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State/Territory Name: Idaho

State Plan Amendment (SPA) #: ID-20-0012

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, Maryland 21244-1850

Children and Adults Health Programs Group

April 14, 2021

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

Dear Mr. Wimmer:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number ID-20-0012, has been approved. Through this SPA, Idaho has demonstrated compliance with section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. This SPA has an effective date of October 24, 2019.

Section 5022 of the SUPPORT Act added Section 2103(c)(5) to the Social Security Act (the Act) and requires child health and pregnancy related assistance to include coverage of services necessary to prevent, diagnose, and treat a broad range of behavioral health symptoms and disorders. Additionally, Section 2103(c)(5)(B) of the Act requires that these behavioral health services be delivered in a culturally and linguistically appropriate manner. Idaho demonstrated compliance by providing the necessary assurances and benefit descriptions that the state covers a range of behavioral health services in a culturally and linguistically appropriate manner.

Your Project Officer is Ms. Janice Adams. She is available to answer your questions concerning this amendment and other CHIP-related matters. Ms. Adams' contact information is as follows:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations, Mail Stop: RX-200
701 Fifth Avenue, Suite 1600
Seattle, WA 98104
Telephone: (206) 615-241
E-mail: Janice.Adams@cms.hhs.gov

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

Sincerely,
/Signed Amy Lutzky/

Amy Lutzky
Deputy Director

State Plan for the Idaho State Children's Health Insurance Program

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

Preamble

Section 490 I of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXl provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any
subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

State Plan for the Idaho State Children's Health Insurance Program

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

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

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

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

_____

Medicaid Director Date
Division of Medicaid
Idaho Department of Health and Welfare

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

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

Name: Matt Wimmer Position/Title: Medicaid Administrator,
Idaho Department of Health and Welfare
Name: Jodi Osborn Position/Title: Financial Executive Officer,
Idaho Department of Health and Welfare
Name: David Bell Position/Title: Deputy Administrator of Policy & Innovation
Name: Elizabeth Kriete Position/Title: Deputy Administrator of Operations
Division of Medicaid

Disclosure Statement This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office

of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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

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

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

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

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

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

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

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, 2003	
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	August 8, 2019	
Effective Date	July 1, 2018	
Amendment #ID-20-0010		Idaho will provide temporary adjustments to the following policies: Tribal consultation, delays in renewals and most changes in circumstances, premiums and premium lock-out periods and cost sharing. This SPA relates to the Federal COVID-19 public health emergency and impacts all counties of the State of Idaho, as declared by the Governor on March 13, 2020.
Submitted	June 29, 2020	
Approved	July 23, 2020	
Effective Date	July 1, 2019 Implementation Date: March 13, 2020	

Amendment #ID-20-0011		SFY20 Technical Updates
Submitted	June 25, 2020	
Approved	TBD	
Effective Date	July 1, 2019	
Amendment #ID12-0012		Compliance with the requirements of Section 5002 of the SUPPORT Act
Submitted	June 25, 2020	
Approved	TBD	
Effective Date	October 24, 2019	

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

SUBJECT	DATE OF NOTIFICATION	DESCRIPTION
Compliance with Section 5002 of the Support Act	April 23, 2020	Compliance with requirements of Section 5002 of the SUPPORT Act
		The State used its standard notification process for our Tribal partners to provide information regarding the proposed changes. The proposed changes align with recent changes within the Alternative Benefit Plans, which support benefits for both our title XIX Medicaid State Plan and title XXI CHIP Plan and to incorporate technical updates as required by Section 5002 of the SUPPORT Act. This SPA was discussed as part of the quarterly meetings with the Tribes in June 2020(delayed due to the public health emergency) and August 2020.

State Plan for the Idaho State Children's Health Insurance Program

Superseding Pages of MAGI CHIP State Plan Material
State: Idaho

Transmittal Number	SPA Group	PDF#	Description	Superceded Plan Section(s)
ID-13-0016 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS 13 CS15	Eligibility – Targeted Low Income Children Eligibility – Deemed Newborns MAGI-Based Income Methodologies	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Incorporate within a separate subsection under section 4.3
ID-13-0014 Effective/Implementation Date: January 1, 2014	Title XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid Expansion section 4.0
ID-13-0015 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
ID-13-0023 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
ID 13-0013 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS20 CS21 CS27	Non-Financial Eligibility – Residency Non-Financial – Citizenship Non-Financial – Social Security Number Substitution of Coverage Non-Payment of Premiums	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1 – L.R.; 4.1.1 – L.R. Supersedes the current section 4.1.9.1 Supersedes the current section 4.4.4

				Supersedes the current section 8.7 Supersedes the current section 4.1.8

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

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

Idaho is a predominantly rural state. The current population of 1,683,140 resides in its 44 counties. Seventy-five percent of Idaho's counties have fewer than 25,000 residents, with a disproportionally high number of people residing in frontier counties. The rural nature of Idaho has a significant impact on health care issues, including insurance coverage and access to health care services.

Idaho's largest ethnic minority is of Hispanic heritage. Southwest, southeast and south-central Idaho in particular have large concentrations of people with Hispanic heritage. Idaho also has five Native American tribes: the Shoshone and Bannock Tribes in eastern Idaho, the Shoshone and Paiute Tribes in Duck Valley, southwestern Idaho, the Nez Perce Tribe in north central Idaho, and the Coeur d'Alene Tribe in northern Idaho.

According to the 2015 American Community Survey, there are 440,000 children under the age of 18 in Idaho. It is estimated that 13,000 are uninsured compared to 30,000 in 2004. This comparison would indicate that the implementation of the Affordable Care Act has had a significant impact on the uninsured rate of Idaho's children, in addition to a significant increase in the enrollment in CHIP and Medicaid.

