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**State/Territory Name:** West Virginia

**State Plan Amendment (SPA) #:** WV-20-0005

This file contains the following documents in the order listed:

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- 2) State Plan Pages

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



**Children and Adults Health Programs Group**

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July 9, 2021

Jean Kranz, Executive Director  
West Virginia Children's Health Insurance Program  
350 Capitol Street, Room 251  
Charleston, WV 25301

Dear Ms. Kranz:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number WV-20-0005, submitted June 29, 2020 with additional information received on July 8, 2021 has been approved. Through this SPA, West Virginia has demonstrated compliance with section 5022 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. This SPA has an effective date of October 24, 2019, except as noted below.

Section 5022 of the SUPPORT Act added Section 2103(c)(5) to the Social Security Act (the Act) and requires child health and pregnancy related assistance to include coverage of services necessary to prevent, diagnose, and treat a broad range of behavioral health symptoms and disorders.

Additionally, Section 2103(c)(5)(B) of the Act requires that behavioral health services be delivered in a culturally and linguistically appropriate manner. West Virginia demonstrated compliance by providing the necessary assurances and benefit descriptions that the state covers a range of behavioral health services in a culturally and linguistically appropriate manner. In addition, West Virginia is revising its utilization management (UM) contract to include the UM vendor's involvement in the development and oversight of a CHIP beneficiary's plan of care as a component of the case management benefit by early 2022.

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

Centers for Medicare & Medicaid Services  
Center for Medicaid and CHIP Services  
7500 Security Boulevard, Mail Stop S2-01-16  
Baltimore, MD 21244-1850  
Telephone: (410) 786-8145  
E-mail: [Ticia.Jones@cms.hhs.gov](mailto:Ticia.Jones@cms.hhs.gov)

Page 2- Ms. Jean Kranz

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

Sincerely,

/Signed by Amy  
Lutzky/

Amy Lutzky  
Deputy Director

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: West Virginia  
(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)) [Redacted Signature] (Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: <u>Jean Kranz</u>	Position/Title: <u>Executive Director</u>
Name: <u>Jeremiah Samples</u>	Position/Title: <u>Deputy Secretary, DHHR</u>
Name: <u>Bill Crouch</u>	Position/Title: <u>Cabinet Secretary, DHHR</u>

**Disclosure Statement** This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**Introduction:** Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children’s Health Insurance Program (CHIP). In February 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

This template outlines the information that must be included in the state plans and the State plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

**Federal Requirements for Submission and Review of a Proposed SPA.** (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete

response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a “clean” copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children’s Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state’s program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children’s Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of

any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

**Program Options.** As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

#### **Medicaid Expansion- CHIP SPA Requirements**

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

#### **Medicaid Expansion- Medicaid SPA Requirements**

States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of



poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state’s assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer  
Centers for Medicare & Medicaid Services  
7500 Security Blvd  
Baltimore, Maryland 21244  
Attn: Children and Adults Health Programs Group  
Center for Medicaid and CHIP Services  
Mail Stop - S2-01-16

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

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

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

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

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State’s Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

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

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State’s Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

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

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

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

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

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

**1.4.** Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan

Effective Date: July 1, 1998

Implementation Date: July 1, 1998

SPA #17 Purpose of SPA: WV-20-0003 Disaster Relief

Proposed effective date: March 1, 2020

Proposed implementation date: March 1, 2020

Effective: July 1, 1998  
Implemented: July 1, 1998

A Medicaid expansion for children ages 1 to 5 from 134% up to 150% PFL

Amendments

General Description

#1 Effective: April 1, 1999  
Implemented: April 1, 1999

Expanded coverage for children ages 6 to 18 from 101% to 150% FPL under a benchmark coverage program based on state's public employees insurance program

#2 Effective: October 1, 2000  
Implemented: October 1, 2000

Combines Medicaid expansion (Phase 1- Ages 1 to 5) with benchmark coverage (Phase II – Ages 6 to 18) into one program under benchmark coverage

#3 Effective: November 1, 2000  
Implemented: October 23, 2000

Expands coverage to 200% FPL and includes cost sharing through copayments

#4 Effective: July 1, 2002  
Implemented: July 1, 2002

Technical amendments to comply with federal statute of August 24, 2001. Also, expansion of pharmacy copayments to families below 150% FPL; and inclusion of annual and lifetime benefit limits.

