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State/Territory Name: Kentucky

State Plan Amendments (SPA) #: KY-18-0001-CHIP

This file contains the following documents in the order listed:

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

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

Children and Adults Health Programs Group

APR 1 9 2019

Ms. Carol Steckel
Medicaid Commissioner
Department for Medicaid Services
275 E. Main Street, 6W-D
Frankfort, KY 40621

Dear Ms. Steckel:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) KY-18-0001-CHIP, submitted to the Centers for Medicare & Medicaid Services (CMS) on June 29, 2018 with additional information submitted on April 18, 2019, has been approved. Through this SPA, Kentucky implements mental health parity requirements to ensure that treatment limitations applied to mental health (MH) and substance use disorder (SUD) benefits are no more restrictive than those applied to medical/surgical (M/S) benefits. This SPA has an effective date of October 2, 2017.

Section 2103(c)(7)(A) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(d)(3)-(5), requires states that provide both M/S and MH/SUD benefits to ensure that financial requirements and treatment limitations applied to MH/SUD benefits covered under the state child health plan are consistent with the mental health parity requirements of 2705(a) of the Public Health Service Act, in the same manner in that such requirements apply to a group health plan. Kentucky demonstrated compliance by providing the necessary assurances and supporting documentation that the state's application of non-quantitative treatment limitations (NQTLs) to MH/SUD benefits are consistent with section 2103(c)(7)(A) 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. Cassie Lagorio. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Lagorio's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4554
E-mail: Cassandra.Lagorio@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lagorio and to Ms. Shantrina Roberts, Deputy Director, Division of Medicaid Field Operations South. Ms. Roberts's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid Field Operations South
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

If you have additional questions, please contact Ms. Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

We look forward to continuing to work with you and your staff.

Sincerely,

/signed Anne Marie Costello/

Anne Marie Costello
Director

Enclosure

cc: Ms. Shantrina Roberts, Deputy Director, Division of Medicaid Field Operations South

STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
KENTUCKY CHILDREN'S HEALTH INSURANCE PROGRAM
(KCHIP)

Preamble

Section 4901 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 XXI 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.

KENTUCKY CHILDREN'S HEALTH INSURANCE PROGRAM (KCHIP)

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

State/Territory: _____Kentucky _____
(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))**

Carol Steckel, Commissioner, Department for Medicaid Services

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State 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))**:

Stephanie Bates, Deputy Commissioner
Lee Guice, Division Director of Policy and Operations
Department for Medicaid Services, 275 East Main Street: 6W-D Frankfort, KY 40621,
Phone: 502-564-4321, Fax: 502-564-0509

1.4 **Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):**

Effective date:	**July 1, 1998**
Implementation date:	**July 1, 1998**

SPA #1 (Medicaid SCHIP Expansion to 150 FPL)

Effective date:	July 1, 1999
Implementation date:	July 1, 1999

SPA #2 (Separate Insurance Program)

Effective date:	November 1, 1999
Implementation date:	November 1, 1999

SPA #3 (Application and Recertification Process Change)

Effective date:	June 1, 2001
Implementation date:	June 1, 2001

SPA #4 (Application Process Change and compliance)

Effective date:	July 1, 2002
Implementation date:	July 1, 2002

SPA #5 (Cost Sharing)

Effective date:	August 1, 2002
Implementation date:	August 1, 2002

SPA #6 (Cost Sharing)

Effective date:	June 1, 2003
Implementation date:	June 1, 2003

SPA #7 (Cost Sharing)

Effective date:	November 1, 2003
Implementation date:	November 1, 2003

SPA #8 (Benefit, Cost Sharing, Delivery System)

Effective date:	May 15, 2006
Implementation date:	May 15, 2006

SPA #9 (Eligibility Determination)

Effective date:	November 1, 2008
Implementation date:	Withdrawn

SPA #10 (Eligibility Determination)

Effective date:	November 1, 2008
Implementation date:	November 1, 2008

SPA #11 (Premium Payments)

Effective date:	July 1, 2010
Implementation date:	July 1, 2010

SPA #12 (Children of State Employees)