2.2 Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR457.80(b))

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

The Idaho Department of Health and Welfare (DHW) strives to increase Idaho children's enrollment in public health insurance programs by coordinating enrollment efforts across DHW divisions, coordinating with other public agencies, and by coordinating with other stakeholders. These coordination efforts include:

Idaho Health Plan Coverage Booklet—a brochure outlining the services available throughout DHW to families, including Title XIX and Title XXI child health programs.
• Idaho CareLine—an 800-number providing referral assistance to DHW customers throughout Idaho. The Idaho CareLine has a direct link to CHIP assistance. CHIP makes up the largest segment of callers on a regular basis. 888 KIDS NOW connects directly to the Idaho CareLine. Coordinated outreach and enrollment activities with the Idaho Department of Education and school lunch and child care food programs.

• Partnerships with stakeholder organizations that encourage posting of links to the State's CHIP website (www.chip.idaho.gov) on stakeholder web sites in order to provide current information to Idaho citizens.
• YourHealthIdaho – DHW contracts with the Idaho state-based marketplace to provide eligibility determination for Medicaid and CHIP, as well as premium tax credits. This allows for streamlined eligibility determination for health coverage.

In addition, DHW provides potential enrollees with several types of application assistance by:

• Providing multiple options such as online submittal, mail-in/fax-in applications—the redesigned application allows potential CHIP enrollees to submit their application by internet, mail or fax.
Self-reliance specialists make CHIP eligibility determinations without a face-to-face visit. When information is missing, self-reliance specialists contact potentially eligible families by telephone.
• Using a simplified Application for Assistance for all benefit programs in the Self-Reliance Program (advanced premium tax credits, Health Coverage, Cash Assistance, Food Stamps, Child Care, Telephone Service and Nursing Home).
• Coordinating with Your Health Idaho, the Idaho health insurance exchange, to facilitate eligibility determination and enrollment of eligible participants in the Medicaid and CHIP programs.
• Presumptive eligibility determinations as conducted by trained facilities

2.3 The steps the state is currently taking to identify and enroll all uncovered children who are

eligible to participate in health insurance programs that involve a public-private partnership:
• IDHW conducts eligibility in coordination with Your Health Idaho, the Idaho health Insurance exchange, to facilitate eligibility determination and enrollment of eligible participants in the Medicaid and CHIP programs.

- IDHW conducts eligibility in coordination with Your Health Idaho, the Idaho health insurance exchange, to facilitate eligibility determination and enrollment of eligible participants in the Medicaid and CHIP programs.

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

- The State of Idaho utilizes routine stakeholder engagement with other entities engaged in providing or coordinating health benefits coverage for children. Programs such as title V, head start, early intervention services and public schools are integral to increasing the number of children with creditable health coverage.

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.

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 targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))

- The 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.
- 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:

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

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

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

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

Healthy Connections (HC) clinics within tier levels three and four, who are PCCM Entities must meet additional Patient-Centered Medical-Home requirements they have chosen to be reimbursed for in accordance with their provider agreement and the Idaho Medicaid provider handbook.

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 subregulatory guidance and contract provisions; and
- ☒ The subcontractor agrees to the audit provisions in 438.230(c)(3).

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

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

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

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

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

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

3.8 Beneficiary Protections

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

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

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

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

3.9 Grievances and Appeals

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

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

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

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

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

☐ Yes
☒ No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- ☒ All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
- ☒ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
- ☒ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
- ☒ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.10 Program Integrity

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

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

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

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

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

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

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

- A compliance program that 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))

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

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

CS3 SUPERSEDED 4.0 – CURRENT MEDICAID EXPANSION SEE MAGI SECTION)

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

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

SUPERSEDED BY CS18 FOR 4.1.0; 4.1-LR & 4.1.1LR (SEE MAGI SECTION)

4.1.1 ☒ Geographic area served by the Plan if less than Statewide:
This State Plan applies to the entire State of Idaho.

4.1.2 ☒ Age: Children are eligible from birth through the month of the 19th birthday.

4.1.3 ☒ Income:
Children with family incomes over 133% through 185% FPL are eligible for Idaho's stand-alone SCHIP under Title XXI. Children who have family incomes over 100% through 133% FPL are eligible for Idaho's Medicaid-expansion SCHIP under Idaho's Title XIX State Plan from the month of their 6th birthday through the month of the 19th birthday.

4.1.1, 4.1.2 & 4.1.3 SUPERSEDED BY CS7 – GEOGRAPHICAL AREA & AGE AND INCOME (SEE MAGI SECTION)

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

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state): SUPERSEDED BY CS17 (SEE MAGI SECTION)
Children served are residents of the State of Idaho.

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

4.1.7 ☒ Access to or coverage under other health coverage:

A child will be ineligible for coverage under this plan if they have access to or are enrolled in other health coverage, including the following scenarios.
• The child is covered by creditable health insurance at the time of application.
• The child has been voluntarily dropped from creditable coverage in the six months preceding application with the intention of qualifying for public coverage.
• The child is eligible under Idaho's Title XIX State Plan.
• The child is eligible to receive health insurance benefits under Idaho's state employee benefit plan.

4.1.8 ☒ Duration of eligibility

The duration of eligibility is 12 months unless the child is terminated for one of the reasons described below.
• The child loses his or her Idaho residency.
• The child attains 19 years of age.
• The child becomes eligible for and is enrolled in Medicaid.
• The child's parent or adult who is legally responsible for the child's health care makes a written request to terminate coverage.
• The application is found to have inaccurate information which effected an incorrect eligibility determination.
• The child dies.