- #5 Effective: January 1, 2006  
Implemented: January 1, 2006  
Institutes a formulary for generic and/or preferred brand drugs for all therapeutic classes (with medical necessity exceptions when demonstrated by physicians) and grandfathering exceptions to changes for seven drug classes related to mental conditions.
- #6 Effective: January 1, 2007  
Implemented: January 1, 2007  
Expansion from 201% to 220% FPL through the addition of premium sharing with a limited dental benefit. Also, copayments for sick visits are excluded when a medical home is designated.
- #7 Submitted: June 11, 2007  
Withdrawn: August 31, 2007  
A special Health Services Initiative to allow for paid comprehensive wellness exams for uninsured children about to enter Kindergarten which included a basic coverage guarantee for subsequent diagnosis and treatment related to any conditions detected as a result of the exams and/or related screens.
- #8 Effective: September 1, 2008  
Implemented: January 1, 2008  
A special Health Services Initiative allowing for paid comprehensive wellness exams for uninsured children about to enter Kindergarten which includes referral but no coverage guarantee for subsequent diagnosis and treatment related to conditions detected as a result of the exam and/or related screens.
- #9 Effective: January 1, 2009  
Implemented: January 1, 2009  
Expanded coverage from 220% to 250% FPL through premium sharing. Also, eliminated use of income disregards when determining maximum upper income limit.
- #10 Effective: July 1, 2010  
Implemented: July 1, 2010  
This amendment combines provisions made effective the prior year to comply with CHIPRA provisions along with an expansion of CHIP dental services to the premium sharing group (above 200% FPL income) which had previously had a maximum \$150 annual limit.
- Effective: July 1, 2011  
Implemented: July 1, 2011  
Expanded coverage from 251% FPL to a maximum gross income limit of 300% FPL. Makes other changes to comply with CHIPRA provisions including elimination of annual and lifetime plan limits, and assurance of mental

health parity accompanied by service limit changes necessary for this assurance.

- |     |  |  |
|-----|--|--|
| #11 | Effective: October 1, 2011<br>Implemented: October 1, 2011                               | To change to a prospective payment system reimbursement methodology for Federally Qualified Health Centers (FQHC's) and Rural Health Centers (RHC's).  |
| #12 | Effective: October 1, 2013<br>Implemented: October 1, 2013                               | Incorporates the MAGI-based eligibility process requirements in accordance with the Affordable Care Act.   |
| #13 | Effective: January 1, 2014<br>Implemented: January 1, 2014                               | Coverage for eligible PEIA children.   |
| #14 | Effective: October 2, 2017<br>Implemented: October 2, 2017<br>Approved: December 6, 2018 | Mental Health Parity   |
| #15 | Effective: July 1, 2019<br>Implemented: July 1, 2019<br>Approved: September 27, 2019     | WV-19-0005 Poison Treatment Advice and Prevention  |
| #16 | Effective: July 1, 2019<br>Implemented: July 1, 2019<br>Approved: October 11, 2019       | WV-19-0006 Coverage for Pregnant Women   |
| #17 | Effective: March 1, 2020<br>Implemented: March 1, 2020<br>Approved:                      | WV-20-0003 Disaster Relief<br>In the event of a disaster, the State will notify CMS of its intent to provide temporary adjustments to the following policies: timely processing of renewals, continuous eligibility, and cost-sharing (premiums and copayments). |
| #18 | Effective: October 24, 2019<br>Implemented: October 24, 2019<br>Approved:                | WV-20-0005 SUPPORT ACT<br>To demonstrate WVCHIP compliance with Section 5002 of the SUPPORT ACT  |

MAGI SPA Roster

Transmittal Number	SPA Group	PDF	Description	Superseded Plan Section(s)
<p><b>WV-13-0001</b> Effective/Implementation Date: January 1, 2014</p>	MAGI Eligibility & Methods	<p>CS7</p> <p>CS13</p> <p>CS15</p> <p>CS10</p>	<p>Eligibility – Targeted Low Income Children</p> <p>Eligibility - Deemed Newborns</p> <p>MAGI-Based Income Methodologies</p> <p>Eligibility – Children Who Have Access to Public Employee Coverage</p>	<p>Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3</p> <p>Incorporate under section 4.3</p> <p>Incorporate within a separate subsection under section 4.3</p> <p>Supersedes language in regard to dependents of public employees in Section 4.1.9</p>
<p><b>WV-13-0002</b> Effective/Implementation Date: January 1, 2014</p>	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
<p><b>WV-13-0003</b> Effective/Implementation Date: January 1, 2014</p>	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within subsection 4.4.1

