephone: (206) 615-2541
E-mail: Janice.Adams@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Adams and to Mr. David Meacham, Deputy Director in our Division of Medicaid Field Operations West. Mr. Meacham's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid Field Operations West
701 Fifth Avenue, Suite 1600, Mail Stop: RX-200
Seattle, WA 98104

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Anne Marie Costello/

Anne Marie Costello
Director

cc: Mr. David Meacham, Deputy Director, Division of Medicaid Field Operations West

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 Submitted: February 17, 1998 Date Approved: June 15, 1998 Effective Date: October 1, 1997		
AMENDMENT#'S	**DATES**	**DESCRIPTION**
Amendment #1		Change income limit from 160% FPG to 150% FPG
Submitted	October 13, 1998	
Approved	December 4, 1998	
Effective Date	July 1, 1998	
Amendment #2		• Program design changes to- • increase coordination of efforts across agencies • simplify the application process, and • improve media and outreach approaches
Submitted	March 10, 2000	
Approved	March 1, 2001	
Effective Date	January 1, 2000	
Amendment #3		• Technical changes to conform to model template • Revise outreach strategies
Submitted	June 28, 2002	
Approved	September 19, 2002	
Effective Date	July 1, 2002	
Amendment #4		Establish Separate Program
Submitted	February 25, 2004	
Approved	June 10, 2004	
Effective Date	July 1, 2003	
Amendment #5		Revise benefit package of separate program
Submitted	August 30, 2004	
Approved	January 13, 2005	
Effective Date	July 1, 2004	
Amendment #6		Removal of enrollment cap
Submitted	June 9, 2005	
Approved	September 7, 2005	
Effective Date	June 1, 2005	
Amendment #7		Addition of child health services initiative (Healthy Schools)
Submitted	April 28, 2006	
Approved	May 25, 2006	

Effective Date	July 1, 2006	
Amendment #8		• Lower the income limit of separate program from 150% to 133% • Remove resource limit • Incorporate Basic and Enhanced Benchmark Benefit Packages • Changes to premium structure
Submitted	May 5, 2006	
Approved	May 25, 2006	
Effective Date	July 1, 2006	
Amendment #9		• Addition of Wellness Preventive Health Assistance • Addition of co-pays
Submitted	January 24, 2007	
Approved	September 28, 2007	
Effective Date	January 1, 2007	Wellness PHA
	February 1, 2007	co-pays
Amendment #10		• Addition of Substance Abuse Treatment Services • Addition of Independent Therapists for Speech Language Pathology (SLP) Services • Reduce limits for Psycho-Social Rehabilitation, Partial Care and Developmental Disability Agency Services
Submitted	March 17, 2009	
Approved	July 15, 2013	
Effective Date	November 1, 2008	Substance use treatment & SLP
	January 1, 2009	Reduction in Mental Health and DDA
Amendment #11		• Contact Lens Coverage Modification • Mental Health Assessment Annual Limitation • Mental Health Treatment Plan Limitation • Collateral Contact & Partial Care Elimination • PSR Limitation • DDA Assessment Annual Limitation • Incorporation of Dental Services Template (Sections 6.2-D & 10.3-D)
Submitted	February 28, 2011	
Approved	July 15, 2013	
Effective Date	January 1, 2011	
Amendment #12		Change to Chiropractic Service Limitations
Submitted	August 29, 2011	
Approved	July 15, 2013	
Effective Date	July 1, 2011	

Amendment #13		Addition of co-payments (co-pays) for certain services
Submitted	December 31, 2011	
Approved	July 2, 2012	
Effective Date	November 1, 2011	Chiropractor, Optometrist and Podiatrist Svcs.
	January 1, 2012	Physical Therapy, Occupational Therapy, Speech
Amendment #14		• Addition of Health Homes for Chronically Ill • Implementation of Children's Redesign Benefit Plan • Implementation of Behavioral Health Managed Care • Developmentally Disabled Children's Benefit Redesign • Removal of Therapy Prior Authorization Requirements
Submitted	June 15, 2013	
Approved	August 29, 2013	
Effective Date	January 5, 2012	Removal of Therapy prior authorization requirements
	January 1, 2013	Health Homes
	July 1, 2013	Developmentally Disabled children's benefit redesign
	September 1, 2013	Behavioral health managed care
MAGI Amendment #13-0014		Medicaid Expansion
Submitted	September 17, 2013	
Approved	December 17, 2013	
Effective Date	January 1, 2014	
MAGI Amendment #13-0015		Establish 2101(f) Group
Submitted	September 17, 2013	
Approved	October 8, 2013	
Effective Date	January 1, 2014	
MAGI Amendment #13-0016		MAGI Eligibility & Methods
Submitted	September 19, 2013	
Approved	December 17, 2013	
Effective Date	January 1, 2014	
MAGI Amendment #13-0023		Eligibility Process

Submitted	October 7, 2013	
Approved	December 18, 2013	
Effective Date	January 1, 2014	
Amendment #15		ACA Changes, Tobacco Cessation, Children's Hospice
Submitted	June 27, 2014	
Approved	October 8, 2014	
Effective Date	January 1, 2014	
Amendment #15-0016		MAGI Eligibility Income Methods
Submitted	June 25, 2015	
Approved	August 12, 2015	
Effective Date	July 1, 2014	
Amendment #15-0016-A		Technical Updates
Submitted	June 25, 2015	
Approved	September 9, 2015	
Effective Date	July 1, 2014	
Amendment #16-0017		Primary Care Case Management
Submitted	June 1, 2016	
Approved	August 11, 2016	
Effective Date	July 1, 2016	
Amendment #ID-17-0018		ABP Alignment & Technical Updates
Submitted	June 29, 2017	
Approved	April 19, 2018	
Effective Date	July 1, 2017	Technical Updates
	January 1, 2017	ABP Alignment
Amendment #ID-18-0008		Mental Health Parity
Submitted	June 29, 2018	
Approved	August 2, 2018	
Effective Date	July 1, 2017	
Amendment #ID-19-0019		Adoption of Managed Care Template; Basic and Enhanced ABP (addition of EIS & Behavioral health services); Technical updates for pharmacy and other areas
Submitted	June 26, 2019	
Approved		
Effective Date	July 1, 2018	

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 used its standard negotiation (with the Tribes of Idaho) process for Tribal Consultation

for this SPA. Hard copies of the Tribal notices were sent to Tribal Leaders and e-mailed to a contact list of Tribal Representatives as indicated in the table below. The notices were subsequently posted to the Idaho Medicaid-Tribes website.