SUPERSEDED BY CS27 (SEE MAGI SECTION)

4.1.9 ☒ Other Standards (Identify and describe):

At the time of application, a) the child must not be a patient in an institution for mental diseases, or b) an inmate of a public institution.
• The Social Security number, proof of application for a Social Security number or resident alien card number must be provided for applicants who are requesting coverage. Individuals on the application that are not requesting coverage are not required to provide Social Security numbers.
• The State does not exclude individuals based on citizenship or nationality, to the extent that the child is a U.S. citizen, U.S. national or qualified alien (as defined at section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, as amended by the BBA of 1997, except to the extent that section 403 of PRWORA precludes them from receiving Federal means- tested public benefits).

SUPERSEDED BY CS19 SECTION 4.1.9.1 (SEE MAGI SECTION)
ADDING CS14 AS SEPARATE SECTION UNDER 4.1 (SEE MAGI SECTION)

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

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

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

Methods of establishing eligibility and continuing enrollment include a combined application for all Idaho children's health insurance programs. The application can be mailed to DHW. Face-to-face interviews are not required. All eligibility determinations will be made within the 45 days following receipt of the application. All applicants are notified in writing regarding the outcome of their eligibility and enrollment status.

Described in 42CFR 457.342(a) cross-referencing 435.926(d)
Federally Declared Disaster Area

The State will temporarily delay acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by Federal COVID-19 such that processing the change in a timely manner is not feasible. The state will continue to act on changes in circumstance in circumstance described in 42CFR 457.342(a) cross-referencing 435.926(d).

Requirements related to timely processing of renewals and deadlines for families to respond to renewal requests will be temporarily waived for CHIP beneficiaries during the Federal COVID-19 public health emergency."

MAGI RELATED CHANGES:
CS24 SUPERSEDES 4.3 SINGLE STREAMLINED APPLICATION SCREEN & ENROLL (SEE MAGI SECTION

An annualized gross income figure is used to determine eligibility. There are no earned income disregards. There is no resource limit. The number of persons in the family determines the applicable income standard.

The eligibility redetermination process entails checking all available interfaces and databases for current pertinent information prior to contacting the participant by phone. If the renewal is not completed at this point, a renewal form is sent to the family at least 45 days before their health coverage will end. The form instructs the family to review the information on the form, provide any updated information, sign and return the form or call and report that there are no changes.

MAGI RELATED CHANGES:
ADDING CS13 TO 4.3 (SEE MAGI SECTION)
ADDING CS15 TO 4.3 (SEE MAGI SECTION)

4.3.1. Describe the State's policies governing enrollment caps and waiting lists (if any) (Section 2102(b)(2)) (42CFR, 457.305(b))

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

4.4. Describe the procedures that assure that:

CS24 SUPERSEDES 4.4 RENEWALS SCREENING BY OTHER INSURANCE AFFORDABILITY PROGRAMS (SEE MAGI SECTION)

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

The State of Idaho will ensure that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. The application for assistance requires information on when the child was last covered by health insurance. Creditable insurance determinations are made if the applicant indicates current health insurance coverage. Place of employment is also required on the application which is used to determine if the applicant is a dependent of a State employee with access to coverage.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX.

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

Through the single application process, all children are first reviewed for Title XIX eligibility. Those that are found eligible are enrolled in Title XIX. Those who are ineligible for Title XIX and meet the income standards for Title XXI are considered for Title XXI enrollment. Eligibility determinations for both Medicaid and SCHIP are handled by State employees.

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

SUPERSEDED BY CS20 (SEE MAGI SECTION)

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

The insurance provided under the state child health plan does not substitute for coverage under group health plans. A six-month period of uninsurance is incorporated as an eligibility requirement for CHIP. The application requires information on when the child was last covered by health insurance. Exceptions to the period of uninsurance will be made if the applicant lost private insurance through no fault of their own (i.e., due to employer decisions) or due to hardship. The State monitors the number of eligibility denials of children that have creditable insurance who subsequently become eligible within six months.

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

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution

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

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

Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. Indian Health Service and tribal clinics are included as CHIP service providers. Idaho Medicaid and Tribal representatives formally meet on a routine basis. Tribal representatives can request that CHIP information be presented at any of these meetings. Additionally, regional Healthy Connections Representatives (primary care case management program coordinators) work with providers and enrollees (both Medicaid and SCHIP) to resolve issues and help ensure assistance is appropriately provided.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(l)) (42CFR 457 .90)

The State of Idaho places equal emphasis on outreach and education activities, which are those administrative procedures and program features that inform and recruit children and their families into potential enrollment. DHW directs outreach and education to the following groups.

- Health Care Providers
- Schools
- HeadStart/Child Care Providers
- Child Advocacy Groups
- Health insurance exchange

Idaho has developed a multi-dimensional approach to outreach including but not limited to the following.

Support of stakeholder efforts to conduct targeted, grass-roots outreach.
Supporting regional efforts by supplying professionally designed promotional materials.
Provision of technical assistance to regional efforts through central office support staff.

In addition, regional outreach activities are conducted by regional Healthy Connections Representatives (primary care case management program coordinators). Healthy Connections Representatives are part of the Division of Medicaid but are located in regional offices, and coordinate outreach and education for CHIP throughout the state.