Effective date:	October 1, 2010
Implementation date:	October 1, 2010

SPA #13 (Update portions impacted by the Affordable Care Act Provisions)

Effective date:	January 1, 2014
Implementation date:	January 1, 2014

SPA #13-0013 (MAGI Eligibility & Methods)

CS7 (Eligibility-Targeted Low Income Children)
CS10 (Children with Access to Public Employee coverage)
CS15 (MAGI-Based Income Methodologies)

Effective date:	January 1, 2014
Implementation date:	January 1, 2014

SPA #13-0014 XXI Medicaid Expansion

CS3 (Eligibility for Medicaid Expansion Program)

Effective date:	January 1, 2014
Implementation date:	January 1, 2014

SPA #13-0015(Establish 2101(f) Group

CS14 (Children ineligible for Medicaid as a Result of the Elimination of Income Disregards)

Effective date:	January 1, 2014
Implementation date:	January 1, 2014

SPA #13-0016(Eligibility Process)

CS24 (Single, Streamlined Application Screen and Enroll Process Screen

Effective date:	October 1, 2013
Implementation date:	October 1, 2013

SPA #13-0017 (Non-Financial Eligibility)

CS17 (Non-Financial Eligibility-Residency)
CS18 (Non-Financial-Citizenship)
CS19 (Non-Financial-Social Security)
CS20 (Substitution of Coverage)

Effective date:	January 1, 2014
Implementation Date:	January 1, 2014

SPA #17-0000 (Eligibility Process)

Supersedes previously approved CS24

Effective date:	July 1, 2017
Implementation date:	July 1, 2016

SPA #18-001 (MHPAEA) CHIP Mental Health Parity

Effective Date	October 2, 2017
Implementation Date	October 2, 2017

KY-18-002 (Financial-Cost Sharing Eliminated)

Effective Date:	January 1, 2019
Implementation Date	January 1, 2019

Superseding Pages of MAGI CHIP State Plan Material

State: Kentucky

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
KY-13-0013 Effective/ Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS10 CS15	Eligibility – Targeted Low Income Children Children With Access to Public Employee Coverage MAGI-Based Income Methodologies	Supersedes the current sections – Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Supersedes only the information on dependents of public employees in Section 4.4.1; supporting documentation should be incorporated as an appendix to the current state plan Incorporate within a separate subsection under section 4.3
KY-13-0014 Effective/ Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
KY-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
KY-13-0016 Effective/ Implementation Date: October 1, 2013	Eligibility Process	CS24	Single, Streamlined Application Screen and Enroll Process Renewals	Supersedes the current section 4.3; 4.4
KY-13-0017 Effective/ Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19	Non-Financial Eligibility – Residency Non-Financial – Citizenship Non-Financial – Social Security Number	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1-LR; Supersedes the current section 4.1.9.1

KY-13-0017 Effective/ Implementation Date: 1/1/2014	Non-Financial Eligibility	CS20	Substitution of Coverage	Supersedes the current section 4.4.4
KY-17-0000 Effective/ Implementation Date: 1/1/2017	Eligibility Process	CS24	Single, Streamlined Application Screen and Enroll Process Renewals	Supersedes the previously approved CS24
KY 18-0001 Effective/ Implementation Date: 10/2/2017	MHPAEA		Demonstrate compliance with Mental Health Parity and Addiction Equity Act requirements.	Insert into current sections: 6.2.0; 8.4.1.1-8.4.8; update 8.1.2 to no; update 8.2.3 cost sharing language;
KY-18-0002 Effective/ Implementation Date: 1/1/2019	Financial		Copayments eliminated	Section 8.2.3, 8.3, 8.4.5, 8.6 & 8.7; cost sharing and copayment language eliminated.

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

Not applicable. Three are no federally recognized American Indian Tribes in Kentucky

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) (Applies to separate program only).

6.2.0- 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).

6.2.0.1-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))

6.2.0.1.1- 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:)

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

☒ Yes

☐ No

6.2.0.2-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.

6.2.0.2.1- 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

6.2.0.2.2- 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.