SUBJECT	DATE(S) OF NOTIFICATION	DESCRIPTION
Basic ABP Enhanced ABP	January 29, 2018	Idaho added new behavioral health services for children in title XIX within its Basic and Enhanced Alternative Benefit Plans (ABP)'s. Our title XXI plan was aligned to adopt those services.
	January 29, 2018	New Early Intervention Services (EIS) under EPSDT authority (delivered by the IDEA Part C agency to participants, ages 0 – 3) were implemented within the ABP's and are available for both Title XIX and Title XXI participants.
	July 12, 2017	Pharmacy reimbursement changes with updated language to align with drug rebate program without impacting benefits.
	The State used its standard notification process for our Tribal partners for the changes which impacted benefits within the ABP's (which included behavioral health services and EIS). Pharmacy reimbursement changes and the addition of the new managed care changes to Title XXI were determined to have no significant impact for the Tribes, so a separate notice was not generated. Hard copies of the Tribal notices were sent to Tribal Leaders and e-mailed to a contact list of Tribal Representatives. The notices were subsequently posted to the Idaho Medicaid-Tribes website. These SPA's were discussed as part of the quarterly meeting with the Tribes in February 2018, May 2018 and August 2018. No additional requests for discussion or consultation were received.	

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.

All Title XXI beneficiaries have the same delivery system for their health care services, as the Title XIX program. Services are primarily reimbursed on a fee-for-service basis under a Primary Care Case Management (PCCM) model of managed care, administered by the State. Behavioral Health and dental services are delivered under separate managed care agreements.

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))

This State Plan uses utilization controls from the Title XIX program, including prior approval controls, peer reviews, claims processing edits, and post-audit and review procedures. Primary care providers are charged with making referrals for medically necessary specialty services. Health services providers are provided a handbook describing the benefit package including limitations. Participants are issued an identification card which is used to determine covered services and service limitations.

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 target 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 same method of assuring delivery of insurance products and delivery of health care services is used for Title XXI and Title XIX. Providers are required by contract to assure that services are delivered in accordance with state and federal regulations. CHIP utilizes the same provider network as Idaho Medicaid.

  network as Idaho Medicaid.
- 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 managed care benefits for children enrolled in our Title XIX and Title XXI programs are administered through the same PAHP and PCCM entities. Dental and behavioral health services are provided through separate Prepaid Ambulatory Health Plans and Primary Care Case Management services are administered by the state.

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: Idaho has two PAHP's. One for behavioral health services and one for dental services. Idaho's PAHP's provide services to both our title XIX Medicaid participants and to our participants under our title XXI program,

which is a combination Medicaid expansion and separate child health program.

☐ Other (please explain)

Describe population served: Idaho has two managed care contractors. A PAHP for behavioral health services and a PAHP for dental services.

☒ Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)

- ☒ Case management fee
- ☐ Other (please explain) Idaho has a state administered PCCM program which provides services to both our title XIX participants and to Medicaid children and to our participants under our title XXI program, which is a combination Medicaid expansion and separate child health program.

☐ Primary care case management entity (PCCM Entity) (42 CFR 457.10)

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

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

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

☐ Other (please describe)

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

3.1.3 Nonemergency Medical Transportation PAHPs

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

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

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

3.2. General Managed Care Contract Provisions

3.2.1 ☒ The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

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

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

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

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

☒ Based on public or private payment rates for comparable services for comparable populations; and

☒ Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

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

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

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

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

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

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

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

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

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

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

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

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

3.4 Enrollment

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

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

3.4.1 Enrollment Process

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

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

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

☒ Yes
☐ No

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

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

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

3.4.2 Disenrollment

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

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

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

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

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

Guidance: Reasons for disenrollment by the MCO, PIHP, PAHP, PCCM, and PCCM entity must be specified in the contract with the State. Reasons for disenrollment may not include an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, PCCM or PCCM entity seriously

impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b)(2))

3.4.2.5 Enrollee Requests for Disenrollment.

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

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

☐ Yes
☒ No *The State only has one PAHP contractor for each PAHP plan and the participants can change providers within the plan at any time. Participants can change PCP's within the state administered PCCM program at any time.

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

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

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

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

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the

temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and

- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

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

3.5 Information Requirements for Enrollees and Potential Enrollees

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

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

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

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

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

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

- The format is readily accessible;
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;

- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

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

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

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

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;
- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;

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

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

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

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

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

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

- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

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

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

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

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

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

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

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

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

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

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

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

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

3.6 Benefits and Services

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

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

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

3.6.3 ☒ The State assures that it:

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

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

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

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

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

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

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

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

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when

medically necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

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

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

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

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

cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

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

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

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

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

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

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

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

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

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

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

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

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

3.7 Operations

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

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

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

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

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

- ☒ The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- ☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or

PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;

☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable sub regulatory guidance and contract provisions; and

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

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

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

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

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

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

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

3.8 Beneficiary Protections

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

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

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

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

3.9 Grievances and Appeals

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

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

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

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

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

☐ Yes

☒ No

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

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

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

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

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

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

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

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

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

to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))

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

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

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

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

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

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

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

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

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

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

3.9.14 ☒ The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP

receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

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

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

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

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

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

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

3.9.20 ☒ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such

methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 ☒ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and
- For appeals not resolved wholly in favor of the enrollees:
  - The right to request a State review, and how to do so.
  - The right to request and receive benefits while the hearing is pending, and how to make the request.
  - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

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

3.9.23 ☐ The State assures that if it offers an external medical review:

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

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

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

- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
- The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and

that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

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

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

3.10 Program Integrity

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

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

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

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

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

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

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

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

network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

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

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

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

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)) The State conducted a quality review just before the regulation changes were implemented and in discussions and in agreement with CMS, we have agreed to comply with this requirement within our next RFP, in accordance with the provisions in our managed care contracts.