Section 6. Coverage Requirements for Children's Health Insurance

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

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

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

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

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

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

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

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

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

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

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:
the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:

- dental services
- inpatient and outpatient hospital services,
- physicians' services,
- surgical and medical services,
- laboratory and x-ray services,
- well-baby and well-child care, including age-appropriate immunizations, and emergency services;

- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

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

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences

in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. **(**Section 2103(a)(2))

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

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

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania.

Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

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

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

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

supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit. If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

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

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

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

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

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

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

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

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

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

6.1.4.7. ☐ Other (Describe)

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

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

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

6.2.1. ☒ Inpatient services (Section 2110(a)(1))
See "Inpatient Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.2. ☒ Outpatient services (Section 2110(a)(2))
See "Outpatient Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.3. ☒ Physician services (Section 2110(a)(3))
See "Physician Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.4. ☒ Surgical services (Section 2110(a)(4))
See "Inpatient Services & Physician Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
See "Physician Services", Essential Providers" & "Ambulatory Surgical Center Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))
See "Prescription Drugs" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))
See "Additional Covered Drug Products" within the "Prescription Drugs" section in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))
See "Diagnostic Test(X-ray and Lab Work) Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9)) See "Physician Services", "Inpatient Hospital", "Family Planning Services" & "Specific Pregnancy-Related Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.10. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12)) See "Medical Equipment, Supplies and Devices", "Vision Services", "Audiology Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.11. ☒ Disposable medical supplies (Section 2110(a)(13))
See "Medical Equipment, Supplies and Devices" in the coverage description table at the end of this section of the State Plan for additional information on these services.

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

6.2.12. ☒ Home and community-based health care services (Section 2110(a)(14))
See "Home Health Care" and "Long Term Care Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

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

6.2.13. ☒ Nursing care services (Section 2110(a)(15))
See "Home Health Care" and "Essential Providers" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.14. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16) See "Physician Services", "Outpatient Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.15. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
See 6.2-DC for addition information on these services.

6.2.16. ☒ Vision screenings and services (Section 2110(a)(24))
See "Vision Services" and "Eyeglasses" in the coverage description table at the end of this section of the State Plan for additional information on this service.

6.2.17. ☒ Hearing screenings and services (Section 2110(a)(24))
See "Audiologist Services" and "Outpatient Hospital Services" in the coverage description table at the end of this section of the State Plan for additional information on this service.

6.2.18. ☒ Case management services (Section 2110(a)(20)) See "Case Management Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.19. ☒ Care coordination services (Section 2110(a)(21)) See "Primary Care Case Management (PCCM)" and "EPSDT" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.20. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22)) See "Essential Providers", "Outpatient Habilitation Services", and "Outpatient Rehabilitation Services" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.21. ☒ Hospice care (Section 2110(a)(23)) See "Hospice Care" in the coverage ` description table at the end of this section of the State Plan for additional information on these services.

6.2.22. ☒ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act See "EPSDT Services" in the coverage table at the end of this section of the State Plan for additional information on this service.

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

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

6.2.23. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24)) See "Essential Providers" and "EPSDT" in the coverage table at the end of this section of the State Plan for additional information on these services.

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

6.2.25. ☒ Medical transportation (Section 2110(a)(26)) See "Essential Providers", "EPSDT", "Medical Transportation" in the coverage table at the end of this section of the State Plan for additional information on these services.

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

6.2.26. ☒ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27)) See "Essential Providers" and "EPSDT" in the coverage table at the end of this section of the State Plan for additional information on these services.

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

6.2.1	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.
- **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.

Limitations	• 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.
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. Vocational, Educational and Recreational services are not reimbursable.
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.

6.2.6 – 6.2.7	**Prescription drugs and Over the Counter Medications**	**(Section 2110(a)(6)) (Section 2110(a)(7))**

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.

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 described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services**	**(Section 2110(a)(11)**

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.

Limitations	• 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.
Excluded Services	• 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.

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.	
6.2.12	**Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)**	**(Section 2110(a)(12))**
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 (Home Health)**	**(Section 2110(a)(14))**

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-first (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.

Specific Pregnancy- Related Services

- **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.

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

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

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

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

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

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

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

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

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

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

Idaho leverages the following tools in our strategy for primary care:

- Require primary care providers to follow AAP's Bright Futures periodicity schedule for appropriate routine and interperiodic behavioral health screenings, including the use of validated screening tools.
- Distribute best practice updates specific to primary care, (provider newsletter available at www.idmedicaid.com) and other informational resources; facilitate provider educational opportunities on ASAM screening tools in conjunction with the Idaho Office of Drug Policy, conduct provider stakeholder engagement in conjunction with the state's behavioral health authority specific to the Idaho Child and Adolescent Needs Survey (CANS) training and certification process
- Promote collaboration on screenings and screening tools between our managed care contractor for the Idaho Behavioral Health Plan (IBHP) and our primary care providers
- Require, monitor and promote the use of validated screening tools through our intra-agency agreement with our IDEA Part C Agency.
- Adopt a value-based care model within primary care, leveraging nationally accepted quality metrics which promote the use of validated screening tools

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

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

6.3.2.1- BH ☒ Psychosocial treatment

Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

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

6.3.2.3- BH ☒ Medication Assisted Treatment
Provided for: ☒Substance Use Disorder

6.3.2.3.1- BH ☒ Opioid Use Disorder

6.3.2.3.2- BH ☒ Alcohol Use Disorder

6.3.2.3.3- BH ☐ Other

6.3.2.4- BH ☒ Peer Support
Provided for: ☒Mental Health ☒ Substance Use Disorder

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

6.3.2.6- BH Respite Care
Provided for: ☐ Mental Health ☐ Substance

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

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

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

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

6.3.3 - ☒ **BH** Day Treatment

Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))
Provided for: ☒ Mental Health ☒ Substance Use Disorder

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

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

6.3.4.2- BH ☒Detoxification
☒ Substance Use Disorder

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

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

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

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

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

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

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

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

6.3.9- BH ☒Other
Provided for: ☒Mental Health ☒Substance Use Disorder

6.4- BH Assessment Tools

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

Idaho does not have standard managed care organizations or MCO's that provide a full range of physical and mental health services but leverages a Pre-paid Ambulatory Health Plan for both its title XIX and XXI children to provide outpatient behavioral health services. Our PAHP has one contractor. Inpatient stays are assessed by our Quality Improvement Organization who uses InterQual criteria for inpatient stays and Institutions for Mental Disease utilize ASAM.

