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State/Territory Name: Idaho

State Plan Amendments (SPA) #: ID-18-0008

This file contains the following documents in the order listed:

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

Children and Adults Health Programs Group

AUG 0 2 2018

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

Dear Mr. Wimmer:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), ID-18-0008, has been approved. ID-18-0008 implements mental health parity regulations at 42 CFR 457.496 to ensure that treatment limitations and financial requirements applied to mental health and substance use disorder benefits are no more restrictive than those applied to medical/surgical benefits. This SPA has an effective date of July 1, 2017.

Section 2103(c)(6)(B) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(b), provides that if CHIP coverage includes Early, Periodic Screening, Diagnostic and Treatment (EPSDT) as defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the state plan will be deemed to satisfy parity requirements. Idaho has provided the necessary assurances and supporting documentation that EPSDT is covered under Idaho's CHIP program and provided in accordance with sections 1905(r) and 1902(a)(43) of the Act.

This approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

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

Official communications regarding program matters should be sent simultaneously to Ms. Adams and to Mr. David Meacham, Associate Regional Administrator (ARA) in our Seattle Regional Office. Mr. Meacham's address is:

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

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

Sincerely,

/ Anne Marie Costello /

Anne Marie Costello
Director

cc: David Meacham, ARA, CMS Region X

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))

/S/Matt Wimmer
CHIP Director
Division of Medicaid
Idaho Department of Health and Welfare

Date

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
Name: David Taylor	Position/Title: Deputy Director, Idaho Department of Health and Welfare
Name: George Gutierrez	Position/title: Deputy Administrator, Division of Medicaid
Name: Elizabeth Kriete	Position/Title: Deputy Administrator, Division of Medicaid

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA 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-
Submitted	March 10, 2000	

Approved	March 1, 2001	• increase coordination of efforts across agencies • simplify the application process, and • improve media and outreach approaches
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
Submitted	March 17, 2009	
Approved	July 15, 2013	

		Speech Language Pathology (SLP) Services • Reduce limits for Psycho-Social Rehabilitation, Partial Care and Developmental Disability Agency Services
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		
Effective Date	July 1, 2017	

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

The State used its standard negotiation (with the Tribes of Idaho) process for Tribal Consultation for this SPA. Hard copies of the Tribal notices were sent to Tribal Leaders and e-mailed to a contact list of Tribal Representatives as indicated in the table below. The notices were subsequently posted to the Idaho Medicaid-Tribes website.

SUBJECT	DATE OF NOTIFICATION	DESCRIPTION
Basic ABP Enhanced ABP	January 20, 2017	Idaho Medicaid's Alternative Benefit Plans were aligned with Blue Cross of Idaho's PPO Plan. The amendments aligned limitations, authorization requirements and/scope limits for certain benefits. Other changes were made to clarify benefits or policy and to align with changes in federal law for mental health parity.
	The State used its standard notification process for our Tribal partners for this SPA. Hard copies of the Tribal notices were sent to Tribal Leaders and e-mailed to a contact list of Tribal Representatives. The notices were subsequently posted to the Idaho Medicaid-Tribes website. This SPA's were discussed as part of the quarterly meeting with the Tribes in February 2017. No additional requests for discussion or consultation were received.	

Superseding Pages of MAGI CHIP State Plan Material
State: Idaho

Transmittal Number	SPA Group	PDF #	Description	Superseded 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 4.3 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	Non-Financial Eligibility – Residency Non-Financial – Citizenship Non-Financial –	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1 – L.R.; 4.1.1 – L.R.

		CS20 CS21 CS27	Social Security Number Substitution of Coverage Non-Payment of Premiums Continuous Eligibility	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 6. Coverage Requirements for Children's Health Insurance

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

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42 CFR 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 provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic, 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 in New York, Pennsylvania or Florida. (under 42 CFR 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 coverage under one of the benchmark plans specified in 457.420, through the 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)) (42 CFR, 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)) (42 CFR 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. ☒ 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))
See "Inpatient Services, Physician Services and EPSDT" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.11. ☒ 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)
See "Community-Based Outpatient Mental Health and Substance Use Services, Physician Services and EPSDT" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.12. ☒ 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))
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.

6.2.13. ☒ 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.

6.2.14. ☒ 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.

6.2.15. ☒ 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.

6.2.16. ☒ 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)
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.

6.2.17. ☒ 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) See 6.2-DC for addition information on these services.

6.2.18. ☒ 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.

6.2.19. ☒ 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.

6.2.20. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
These services are coverable when medically necessary as EPSDT.

6.2.21. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))
See "Community-Based Outpatient Mental Health and Substance Use Services, Physician Services and EPSDT" in the coverage description table at the end of this section of the State Plan for additional information on these services.

6.2.22. ☒ 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.

6.2.23. ☒ 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.

6.2.24. ☒ 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.

6.2.25. ☒ 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.

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

6.2.26. ☒ 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.

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.

6.2.27. ☒ 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.

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

6.2.29. ☒ 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.

6.2.30. ☒ 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.

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

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

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

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

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

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

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

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] 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)

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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 42 CFR 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. (42 CFR 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 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 ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

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

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

☒ Yes

☐ No

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 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

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, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as 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 (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

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

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

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

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

☒ Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner

that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

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

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

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

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 42 CFR 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. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

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

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 (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, 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 (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar 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. (42 CFR 457.496(c))

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

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☐ No dollar limit is applied

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. (42 CFR 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 (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

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

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 and the results 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 (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

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

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR

457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

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

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results 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 (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

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

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

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 QTLs 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 portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

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

Guidance: Please include the state's methodology and results 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? (42 CFR 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. (42 CFR 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 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

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

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 predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 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. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

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

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

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 and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

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

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

☐ Yes

☐ No

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.

COST OF APPROVED CHIP PLAN

Benefit Costs	**2017**	**2018**	**2019**
Insurance payments			
Managed Care	22,782,044	23,921,146	25,117,203
Fee for Service	53,158,102	55,816,007	58,606,808
Total Benefit Costs	75,940,146	79,737,153	83,724,011
(Offsetting beneficiary cost sharing payments)	(875,043)	(932,183)	(993,055)
Net Benefit Costs	75,065,103	78,804,970	82,730,956

Administration Costs			
Personnel			
General Administration	**885,469**	955,710	1,029,127
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing	**33,671**	36,342	39,134
Outreach/Marketing costs			
Other (e.g., indirect costs)			
Health Services Initiatives	**1,952,796**	**2,107,704**	**2,269,615**
Total Administration Costs	**2,871,936**	**3,099,756**	**3,337,875**
10% Administrative Cap (net benefit costs ÷ 9)	**8,340,567**	**8,756,108**	**9,192,328**

Federal Title XXI Share	**77,937,039**	**81,904,726**	**86,068,831**
State Share			

	2017		2018		2019	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
Managed Care	22,437	83.64	23,483	$83.90	24,725	$83.65
Fee for Service	22,437	195.16	23,483	$195.76	24,725	$195.19
Total	22,437	$278.80	23,483	$279.65	24,725	$278.84