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))

6.2.1	Inpatient Hospital Services	(Section 2110(a)(1))
Covered services include: Semi-private room, intensive and coronary care units, general nursing, drugs, oxygen, blood transfusions, laboratory, imaging service, physical, speech, occupational, heat, radiation and inhalation therapy; renal dialysis, respiratory therapy, enterostomal therapy, operating, recovery, birthing, and delivery rooms, routine and intensive care for newborns and other medically necessary benefits and prescribed supplies for treatment of injury or illness are covered. • Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment. • Inpatient hospital services do not include those services provided in an institution for mental diseases. • Inpatient services that are being furnished to infants and children described in 42 CFR 457.310 (targeted low-income child) on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.		
Limitations	Inpatient stays are reviewed by the Department or its contractor after three (3) days, or in four (4) days if the participant has had a cesarean section. Selected services require prior authorization.	
Excluded Services	Elective medical and surgical treatments, except family planning services and non-medically necessary cosmetic surgery, are excluded from payment unless prior approved by the Department or its authorized agent. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program are excluded from payment. • Acupuncture, bio-feedback therapy, and laetrile therapy are excluded from Medicaid payment. • Procedures, counseling, and testing for the inducement of fertility are excluded from Medicaid payment. • Surgical procedures for the treatment of morbid obesity and panniculectomies are excluded unless prior approved by the Department or its authorized agent.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the	

	Department.	
6.2.2	**Outpatient Hospital Services**	**(Section 2110(a)(2))**
Covered services include: All benefits described in the inpatient hospital section which are provided on an outpatient basis in a hospital (including, but not limited to, observation beds and partial hospitalization benefits) or ambulatory surgical center; chemotherapy; emergency room benefits for surgery, injury or medical emergency; and other services for diagnostic or outpatient treatment of a medical condition, injury or illness. • Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.		
Limitations	• PT, SLP, OT services for the purposes of Rehabilitation (restoring functional losses due to disease, illness or injury)are limited to 20 (twenty) visits, as a separate but equal benefit to the 20 (twenty) visits, as Habilitative services, in accordance with 45CFR 156.115(a)(5)(iii). These services are not provided through a Home Health Agency. • PT, SLP, OT services for the purposes of Habilitation (related to developing skills and functional abilities necessary for daily living skills related to communication of persons who have never acquired them)are limited to 20 (twenty) visits, as a separate but equal benefit to the 20 (twenty) visits in accordance with 45CFR 156.115(a)(5)(iii). These services are not provided through a Home Health Agency. • Community based behavioral health services will be provided under the Idaho Behavioral Health Plans' PAHP contract. • Psychological evaluation, speech and hearing evaluations, physical therapy evaluation and, occupational therapy evaluation, and diagnostic services are limited to twelve (12) hours for each eligible recipient per calendar year. • Diabetic education and training services are limited to twenty-four (24) hours of group counseling and twelve (12) hours of individual counseling through a diabetic education program or by a certified diabetic educator recognized by the American Diabetes Association. • Dietary Counseling services are limited to two (2) visits per calendar year. • Tobacco Cessation Counseling is covered in accordance with USPSTF recommendations	
Excluded Services	Abortion Services (see Section 6.2.16) of this table for information specific to those services); Hysterectomies that are not medically necessary; Sterilization procedures, and those services within section *6.2.1 Inpatient Hospital Services* of this table, listed as "Excluded Services", are excluded from payment.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT,may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.3	**Physician Services** **(Corresponds to EHB 1 and EHB 3 of Idaho Title XIX)**	**(Section 2110(a)(3))**
Covered services include: Those provided as treatment for an illness, condition or injury by Doctor of Medicine or osteopathy, subject to the limitations of their licensure under state law and in accordance with the restrictions and exclusions, as provided in applicable Department rules. These services may be provided in an office, clinic, hospital, urgent care, patient's home or elsewhere.		
Limitations	All covered physician services are subject to the limitations of the licensure of the physician providing the service, as provided under state law, and are subject to the restrictions and exclusions, as provided in applicable Department rules; Selected services may require prior authorization and/or a referral from the participant's primary care physician.	
Excluded Services	Abortion Services (see Section 6.2.16) of this table for information specific to those services); Hysterectomies that are not medically necessary; Sterilization procedures and those services within section *6.2.1 Inpatient Hospital Services* of this table, listed as "Excluded Services" are excluded from payment.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT,may receive	

	additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.4	**Surgical services and Ambulatory Surgical Center Services (ASC)**	**(Section 2110(a)(4))**
Covered services include: Surgical services provided as treatment for an illness, condition or injury by a physician, surgeon or Doctor of Dental Surgery provided in a hospital, outpatient surgical center, clinic or ambulatory surgical center. These services may be provided in a hospital, an outpatient surgical center, ASC or clinic in accordance with the restrictions and exclusion, as provided in applicable Department rules. • Medically appropriate second opinions • Ambulatory Service Center facility fees.		
Limitations	All covered surgical services are subject to the limitations of the licensure of the physician or surgeon providing the service, as provided under state law, and are subject to the restrictions and exclusions, as provided in applicable Department rules. • Selected services may require prior authorization and/or a referral from the participant's primary care physician. • Surgical services provided in an ASC must be provided in a Medicare certified ASC and are restricted to those procedures identified in 42CFR 416.65 or identified by the Department as meeting those requirements.	
Excluded Services	Abortion Services (see Section 6.2.16) of this table for information specific to those services); Hysterectomies that are not medically necessary; Sterilization procedures and those services within section *6.2.1 Inpatient Hospital Services* of this table, listed as "Excluded Services" are excluded from payment.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT,may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.5	**Clinic services (including health center services) and other ambulatory health care services.**	**(Section 2110(a)(5))**
Covered services include: • **Clinic Services and Rehabilitative Services.** are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician and which may include those services provided by community health centers. • **Rural Health Clinic services**. and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State plan. • **Federally Qualified Health Center (FQHC) services**. and other ambulatory services that are furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4). • **Indian Health Service Facility services.** are provided in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers. **Independent School Districts** which have entered into a provider agreement with the Department may bill for the following services when the service(s) and the amount needed are identified by the interdisciplinary team and listed on the student's Individual Education Plan (IEP).All provider qualification and prior authorization requirements as specified in IDAPA 16.03.09 for these services apply. • **Audiology Services** Diagnostic, screening, preventive or corrective services provided by an audiologist licensed by the Speech and Hearing Services Board in the Idaho Board of Occupational Licensing. • **Behavioral Consultation** with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members.		

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Behavioral Intervention Continuous intervention method focused on promoting the student's ability to participate in educational services through a consistent, assertive intervention process. It includes the development of replacement behaviors with the purpose to prevent or treat behavioral conditions of students who exhibit maladaptive behaviors.
Evaluation and Diagnostic Services Evaluation and diagnostic services are reimbursable if they are to determine eligibility or need for health-related services. Evaluations must meet the criteria in IDAPA rule, section 852 School Based Services. Evaluations completed for education services only are not reimbursable.
Medical Equipment and Supplies Medical equipment and supplies that are covered by Medicaid and are needed for use at school but are too large or unsanitary to transport from home to school. They must be for the student's exclusive use and transfer with the student if the student changes schools.
Nursing Services Skilled nursing services that must be provided by a licensed nurse. Emergency, first aide or assistance with non- routine medications not identified on the IEP as health-related services are not reimbursable.
Occupational Therapy, Physical Therapy or Speech Language Pathology Rehabilitation Services for the purpose of restoring certain functional losses due to disease, illness or injury. Services for vocational assessment, training or vocational rehabilitation are not covered.
Personal Care Services School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements while at school. Personal care services do not require a goal on the plan of service.
Psychological Evaluation Evaluations of cognitive abilities, mental health issues and issues related to brain injury.
Psychotherapy Rehabilitative therapeutic interventions to address alcohol or drug abuse and/or emotional, behavioral or cognitive problems.
Community Based Rehabilitation Services to assist the student in gaining and utilizing skills necessary to participate in school such as training in behavior control, social skills, communication skills, activities of daily living and coping skills. This service is to prevent placement in a more restrictive educational situation.
Social History and Evaluation Assessment of home and family environment, to determine suitability to meet the participant's medical needs.
Transportation. Student must require special transportation that is ordered by a physician and included on the IEP and receive another Medicaid reimbursable service on the same day.
Interpretive Services. May only be billed when the student needs the service of an interpreter to receive a Medicaid reimbursable service. Not covered if the person providing the service is able to receive a Medicaid reimbursable service. Not covered if the person providing the service is able to communicate in the student's primary language.

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<tr><td>Limitations</td><td colspan="2">

Audiology Services do not include equipment.
Equipment is included under the DME benefit.
Behavioral Consultation is limited to thirty-six (36) hours per student per year.

</td></tr>
<tr><td>Excluded Services</td><td colspan="2">Abortion Services (see Section 6.2.16) of this table for information specific to those services); Hysterectomies that are not medically necessary; Sterilization procedures and those services within section 6.2.1 Inpatient Hospital Services of this table, listed as "Excluded Services" are excluded from payment.

Vocational, Educational and Recreational services are not reimbursable.</td></tr>
<tr><td>EPSDT</td><td colspan="2">Individuals from birth through the month of their 21st birthday, pursuant to EPSDT,may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.</td></tr>
<tr><td>6.2.6 – 6.2.7</td><td>Prescription drugs and Over the Counter Medications</td><td>(Section 2110(a)(6)) (Section 2110(a)(7))</td></tr>
<tr><td colspan="3">Prescribed Drugs are those prescribed by a practitioner acting within the scope of his practice, chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines and prenatal vitamins.</td></tr>
</table>

Idaho Medicaid provides coverage to Medicaid participants for the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under § 1927(d)(2) of the Social Security Act:
| | (A) Agents when used for anorexia, weight loss, or weight gain.
| | (B) Agents when used to promote fertility.
| | (C) Agents when used for cosmetic purposes or hair growth.
| | (D) Agents when used for the symptomatic relief of cough and colds.
| X | (E) Agents when used to promote smoking cessation.
| X | (F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
Covered agents include: Injectable vitamin B12 (cyanocobalamin and analogues); vitamin K and analogues; prescription vitamin D and analogues; prescription pediatric vitamin-fluoride preparations; prescription pediatric vitamins, minerals, and fluoride preparations; prenatal vitamins for pregnant or lactating individuals; prescription vitamin D and analogues; prescription folic acid; and oral prescription drugs containing folic acid in combination with vitamin B12 and/or iron salts, without additional ingredients.
| X | (G) Nonprescription drugs, except, in the case of pregnant women when recommended in accordance with Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposed of promoting, and when used to promote, tobacco cessation. Certain prescribed non-prescription products are covered, including: Permethrin; oral iron salts; disposable insulin syringes and needles; insulin; and tobacco cessation products.
| | (H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
| X | (I) Barbiturates
| X | (J) Benzodiazepines
| | (K) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

Drugs are also not covered when the following circumstances apply: • The participant's practitioner has written an order for a prescription drug for which federal financial participation is not available. The participant's practitioner has written an order for a prescription drug that is deemed to be experimental or investigational, as defined in IDAPA 16.03.09.390.03. Investigational drugs are not a covered service under the Idaho Medicaid pharmacy program. The Idaho Department of Health and Welfare may consider Medicaid coverage on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available. • The participant's practitioner has written an order for a covered outpatient drug for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee. • The Idaho Medicaid Pharmacy Program receives a provider reimbursement claim for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment. • The participant is dually eligible for Medicare and Medicaid, and the prescribed drug or drug class is covered under Medicare Part D. In the case of dual eligibles, the Department will pay for only those Medicaid-covered drugs not covered under Medicare Part D.