☒ASAM Criteria (American Society Addiction Medicine)

☒Mental Health ☒Substance Use Disorders

☒InterQual
☒Mental Health ☒Substance Use Disorders

☒MCG Care Guidelines
☒Mental Health ☒Substance Use Disorders

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

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

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

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

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

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

Psychological and Neuropsychological Testing Guidelines
A CANS assessment is required to determine medical necessity for all services– with the exception of the following : Neuropsychological/Psychological Testing, Medication Management, and Crisis Services. If a child is receiving SUD services, they still need a CANS.

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

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.
We maintain the AAP periodicity schedule within our provider handbook at www.idmedicaid.com (updated on an annual basis), as the standard for developmentally appropriate screenings and require referrals for appropriate assessments. Throughout the year, we distribute best practice updates and provider education and resources to our state administered PCCM and all fee-for-service providers, through our monthly provider newsletter (also available at www.idmedicaid.com).

Our managed care contractor for the Idaho Behavioral Health Plan is responsible for providing ongoing education and training on best practices and requirements for assessment tools to our outpatient behavioral health service providers, which includes the Idaho specific CANS assessment tool. The CANS tool is utilized by all state agencies, schools and juvenile corrections agencies in Idaho who interact with youth up to the age of 18 with behavioral health needs, to meet their needs for behavioral health services and supports.

The Praed Foundation, which developed the Idaho-specific CANS functional assessment tool, tests providers for proficiency in the use of the CANS and certifies those who pass the test. Throughout the year, the IBHP contractor offers trainings covering the CANS and its purpose, the role of structured assessments, preparation for the online certification test, and a brief overview of the connection between CANS and treatment planning. A separate series of trainings delivered by the IBHP contractor covers use of the ICANS web platform, where CANS results are entered and tracked as a measurement of participants' outcomes and progress in treatment.

As part of the state's strategy to facilitate the use of validated assessment tools, in accordance with our Intra Agency Agreement for Early Intervention Services, children ages 0 up to age three receive developmental screenings (ASQ, ASQ-3, BDI-ST, BINS, Brigance Screens-II, CDI, Infant Development Inventory, PEDS, Dev Milestones) in accordance with 34CFR 303.320; and evaluations, assessments, and access to Early Intervention Services in accordance with 34CFR 303.13, 303.321- 303.322.

Our Agency is partnering with community stakeholders to produce a statewide strategic plan for the development of a more effective behavioral health system and our strategy for the use of validated assessment tools within the Medicaid/CHIP program is a significant component to this process.

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

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.
☒The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

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

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

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

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:
☐State-developed Medicaid-specific
☒American Academy of Pediatric Dentistry
☐Other Nationally recognized periodicity schedule
☐Other (description attached)

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

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

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

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

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

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description. In the event that the State provides benefits through a group health plan or group health coverage or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 457.1201(l).

The State ensures that its Title XXI State Plan complies with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that its Title XIX State Plan meets this requirement.

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice (§457.496(f)(1)(i)). *As specified below:*

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for the different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

☐ International Classification of Disease (ICD)

☒ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☐ Other (Describe:)

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

☒ Yes

☐ No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((§457.496(f)(1)). Continue on to Section 6.3.

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

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

☒ Yes

☐ No

Guidance: If the State child health plan does not provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to

complete the required parity analysis of the State child health plan.

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

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☒ All children covered under the State child health plan

☐ A subset of children covered under the State child health plan.

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

Not applicable

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

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

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

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

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

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

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

☒ EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis (Section 1905(r)(5)).

☒ The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary (Section 1902(a)(43)).

☒ All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them (Section 1902(a)(43)(A)).

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3-MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements §457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs (§§457.496(d)(2)(ii); 457.496(d)(3)(ii)(B)).

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

6.2.3.1.1 MHPAEA The state assures that:

☐ The State has classified all benefits covered under the State plan into one of the four classifications.

☐ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the state use sub-classifications to distinguish between office visits and other outpatient services?

☐ Yes

☐ No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

☐ The sub-classifications are only used to distinguish office visits from other outpatient items and services and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to "classification(s)" includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

☐ Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits. However if a state does provide any mental health or substance use disorders, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan.

Annual and Aggregate Lifetime Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan (§457.496(c)).

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☐ No dollar limit is applied

Guidance: A monetary coverage limit that applies to all CHIP services provided under the State child health plan is not subject to parity requirements. If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☐ Yes (Type(s) of limit:)

☐ No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on any mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on any mental health or substance use disorder benefits (§457.496(c)(1)).

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (457.496(c)).
The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits (457.496(c)(3)).