<b>WV-13-0004</b> Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
<b>WV-13-0005</b> Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5
		CS18	Non-Financial – Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR
		CS19	Non-Financial – Social Security Number	Supersedes the current section 4.1.9
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
		CS21	Non-Payment of Premiums	Supersedes the current section 8.7
		CS27	Continuous Eligibility	Supersedes the current section 4.1.8
<b>WV-19-0006</b> Effective/Implementation Date: July 1, 2019	MAGI Eligibility & Methods	CS8	Eligibility– Targeted Low Income Pregnant Women	Incorporate under section 4.1-PW, 4.1.3
		CS11	Eligibility – Pregnant Women Who Have Access to Public Employee Coverage	Incorporate under section 4.1-PW, 4.1.7

**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.  
**There are no federally recognized tribes in West Virginia.**

TN No: Approval Date Effective Date

**Section 2. General Background and Description of Approach to Children’s Health Insurance Coverage and Coordination**

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

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

West Virginia has two public health insurance programs targeted to low-income children: the West Virginia Medicaid program (WV Medicaid) and the West Virginia Children's Health Insurance Program (WVCHIP). Currently, no public-private partnerships provide creditable coverage.

The WV Medicaid program offers health insurance coverage to all children in the state who meet the following eligibility net income criteria:

- birth to age 1: income up to 150% of the Federal Poverty Level (FPL)
- ages 1 through 5: income up to 133% of the FPL
- ages 6 through 18: income up to 133% of the FPL

WV Medicaid also uses deductions and disregards in computing income for eligibility



determination, as allowed and approved in its State Plan, and as described in Section 4.3. of this Plan.

WV Medicaid extended 12 months coverage to all eligible children effective June 2001.

State Legislation establishing the West Virginia Children's Health Insurance Program was signed into law in April 1998; further, this legislation provided for the creation of an oversight body, the Children's Health Insurance Board whose role is to review and monitor the program's fiscal standing and approve an annual fiscal plan.

The original baseline for uninsured children in households with family incomes greater than Medicaid eligibility limits and up to 200% Federal Poverty Level (FPL) was 14,000. This was based on Lewin Group, Inc. estimates using the Household and Income and Tax Simulation Model (HITSM) and pooled 1995 and 1996 West Virginia Current Population Survey. The current program has been developed through several phases:

1. WVCHIP was first implemented July 1, 1998 (effective date of July 1, 1998). This is described as Phase I of the program.
  - This start-up phase was a Medicaid expansion providing coverage for children ages 1 to 5 in families with household incomes greater than 133% and up to 150% FPL.
  
2. STATE PLAN AMENDMENT #1  
WVCHIP Phase II was implemented April 1, 1999 (effective date of April 1, 1999).
  - This was a benchmark equivalent coverage program whose actuarial-base was the West Virginia Public Employees Insurance Agency Preferred Provider Benefit Plan.
  - This phase expanded coverage to children from ages 6 to 18 in families with household incomes greater than 100% FPL and up to 150% FPL.
  
3. STATE PLAN AMENDMENT #2  
This State Plan Amendment combined WVCHIP Phase I and Phase II effective October 1, 2000.
  - The State submitted an amendment June 26, 2000 to withdraw the Phase I Medicaid expansion program and incorporate it into the Phase III benchmark equivalent program.
  - In September 2000, the State notified the 1425 participants in the Medicaid expansion (Phase I) program of the change through a cover letter. Participants were also provided with a side-by-side comparison of the Phase I program benefits with those of Phase II.
  
4. STATE PLAN AMENDMENT #3  
WVCHIP Phase III was implemented October 23, 2000 (effective date of October 23, 2000).
  - Eligibility for the benchmark equivalent coverage was expanded to children in families

with incomes up to the 200% FPL.

- Cost sharing in the form of co-payments for specified services (see Section 8.2) was included for families with household incomes greater than 150% up to 200%.

5. STATE PLAN AMENDMENT #4

- Effective July 1, 2002 the State Plan is amended with required updates and amendments effective under federal statute August 24, 2001 and to expand participation in pharmacy co-payment to families in households with incomes below 150% FPL. It also eliminated the \$5 co-payment for generic drug use.

- This amendment also includes a lifetime benefit limit of \$1 million which is part of the original benchmark program noted above.

- This amendment also includes an annual benefit limit of \$200,000 per participant.

6. STATE PLAN AMENDMENT #5

- Effective January 1, 2006, the State Plan is amended to reflect a formulary that includes approved generic and/or preferred brand drugs for all therapeutic classes.

- There is no coverage for non-listed drugs except where clinical documentation from a physician demonstrates medical necessity. For a few listed therapeutic classes, Over the Counter (OTC) medications approved.