Covered Outpatient Drugs
Medical necessity is the primary determinant of whether a therapeutic agent will be covered. The Department will cover generic drugs, and also brand drugs when medically necessary and that necessity is adequately documented. If case-specific indications of medical necessity are present, the Department may also issue prior authorization for otherwise excluded drugs.

Idaho Medicaid maintains a Preferred Drug List (PDL) that identifies the preferred drugs and non-preferred drugs within a therapeutic class. The Director of the Department makes final decisions regarding drugs' designated preferred or non-preferred status based on therapeutic recommendations from the Pharmacy and Therapeutics Committee and cost analysis from the Idaho Medicaid Pharmacy Program A brand name drug may be designated as a preferred drug by the Department if, after consideration of all rebates, the net cost of the brand name drug is less than the cost of the generic equivalent.

The Director of the Department of Health and Welfare, acting upon the recommendation of the Pharmacy and Therapeutics Committee, may determine that a non-prescription drug product is covered when the nonprescription product

is found to be therapeutically interchangeable with prescription drugs in the same pharmacological class following evidence-based comparisons of efficacy, effectiveness, clinical outcomes, and safety, and the product is deemed by the Department to be a cost-effective alternative.		
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT,may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.8	**Laboratory and radiological services**	**(Section 2110(a)(8))**
	Covered services include: Imaging and laboratory services for diagnostic and therapeutic purposes due to accident, illness or medical condition, (imaging, CT/PET Scans, MRI's, Nuclear Cardiology).	
Limitations	Upon or under physician or other licensed practitioner required.	
Excluded Services	Diagnostic tests and lab work which are associated with excluded Hospital Services and Physician Services are excluded from payment.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.9.	**Pre-pregnancy family services and supplies**	**(Section 2110(a)(9))**
Family Planning Services include pre-pregnancy family planning services and prescribed supplies including birth control contraceptives for individuals of child-bearing age include counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. • The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning. • All requirements of 42 CFR Part 441, Subpart F are met.		
Limitations	Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply.	
Excluded Services	Hysterectomies performed solely for sterilization are ineligible for payment.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.10	**Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services**	**(Section 2110(a)(10))**
Covered services include: Inpatient psychiatric facility services, which meet medical necessity criteria, as determined by the Department or its authorized agent and are provided in a psychiatric unit of a general hospital.		
Limitations	Does not include services provided in Psychiatric Residential Treatment Facility (PRTF)'s or Institutions for Mental Diseases (IMD)'s.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.11.	**Outpatient mental health services, other than services**	**(Section 2110(a)(11)**

<table>
<tr><td></td><td>described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services</td><td></td></tr>
<tr><td colspan="3">Covered services include: Medically necessary community-based outpatient mental health services for rehabilitation which evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and restore independent functioning. These services include:

• Case Consultation
• Case Management
• Community-based Rehabilitation Services (skills-building/basic living skills training)
• Crisis Intervention
• ECT Therapy
• Partial Care (which includes: skill building component, supportive therapy, and medication monitoring)
• Pharmacological management
• Psychoeducation
• Psychological and neuropsychological testing
• Psychotherapy (group, family and individual)
• Screening, Evaluation & Diagnostic Assessment
• Treatment Planning
• Intensive Outpatient Program (IOP)

All community based mental health and services will be provided through a Pre-paid Ambulatory Health Plan known as the Idaho Behavioral Health Plan.</td></tr>
<tr><td>Limitations</td><td colspan="2">• All community-based outpatient mental health and substance use services are subject to limitations of practice imposed by state law, federal regulations and according to applicable Department rules, the PAHP contract as awarded or amended and approved by the Department or its authorized agent based upon medical necessity.
• Outpatient psychotherapy services are in-person, non-electronic services (except when telehealth is provided in accordance with board regulations) and are used to treat mental health conditions. Family and individual psychotherapy may be delivered in a home or community-based setting.
• The IOP provider is responsible for coordination of care with the participant's primary care provider and other behavioral health providers.</td></tr>
<tr><td>Excluded Services</td><td colspan="2">• During the participants treatment in IOP, behavioral health services, other than psychiatric services and medication management are excluded from payment, as they are included in the per diem for IOP.
• Experimental or Non-medically necessary services as determined by the Department or its authorized agent will be excluded.</td></tr>
<tr><td>EPSDT</td><td colspan="2">Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.</td></tr>
<tr><td>6.2.12</td><td>Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)</td><td>(Section 2110(a)(12))</td></tr>
</table>

Covered Services include:

- **Durable Medicaid Equipment Items** that are primarily used to serve a therapeutic purpose and that are generally useful to a person in the absence of injury, disease or an illness and that are appropriate for use in any setting in which normal life activities take place.
- **Hearing Aids.** Hearing aids and related services will be covered by the Department.
- **Augmentative Communication Devices**. Augmentative communication devices are covered as specified in applicable Department rules.

Limitations	The Department will replace DME more frequently than five (5) years when determined to be medically necessary. The Department will prior authorize audiometric examination and testing if needed more frequently than once per year.
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

6.2.13.	**Disposable medical supplies, Medical Equipment and Devices**	**(Section 2110(a)(13))**

Covered services include:
Durable medical equipment and other medically-related or remedial devices. These also include medical supplies, equipment, and appliances suitable for use in the home.