☐ The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable, as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on any mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on any mental health or substance use disorder benefits (§457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (§§457.496(c)(4)(i)(B); 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated

for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with §§457.496(c)(4)(i)(B) and 457.496(c)(4)(ii). Please include the state's methodology as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (§457.496(c)(2)(i); (§457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☐ No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply financial requirements to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

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

☐ Yes

☐ No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to

Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (§457.496(d)(3)(i)(C))

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (§457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to "substantially all" (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (§457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose that type of QTL on mental health or substance use disorder benefits in that classification. (§457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in §§457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in

§457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (§457.496(d)(3)(i)(E))

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominate level is the least restrictive level of the levels combined to meet the one-half threshold (§457.496(d)(3)(i)(B)(2)).

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements (§§457.496(d)(4); 457.496(d)(5)).

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☐ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits, provider reimbursement rates and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in §457.496(d)(4)(ii).

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the state or MCE contracting with the State provide coverage of services provided by out of network providers?

☐ Yes

☐ No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

☐ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

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

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

☐ State

☐ Managed Care entities

☐ Both

☐ Other

Guidance: If other is selected, please specify the entity.

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

☐ State

☐ Managed Care entities

☐ Both

☐ Other **Guidance: If other is selected, please specify the entity.**

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

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

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

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6.

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

6.4.1. ☐ **Cost Effective Coverage**- Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for

outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

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

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

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ **Purchase of Family Coverage**- Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective . relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low-income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

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

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

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

☐ Yes
☒ No

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

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

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

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

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

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

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described

in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

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

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

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

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

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

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

☐ Yes
☐ No

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

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

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

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

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

Section 7. Quality and Appropriateness of Care

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

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

Claims data are collected and analyzed to assess performance using National Performance Measurements (see section 9.3.6). An annual participant survey monitors and assesses quality and appropriateness of care.

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

7.1.1. ☐ Quality standards
7.1.2. ☐ Performance measurement
7.1.3. ☐ Information strategies
7.1.4. ☐ Quality improvement strategies

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

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

Enrollment in Idaho's primary care case management program (Healthy Connections) is required in most areas of the state, which helps to ensure that enrollees have a usual source of care. Primary care providers are required by contract to provide primary care services to their enrollees. This includes wellness care and immunizations. In addition, Healthy Connections Representatives (primary care case management program coordinators) work with enrollees and providers to help ensure appropriate covered services are provided.

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

The State of Idaho will ensure access to covered services, including emergency services as defined in 42 CFR 457.10. Referrals are not required to access emergency services. All provider types necessary to provide covered services are included in the provider panel

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

The State of Idaho will ensure access to appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of- network providers when the network is not adequate for the enrollee's medical condition.

Contractually, primary care providers are required to make referrals for most medically necessary specialty services. All provider types necessary to provide covered services are included in the provider panel. In addition, Healthy Connections Representatives (primary care case management program coordinators) work with enrollees and providers to help ensure appropriate covered services are provided.

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

Decisions related to prior authorization of health services will be completed in accordance with State law and/or Administrative Rule and the medical needs of the patient.

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☒ No, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. ☐ Premiums: Enrollees with family incomes at or above 150% FPL will be subject to a premium in the amount of $10 per member per month for medical services and an additional $5 per member per month for dental services. Premium amounts paid apply first to medical services in determining delinquency. Enrollees with family incomes above 142% FPL up to 150% FPL will be subject to a premium in the amount of $10 per member per month for medical services and are not subject to the dental premium.

Wellness Preventive Health Assistance (PHA): The state has established a mechanism to assist participants with their premium payment obligations. This mechanism is called Wellness PHA. participants with their premium payment obligations. This mechanism is called Wellness PHA. Each participant who is required to make premium payments can earn 30 points every 3 months by receiving recommended wellness visits from their PCP and demonstrating up-to Date immunizations. These Wellness PHA points can be used to offset premium payments. Each point equals one dollar.

A child with family income below 150% FPG may have all his premium obligations met by utilizing Wellness PHA. Children in families 150-185% FPG may offset up to two-thirds (two out of every three) of their payments.

8.2.2. Deductibles: Not applicable.
8.2.3. Coinsurance or copayments:

Co-payment amount: Beginning on November 1, 2011, the nominal fee amount required to be paid by the participant as a co-payment is three dollars and 65 cents ($3.65). The reimbursable amount of the services rendered during a visit must be at least ten times the amount of the co-pay. Visits where the provider is reimbursed $36.50 or less for their services are not subject to co-pay and providers are directed not to assess co-pays for services where reimbursement is less than or equal to $36.50. Well-baby and well-child care as defined in 42 CFR 457.520 are not subject to co-pay.

The State will submit a State Plan Amendment for any future changes to the co-pay amount.

Co-pays for use of emergency services for a non-emergent medical condition

- A participant who seeks care at a hospital emergency department for a condition that is not an emergency medical condition may be required to pay a co-payment to the provider. The determination that the participant does not have an emergency medical condition is made by the emergency room physician conducting the medical screening and using the prudent layperson standard.
- A participant who accesses emergency transportation services for a condition that is not an emergency medical condition may be required to pay a co-payment to the provider of the service. The determination that the participant did not have an emergency medical condition is made by Idaho Medicaid.

Co-pays for other services

- Chiropractic services
- Occupational Therapy
- Optometric Services
- Physical Therapy
- Physician Office Visits unless the visit is for preventive care or family planning
- Speech Therapy
- The reimbursable amount of the services rendered during a visit must be at least ten times the amount of the co-pay. Otherwise, the visit is exempt from co-pay. The provider may provide the service and decline to collect the co-pay at the time of service, if the participant can't pay. The provider may also choose not to bill the participant for the co-pay.
- Population: All children 142% - 185% of the federal poverty guidelines.

Cost sharing may be temporarily waived for CHIP applicants and/or existing beneficiaries during the Federal COVID-19 public health emergency.