6.2.0.2.3- 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))

All areas above apply to all State Plans except for KCHIP III recipients. They do not receive EPSDT special services, but receive all screenings. EPSDT Special Services may be preventive, diagnostic or treatment, or rehabilitative. The Special Service benefits are not MH/SUD related.

6.2.0.3-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))

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

The state defines the benefit classifications as follow:
Inpatient: All covered services or items provided to a member in a setting that requires an overnight stay including residential services.
Outpatient: All covered services or items provided to a member in a setting that does not require an overnight stay, which do not otherwise meet the definition of inpatient, prescription drug or emergency care services.

Emergency care: All covered emergency services or items to treat an emergency condition delivered in an emergency department (ED) setting.
Prescription drugs: Covered medications, drugs, and associated supplies and services that require a prescription to be dispensed.

6.2.0.3.1.1 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.

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

☒ Yes

☐ No

All included as one. MCO's can separate out accordingly.

6.2.0.3.1.2.1- 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).

6.2.0.3.2 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.

Annual and Aggregate Lifetime Dollar Limits

6.2.0.4-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))

6.2.0.4.1- 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

6.2.0.4.2- 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

6.2.0.4.3 – 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))

☒ Does Not Apply

☐ 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.

6.2.0.4.3.1 – 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:

☒ Does Not Apply

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.0.4.3.2 – 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:

☒ Does Not Apply

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.0.4.3.2.1- 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)):

☒ Does Not Apply

☐ 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.

6.2.0.4.3.2- 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.

☒ Does Not Apply

Quantitative Treatment Limitations

6.2.0.5 - 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

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

☐ Yes

☒ No

6.2.0.5.2- 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))

☒ Does Not Apply

6.2.0.5.3- 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

☒ Does Not Apply

6.2.0.5.3.1-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))

☒ Does Not Apply

Non-Quantitative Treatment Limitations

6.2.0.6 - 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))

6.2.0.6.1 – 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.

6.2.0.6.2 – 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.

6.2.0.6.2.1 – 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

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

☒ The State 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 that 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

6.2.0.7-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.

6.2.0.7.1- 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

MCO's are deemed complaint with this requirement if they disseminate practice guidelines in compliance with the Medicaid managed care rule (42 CFR 438.236 (c)). Also if they provide notice of adverse benefit determination for denials.

6.2.0.7.2- 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

MCO's are deemed complaint with this requirement if they disseminate practice guidelines in compliance with the Medicaid managed care rule (42 CFR 438.236 (c)). Also if they provide notice of adverse benefit determination for denials.

Section 8. Cost Sharing and Payment (Section 2103(e))

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)**

8.1.1. YES
8.1.2. ☒ 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 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) &(c), 457.515(a)&(c))

8.2.1. Premiums:
Not Applicable

8.2.2. Deductibles:

Not Applicable

8.2.3. Coinsurance or copayments:

Copays were not applied by the state and the MCO plans as of 10/2/2017 and the state's financial requirements were consistent with parity as of the effective date of the parity SPA.

MHPAEA

8.4.1.1 – MHPAEA ☐ There is no separate accumulation of cumulative financial requirements, as define in §457.496(a), for mental health and substance use disorder benefits compared to medical/surgical benefits (§457.496 (d) (3)(iii)).

8.4.2.2 – MHPAEA ☐ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health and substance use disorder benefits (§457.496 (d) (3)(iii)(A)).

8.4.3.3 – MHPAEA ☐ Cost sharing applied to benefits provided under the State child health plan will remain capped at five (5) percent of the beneficiary's income as required §457.560 (§457.496(d)(i)(D)).

8.4.4.4 – MHPAEA ☐ Does the State apply financial requirements to any mental health or substance us disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☐ Yes (Specify: CHIP III kids are responsible for copays for a non-emergent use of the ER and for pharmacy benefits.)

☒ No

8.4.5 – MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☐ Yes

☒ No

8.4.6 – MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the proportion of medical and surgical benefits in the class which are subject to the limitation.

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits (§457.496(d)(3)(i)(E)).

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

☐ Yes

☐ No

8.4.8 – MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in §457.496(d)(3)(i)(B)(1)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to all substantially all medical/surgical benefits in a classification, the State assures:

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

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