Medical equipment and medical supplies must be ordered in writing by a physician. Medical equipment and supplies are provided only on a written order from a physician that includes the medical necessity documentation listed in the Medicare DMERC Supplier manual.

Specialized Medical Equipment and Supplies

Oxygen and related equipment is covered for individuals qualifying under EPSDT when the medical need is discovered during a screening service and is physician ordered. PRN oxygen, or oxygen as needed on less than a continual basis, will be authorized for six (6) months following receipt if medical documentation from the attending physician as to an acute or chronic medical condition which requires oxygen support to maintain respiratory status. Medical documentation will include a diagnosis, oxygen flow rate and concentration, and an estimate of the frequency and duration of use. Portable oxygen systems may be ordered to compliment a stationary system if the recipient is respirator dependent, or the attending physician documents the need for a portable oxygen system for use in transportation. Laboratory evidence for hypoxemia is not required under the age of six (6) months.

Prosthetic Devices
These services include prosthetic and orthotic devices and related services prescribed by a physician and fitted by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics.

The Department will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body.

Limitations	• Items not specifically listed in applicable Department rules will require prior authorization by the Department or its authorized agent. • Limit of one refitting, repair or additional parts in a calendar year for prosthetic devices.
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

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

	(Home Health)	
Covered services include: Intermittent or part-time skilled nursing services, Home Health Aide services, Occupational Therapy, Physical Therapy or Speech Language Pathology services provided by a home health agency.		
Limitations	• Services by a licensed nurse, when no home health agency exists in the area, must be prior approved by the Department as defined in 42 CFR 440.70(b)(l). • Home health visits are limited to one hundred (100) per recipient per calendar year provided by any combination of home health agency licensed nurse, home health aide, home health physical therapist, home health occupational therapist, licensed nurse. • Home health services are provided in accordance with the requirements of 42 CFR 441.15.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.15.	**Nursing care services**	**(Section 2110(a)(15))**
Covered Services include: **Personal Care Services (PCS)** furnished to a participant who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for people with intellectual disabilities, or institution for mental diseased that are: Authorized by a physician • provided in accordance with a plan of care; • provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and • provided in the participant's place of residence. **Private Duty Nursing (PDN)** are nursing services provided by a registered nurse or licensed practical nurse to a non-institutionalized child under the age of 21 requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. PDN Services must: Be ordered by a physician, provided under a written plan of care. and include: The medical severity and complexity of the child's condition must require more individual and continuous care than is available from a visiting nurse and the needed services cannot safely be delegated to Unlicensed Assistive Personnel (UAP). The nursing needs of the participant must be of such a nature that Idaho Code, Idaho Nursing Practice Act or IDAPA rules or policies require the service to be provided by an Idaho Licensed Registered Nurse (RN) or by an Idaho Licensed Practical Nurse (LPN) and require more individual and continuous care than is available from Home Health nursing services. PDN Services may be provided only in the child's personal residence or when normal life activities take the child outside of this setting. However, if service is requested only to attend school or other activities outside of the home, and the child does not need such services in the home, private duty nursing will not be authorized. The following are specifically excluded as personal residences: • Licensed Nursing Facilities (NF); • Licensed Intermediate Care Facilities for Individuals with Intellectual Disabilities • Licensed Residential Care Facilities; • Licensed hospitals; and • Public or private school		
Limitations	PCS services are limited to sixteen (16) hours per calendar week, per participant and must be ordered by a physician.	

	PDN services must be prior authorized by the Department or its authorized agent	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.16.	**Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest**	**(Section 2110(a)(16)**
Abortions Services: A legal abortion is only covered to save the life of the mother or in cases of rape or incest as determined by the courts. When a pregnancy is life threatening and abortion is provided to save the life of the mother, one licensed physician or osteopath must certify in writing that the woman may die if the fetus is carried to term.		
Limitations	Cases of rape or incest must be determined by a court or documented by a report to law enforcement, except that if the rape or incest was not reported to law enforcement, a licensed physician or osteopath must certify in writing that, in his/her professional opinion, the women was unable to report the rape or incest to law enforcement for reasons related to her health.	
6.2.17.	**Dental services**	**(Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)**
Dentures for the purpose of restoring oral form and function due to loss of permanent teeth that would result in significant occlusal dysfunction.		
Limitations	Dentures are limited to one set every seven years.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.18.	**Vision screenings and services (EPSDT)**	**(Section 2110(a)(24))**
Covered Vision Services include: Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist. The Department will pay for vision services and supplies. One eye exam by physicians and/or optometrists is allowed during any twelve (12) month period. The Department will cover vision-screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens; the vision is considered part of the medical screening service, (i.e. eye chart). **Eyeglasses.** Each recipient, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive one (1) pair of eyeglasses per year, except in the following circumstances: In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize		

a second eye examination to determine that visual change; or the		
Limitations	• **Vision Services:** The Department will pay for one (1) eye examination by an ophthalmologist or optometrist during any twelve (12) month period for each eligible recipient to determine the need for glasses to correct or treat refractive error. • **Eyeglasses:** Polycarbonate lenses will be purchased only when it is documented that the prescription is above plus or minus two (2.00) diopters of correction. Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of extreme medical conditions as determined by the Department. Contact lenses will be covered only when documentation of an extreme myopic condition requiring a correction equal or greater than minus four (-4) ten diopters, cataract surgery, keratoconus, or other extreme medical condition preclude the use of conventional lenses. Replacement lenses will be purchased only when there is documentation of a major visual change of at least one-half (.50) diopter plus or minus. • Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one of these reasons on his claim. If repair costs are greater than the cost of new frames, new frames may be authorized. • Lenses will be provided when there is documentation that the correction needed is equal to or greater than plus or minus one-half (.50) diopters of correction.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.19.	**Hearing screenings and services**	**(Section 2110(a)(24))**
Covered services include: Audiologist services for individuals with hearing disorders when provided by an audiologist who is licensed by the Speech and Hearing Services Board of the Idaho Board of Occupational Licenses. These services also include medically necessary audiometric services and supplies.		
Limitations	Limited to one per year. Additional will be subject to prior authorization.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.20.	**Inpatient and Residential Substance Use Disorder Treatment Services**	**(Section 2110(a)(18))**
Covered services include. Those provided as inpatient services within a general hospital for the treatment of Substance Use Disorder.		
Limitations	• The State substitutes its coverage for Community-Based Rehabilitations Services and Partial Care for Residential Treatment and Partial Hospitalization within its Title XIX State Plan. There are no Psychiatric Residential Treatment Facilities licensed or certified in the State of Idaho. • Services are not provided in an IMD. • Services must meet all medical necessity criteria.	
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.	
6.2.21.	**Outpatient Substance Use Disorder treatment services**	**(Section 2110(a)(19))**