Idaho is temporarily instituting a premium reduction for all CHIP applicants and beneficiaries during the Federal COVID-19 public health emergency.

8.2.4. ☐ Other: Not applicable

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:
8.2.2-DS ☐ Deductibles:
8.2.3-DS ☐ Coinsurance or copayments:
8.2.4-DS ☐ Other:

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

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

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

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

The State of Idaho will ensure that the annual aggregate cost-sharing for a family does not exceed five (5) percent of such family's income for the length of the child's eligibility period in the State. Upon enrollment participants are sent a notice advising them of their cost-sharing responsibilities. This includes notice of the five percent maximum. Cost-sharing in the Idaho plan is set so low that very few families will reach their 5% limit. The State informs families of the co-payment requirement and limitations in writing at the time of eligibility determination or re-determination. Idaho monitors co-payments and premiums on at least a monthly basis based on information from its systems that show the amount paid compared with family income. When the State identifies that co-pays and premiums assessed have reached 95% or more of the maximum amount for the eligibility period, a letter is sent to the family informing them that they are approaching their limit and that they will be exempted for the remainder of the eligibility period. The status of the beneficiary is changed to co-pay exempt in the information system at that point for the remainder of the eligibility period. Providers are instructed to check each participant's eligibility prior to rendering services. The co-pay field of the eligibility response indicates whether the participant is subject to co-pay or is exempt.

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

The state will ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. Native American and Alaskan Native children will not be charged monthly premiums or co-payments. The family will be asked to declare Native American/Alaskan Native status so that the cost sharing exemption can be processed.

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

Premiums Renewal: If premium payments are two or more months in arrears at the time of renewal, the child(ren) will lose eligibility for the program and be prohibited from participation until the delinquency is paid. Delinquent accounts will be sent a delinquency notice monthly. The notice includes the amount of the delinquency, their right to be considered for Medicaid eligibility and the consequence of not bringing their account current. The notice also includes a reminder that the family may receive help with their premium payments by participating in Wellness PHA.

Co-pays
If a participant is unable to make a co-pay the provider can bill the patient, waive the co-pay or refuse to provide services.

MAGI RELATED CHANGES:
SUPERSEDED BY CS21 (SEE MAGI SECTION)

The premium lock-out policy is temporarily suspended, and coverage is available regardless of whether the family has paid their outstanding premium for existing beneficiaries during the Federal COVID-19 public health emergency

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (42CFR 457.570(a))

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

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

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

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

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

The state of Idaho has developed a set of strategic objectives, performance goals, and performance measures to assess the success of implementing its Children's Health Insurance Program. Idaho will track enrollment, retention, access, comprehensiveness, and quality of care. All performance measures will be linked to performance standards and strategic objectives. These measures are designed to measure the effectiveness of both Title XIX and Title XXI Programs. The objectives, goals, and measures focus on standard indicators of success in enrollment and retention and in basic health outcomes. The measures have been developed based upon data that is readily available to the Department of Health and Welfare.

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

<table>
<tr><th colspan="4">Table 9.1</th></tr>
<tr><th>(1) Strategic Objectives</th><th>(2) Performance Goals for Strategic Objective</th><th colspan="2">(3) Performance Measures and Progress (specify data sources, methodology, time period, etc.)</th></tr>
<tr><td colspan="4">Objectives related to Reducing the Number of Uninsured Children</td></tr>
<tr><td rowspan="2">To increase the number of children participating in Title XIX and XXI health programs</td><td rowspan="2">The targeted increase in enrollment is 8,000 children annually</td><td>New/Revised</td><td>Continuing X</td></tr>
<tr><td colspan="2">Data Sources: Enrollment data from the Division of Medicaid claims payment system</td></tr>
<tr><td colspan="4">The total number of new uninsured children in both programs compared to the previous federal fiscal year.
• The total number of new uninsured children enrolled in both programs compared to the base number of enrollees as of 9/30/99: 54,824
• Numerator: Number of enrollees on 9/30/16: (218,408)
• Denominator: Number of enrollees on 10/1/15 (205,407) • Progress summary: Idaho achieved its annual target by increasing enrollment an additional 14,073 children, as reported in its FFY2015 Annual Report.</td></tr>
<tr><td></td><td></td><td colspan="2">Progress Summary: Idaho achieved its annual target by increasing enrollment an additional 14,073 children in FFY16. As of 9/30/16, Idaho has enrolled an additional</td></tr>
</table>

		164,656 children, more than quadrupling the number of children covered by Title XIX & Title XXI in the past 18 years.

Objectives Related to SCHIP Enrollment			
To increase the number of children enrolled in the Title XXI. program	The targeted increase in enrollment is 2,000 children annually	New/Revised	Continuing **X**
		Data Sources: Enrollment data from the Division of Medicaid claims payment system	
		The total number of children enrolled in XXI program compared to the previous federal fiscal year. • Numerator: Number of enrollees on 9/30/16 (23,304) • Denominator: Number of enrollees on 10/1/15 (18,345)	
		Progress Summary: increased this year By 4,959 children. Idaho exceeded its goal by 2,959 as reported in its FFY2015 Annual report.	

Table 9.1			
(1) Strategic Objectives	**(2) Performance Goals for Strategic Objective**	**(3) Performance Measures and Progress (specify data sources, methodology, time period, etc.)**	
Objectives related to Increasing Medicaid Enrollment			
To increase the number of children enrolled in Title XIX health programs	The targeted increase in enrollment is 6,000 children annually	New/Revised	Continuing **X**
		Data Sources: Enrollment data from the Division of Medicaid claims payment system	
Uninsured children in XIX program compared to the previous federal fiscal year. • The total number of new uninsured children enrolled in Title XIX programs compared to the base number of enrollees as of 9/30/99, 3,735 • Numerator: Number of enrollees on 9/30/16 (196,176) Denominator: Number of enrollees on 10/1/15 (187,062)			
		Progress Summary: An increase of 9,114 as reported on our FFY15 Annual Report. This exceeded our goal by 3,114 children.	

Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)			
To ensure that enrolled children have a medical home.	There will be a 10% annual increase in the number of children participating in Healthy Connections and having a primary care provider as a "medical home".	New/Revised	Continuing **X**
		Data Sources: Division of Medicaid, Healthy Connections (PCCM) Program	

		Methodology: The total number of XIX children enrolled compared to the base number of enrollees as of 9/30/99 Number of enrollees on 9/30/99: 3,735 • Numerator: Number of children enrolled in HC on 9/30/16 (208,506)Denominator: Number of children enrolled in HC on 10/01/15 (219,480)
		Progress Summary: Idaho reported an improvement of 1%, and reached its goal of 95% as reported on its FFY2016 Annual report.

Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)			
To ensure that enrolled children receive appropriate and necessary medical care.	90% of enrolled 2-year-olds will have up-to-date appropriate vaccinations.	New/Revised	Continuing **X**
		Data Sources:	
		Progress Summary: Idaho Medicaid has reported on this measure as part of the core set of CHIP measures during FFY14, FFY15 and FFY16. Combo 2, Combo 3 and Combo 4 have all had an increase of 9% since the baseline year (FFY14). FFY16 = Combo 2 rate was 40%; Combo 3 rate was 38% and Combo 4 rate was 37.8%.	

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

Performance goals are listed in Table 9.1.

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

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

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

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

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

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

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

9.3.6. ☒ Other child appropriate measurement set. List or describe the set used.

The State of Idaho uses a modified set of National Performance measures.

- Well child visits for children in the first 15 months of life.
- Well child visits in the 3rd, 4th, 5th, and 6th years of life.
- Well child visits for Adolescents
- Medication Management for children with asthma.
- Childhood Immunization Status
- Immunization Status for Adolescents
- Children's access to primary care services.
- Chlamydia Screening for female adolescents
- Ambulatory Care – Emergency Department Visits
- CAHPS 5.0 Survey
- HPV for Female Adolescents

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. Immunizations ☐
9.3.7.2. Well childcare ☐
9.3.7.3. Adolescent well care ☐
9.3.7.4. Satisfaction with care ☐
9.3.7.5. Mental health ☐
9.3.7.6. Dental care ☐
9.3.7.7. Other, please list: ☐

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. ☒ The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

The assessments will be built upon the data obtained to monitor the achievement of the strategic objectives listed in Table 9.1.

9.6. ☒ The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7. ☒ The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. ☒ The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

When the State determines the need to submit a SPA, a Tribal Solicitation notice is sent to Tribal contacts. The notice is mailed hard copy to Tribal Leaders, e-mailed to a distribution list of Tribal contacts and posted to the Idaho Medicaid-Tribes Teamsite (web-based). The State also meets quarterly with the Tribes. A standing agenda item for these meetings is discussion of SPAs.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

Public hearings, advertised through prior public notice, are held in conjunction with

Administrative Rules promulgation required to amend eligibility or benefits for the Children's Health Insurance Program. These hearings allow public comment on the entire program. Public notification of proposed changes to Administrative Rules is published the first Wednesday of each month in the Administrative Bulletin and also posted to the state's website.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option. N/A

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low-income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc. All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

COST OF APPROVED CHIP PLAN

Benefit Costs	**2020**
Insurance payments	$365
Managed Care	$23,733,548
Fee for Service	$65,562,002
Total Benefit Costs	$89,295,915
(Offsetting beneficiary cost sharing payments)	$504,802
Net Benefit Costs	$88,791,113

Administration Costs	**2020**
Personnel	
General Administration	$ 1,585,115
Contractors/Brokers (e.g., enrollment contractors)	
Claims Processing	$ 148,660
Outreach/Marketing costs	
Other (e.g., indirect costs)	$ 1,358,556
Health Services Initiatives	$ 406,338
Total Administration Costs	$ 3,498,669
10% Administrative Cap (net benefit costs/9)	$ 9,865,679
Federal Title XXI Share	$ 87,747,279
State Share	$ 4,542,503
TOTAL COSTS OF APPROVED CHIP PLAN	**$ 92,289,782**

Section 10. Annual Reports and Evaluations (Section 2108)

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

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

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

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

Section 10.3-DC ☒ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Expanded eligibility under the state's Medicaid plan, and continue to Section 12.

Section 11. <u>Program Integrity (Section 2101(a))</u>

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

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

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

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

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

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

11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

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

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

12.1. Eligibility and Enrollment Matters-

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

The State of Idaho uses a review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Idaho CHIP will use the same Fair Hearing rights and process for CHIP as for Idaho Medicaid. Families are informed of their rights and responsibilities upon application for coverage and via the "Notice of Decision" sent upon eligibility determination. A Fair Hearing can be requested to review any adverse decision made in determining eligibility or enrollment.

12.2. Health Services Matters

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

The State of Idaho uses a review process for health services matters that complies with 42 CFR 457.1120. Upon enrollment, participants are provided instruction and contact information regarding how to file a grievance or make a complaint regarding service delivery. Idaho CHIP uses the same Fair Hearing rights and process for CHIP as for Idaho Medicaid.

12.3. Premium Assistance Programs

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

Not applicable.