Covered services include: Medically necessary Community-Based Outpatient Substance Use Disorder Treatment Services for rehabilitation which evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of substance use disorders and restore independent functioning. These services may be provided by:

- Licensed physician
- Advanced Practice Registered Nurse
- Physician Assistant
- Licensed Social Worker
- Licensed Counselor
- Licensed Marriage and Family Therapist
- Providers who hold at least a bachelor's degree, a Certification or Licensing in their filed, and meet requirements of Idaho Department of Health and Welfare
- Licensed Psychologist, Psychologist Extender (Registered with the Idaho Bureau of Occupational Licenses)
- Registered Nurse

All community-based substance use disorder treatment services will be provided through a Pre-paid Ambulatory Health Plan known as the Idaho Behavioral Health Plan.

Limitations	• All community-based outpatient substance use disorder services are subject to limitations of practice imposed by state law, federal regulations and according to applicable Department rules, the PAHP contract as awarded or amended and approved by the Department or its authorized agent based upon medical necessity. • Not provided in an Institution for Mental Disease.
Excluded Services	Experimental or Non-medically necessary services as determined by the Department or its authorized agent are excluded.
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

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

Covered services include: Case management services provided to targeted children who meet the requirements set forth in Department rules. The Department or its authorized agent must approve the Service Plan for continued authorization.

Limitations	Initial service plans must be prior authorized by the Department or its authorized agent. Plans must be updated annually by the case manager. The case manager must review and update the plan at least annually and a new prior authorization must be issued by the Department or its authorized agent.
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

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

Covered Services include : Physical therapy, occupational therapy, or speech-language pathology services provided by a home health agency or medical rehabilitation facility for the purpose of restoring certain functional losses due to disease, illness, or injury.

Therapy services by an independent provider may be furnished by the following providers:

- Physical therapist who in accordance with 42 CFR 440.110(a) is licensed by the PT Licensing Board within the Board of Occupational Licensing.
- Occupational Therapist who in accordance with 42 CFR 440.110(b) is licensed by the Board of Occupational Licensing.
- Speech-Language Pathologist who in accordance with 42 CFR 440.110(c), is licensed by the Speech and Hearing Services Licensure Board within the Board of Occupational Licensing.

All therapy services are provided according to a written physician order as a part of a plan of care and must be provided either in the patient's home or in the therapist's office. An office in a nursing home or hospital is not considered an independent therapist's office.

Limitations	To comply with 45 CFR 156.115(a)(5)(iii), Idaho Medicaid provides separate, equal 20-visit limits each for rehabilitation and habilitation.
Excluded Services	Services provided through a Home Health Agency.
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

6.2.25.	**Hospice care**	**(Section 2110(a)(23))**

Covered services include: Hospice Care provided to terminally ill recipients.

Limitations	Services must be provided by a Medicare certified hospice and in accordance with Section 2302 of the Affordable Care Act, which requires hospice services to be provided to children concurrently with curative treatment.
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

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

Covered services include diagnosis and treatment involving medical care as well as such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in this State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. The Department will set amount, duration and scope for services provided under EPSDT. Needs for services discovered during a screening which are outside the coverage provided by applicable Department rules must be medically necessary and prior authorized in accordance with Department rules.

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

Covered services include:

- **USPSTF Recommended "A and B grade services;** Advisory Committee for Immunization Practices (ACIP) vaccines; HRSA's Bright Futures preventive care and screening for infants and children; and additional preventive services for women recommended by the Institute of Medicine (IOM).
- **Periodic and interperiodic Well Child Screens.** completed at intervals recommended by the American Academy of Pediatrics (AAP), constitutes as a health risk assessment. Developmental screening is considered part of every routine periodic examination. If the screening identifies a developmental problem, then a developmental assessment will be ordered by the physician and conducted by qualified professionals.
- **Early Intervention Services (EIS)**

Early, Periodic, Screening, Diagnostic and Treatment Services (EPSDT) provided to CHIP participants by the IDEA Part C Lead Agency. The IDEA Part C Lead Agency is responsible for assessing and treating the developmental needs of infants and toddlers (and the needs of their significant others) related to enhancing the child's development. Services to the participant's family/caregivers are developed in accordance with the treatment goals and needs of the participant identified in their Individualized Family Service Plan (IFSP), which is developed for the purpose of assisting in the participant's recovery.

- **Covered services include.**
  - age-appropriate screenings, evaluations and services for development relative to motor, language, social, adaptive, and cognitive functioning testing and interpretation; Development, review, and implementation of IFSPs; .EIS including therapy services, family training, home care training, and interdisciplinary teaming.
- **Optometrist Services** are limited to providing eye examination and eyeglasses unless the optometrist has been issued and maintains certification under the provisions of Idaho Code to diagnose and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services.
- **Orthodontia.** Children through the month of their twenty-firth (21st) birthday.

Limitations	All EIS service providers must be employed by or contracted with the IDEA Part C lead agency and meet all IDEA Part C requirements, all Medicaid regulations and licensure standards under Idaho law. Services must be delivered in accordance with the intra-agency agreement between the IDEA-Part C Agency and the Medicaid/CHIP Agency.
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department or the Department's designee.

6.2.29.	**Non-Emergency Medical transportation and Emergency Medical Transportation**	**(Section 2110(a)(26))**

Covered services include: Transportation services and assistance for eligible persons to medical facilities. Payment for meals and lodging may be authorized where appropriate.

Ambulance services will be covered in emergency situations or when retroactively authorized by the Department or its authorized agent.

Limitations	• There is no limit on medically necessary medical transportation. • Requests for transportation will be reviewed and authorized by the Department or its authorized agent. • Authorization is required prior to the use of transportation services except when the service is emergent in nature. Payment for transportation services will be made, for the least expensive mode available, which is most appropriate to the recipient's medical needs.
Excluded Services	Transportation to medical facilities for the performance of medical services or procedures which are excluded from payment is excluded.
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT,may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

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

- **Covered services include:**

- Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- **Certified nurse-midwife services** are those services provided by certified nurse midwives as defined by state and federal law. This coverage has the same exclusions as Physician Services.

- **Certified Pediatric or Family Nurse Practitioners' Services** are those services provided by certified pediatric or family nurse practitioners as defined by state and federal law. This coverage has the same exclusions as Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners .Services provided by nurse practitioners are limited to Section 54-1402(d) of Idaho Code.

- **Chiropractor Care**. Coverage only for treatment involving manipulation of the spine to correct a subluxation condition.

- **Diabetes Education.** Diabetes education and training services provided as individual or group sessions, provided by Certified Diabetes Educators.

- **Diagnostic Screening Clinics.** Services provided in a diagnostic screening clinic are outlined in applicable Department rules.
- **Dietary Counseling.**
    - Include intensive nutritional education, counseling and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetic Association
- **Nurse-Midwife Services** are provided to the extent that nurse-midwives are authorized to practice under State law or regulation. Services include antepartum, intrapartum, up to six (6) weeks of postpartum maternity care, and up to six weeks of newborn care.
- Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid/CHIP agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.
- **Physician Assistant Services** include those services provided by a physician assistant as defined by state and federal law. This coverage has the same exclusions as Physician Services.
- **Podiatrist Services** are services to diagnose and treat medical conditions affecting the foot, ankle and related structures. Routine foot care is not covered.
- **Prevention and Health Assistance (PHA) Benefits**
    - Targets overweight/underweight individuals to address weight management. Participants who are recommending by their PCM because they meet screening criteria can receive additional assistance towards services for weight loss programs focused on exercise or diet/nutrition/health education.
- **Tobacco Cessation Counseling** – Covered according to USPSTF Recommendations.

- **<u>Specific Pregnancy- Related Services</u>**
- **Risk Reduction Follow-up**. Services to assist the client in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. Payment is available to licensed social workers, registered nurses and physician extenders either in independent practice or as employees of entities which have current provider agreements with the Department.
- **Individual and Family Medical Social Services.** Services directed at helping a patient to overcome social or behavioral problems which may adversely affect the outcome. Payment is available for two (2) visits during the covered period to a licensed social worker qualified to provide individual counseling according to the provisions of the Idaho Code and the regulations of the Board of Social Work Examiners.
- **Nutrition Services.** Intensive nutritional education, counseling and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/profession requirements in dietetics as approved by the American Dietetic Association to assure the patient's proper nutrition. Payment for two (2) visits per pregnancy is available.
- **Nursing Services**. Home visits by a registered nurse to assess the client's living situation and provide appropriate education and referral during the covered period. A maximum of two (2) visits per pregnancy is provided.**Maternity Nursing Visit.** Office visits by a registered nurse, acting within the limits of the Nurses Practices Art, for the purpose of checking the progress of the pregnancy. These services must be

	prior authorized by the Department's care coordinator and can be paid only for women unable to obtain a physician to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. • **Qualified Provider Risk Assessment and Plan of Care.** When prior authorized by the Department care coordinator, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care.
Limitations	• **Chiropractor Care** -Six (6) visits. The Department will review for medical necessity and prior authorize chiropractic services after the initial six visits per year. • **Diabetic education and training** services are limited to twenty-four (24) hours of group counseling and twelve (12) hours of individual counseling through a diabetic education program or by a certified diabetic educator recognized by the American Diabetes Association. • **Diagnostic Screening Clinics.** five (5) hours of medical social services per eligible recipient per state fiscal year is the maximum allowable. • **Dietary Counseling** services are limited to two (2) visits per calendar year. • **Nurse-Midwife Services and Certified Nurse-midwife services.** This coverage has the same exclusions as Physician Services. • **PHA services** must be prior authorized. • **Physician Assistants.** Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code. • **Skilled Nursing Facility** – Limited to (30) thirty days per year. • **Tobacco Cessation** Counseling is covered in accordance with USPSTF recommendations.
EPSDT	Individuals from birth through the month of their 21st birthday, pursuant to EPSDT,may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

COST OF APPROVED CHIP PLAN

Benefit Costs	**2018**
Insurance payments	$400
Managed Care	$19,485,914
Fee for Service	$61,850,378
Total Benefit Costs	$81,336,692
(Offsetting beneficiary cost sharing payments)	-$1,043,500
Net Benefit Costs	$80,293,192

Administration Costs	**2018**
Personnel	
General Administration	$ 955,710
Contractors/Brokers (e.g., enrollment contractors)	
Claims Processing	$ 36,342
Outreach/Marketing costs	
Other (e.g., indirect costs)	
Health Services Initiatives	$ 2,107,704
Total Administration Costs	$ 3,099,756
10% Administrative Cap (net benefit costs ÷ 9)	$ 8,921,466

	2018
Federal Title XXI Share	$ 83,392,948
State Share	$ -
TOTAL COSTS OF APPROVED CHIP PLAN	**$ 83,392,948**