- Upon implementation, program participants who are currently taking a drug that is used to treat, or is sensitive to, mental conditions, can continue to have their current prescription(s) covered even if their current medication is not on the Preferred Drug List when it is in one of the following seven drug classes:

Antipsychotics; Serotonin Selective Response Inhibitors (SSRI's); Central Nervous System Stimulants; Anticonvulsants; Sedative Hypnotics; Aliphatic Phenothiazines; and Attention Deficit Disorder Drugs.

- Program participants who are newly prescribed a drug used to treat, or is sensitive to, mental conditions in one of the seven drug classes named above will have coverage from the Preferred Drug List at the time the new prescription is filled, except where there has been a demonstrated need for exception due to medical necessity.

7. STATE PLAN AMENDMENT #6

- Effective January 1, 2007, the State Plan is amended to expand coverage to those children in households at or under 220% FPL net income when they are willing to participate in a premium payment option.

- This amendment also modifies cost sharing provisions and cost sharing maximum limits described in Section 8 to permit increased copayments for enrollees at income levels above 200% FPL.

- Copayments for non-well visits are modified at all enrollee income levels to afford an incentive for designating and using a medical home.

- Children in households between 201% to 220% FPL (WVCHIP Premium) who have had group health care coverage in the 12 month “look back period” are not eligible.
- For children in the WVCHIP Premium group (201 to 220% FPL) there is no vision coverage as specified in Section 6.2.12; also dental coverage for this group is limited to \$150.00 per child per year as specified in Section 6.2.17.

8. STATE PLAN AMENDMENT #7

- A special health services initiative to allow for payment of comprehensive wellness exams for uninsured children about to enter Kindergarten was submitted on June 11, 2007 and withdrawn on August 31, 2007.

9. STATE PLAN AMENDMENT #8

➤ Effective January 1, 2008, the state plan is amended at Section 3.1 to allow a special health service initiative (HSI), named Kids First, that assures Comprehensive Wellness Exams performed at either local school sites or in provider offices are reimbursed for the estimated five percent of children ages four to five who are entering kindergarten without any health insurance. Of the approximately 21,000 children entering kindergarten, the age at which compulsory school attendance begins in this state, about 1,100 are estimated to be without any insurance. These exams performed by medical providers will be offered on site at schools, school based health clinics or in provider offices, and Title XXI funds will be used to reimburse exam costs.

➤ In order to promote participation by medical providers and parents, exams will be offered on site at schools at Kindergarten Round-ups. Local education authorities for West Virginia’s 55 school districts will draw up Memoranda of Understanding with all providers of medical services willing and available to provide exams on site at school or in their medical office and to provide follow-up services to children at either sliding fee-scale or reduced cost, regardless of insurance status.

➤ The kindergarten entry point will also be used as an opportunity to provide all families information about the joint application process through the state’s WVCHIP and Medicaid programs, and to assist them in obtaining a medical home.

➤ In this initiative the costs of any services resulting from any exam findings are to be paid by the parent. To facilitate access to health services a service practitioner directory will be prepared to include information about existing health resources including offerings of sliding fee schedules by the community health centers network.

- Children whose insurance plan does not cover these same wellness exams may be offered the exam, but there will be no reimbursement using Title XXI HSI funds. All claimed expenditures for this initiative are subject to WVCHIP’s ten-percent administrative cap of total expenditures. A revised budget is submitted as part of this plan amendment.

The goal of Kids First is to assure that as many children in West Virginia as possible have the same opportunity to enter school healthy and ready to learn by providing a wellness exam performed by a medical practitioner. Many children with commercial insurance, as well as those enrolled in either WVCHIP or Medicaid, already have access to this special preventive service. Under this initiative, children without insurance will be also be able to access this important exam.

#### 10. STATE PLAN AMENDMENT #9

- Effective January 1, 2009, the State Plan is amended at Sections 4.2 through 4.4 to expand coverage to children in families with household incomes up to and including 250% FPL in gross income through disregarding all gross income from 200% up to and including 250% FPL to meet the targeted low income child criteria at 42 CFR 457.310 This expansion also makes the following provisions:

- The same standard income deductions as used by West Virginia’s Title XIX program to calculate net income are used to assign participants to copayment levels and to determine premium payment participation, also referred to as enrollment groups.

- No changes are made to cost sharing amounts and provisions in Section 8.2.1, or to premium sharing costs or provisions in Section 8.2.3.

- Substitution of Coverage requirements remain the same, that is, applicants with net household incomes over 200% FPL are subject to a twelve (12) month look back review period, and are not eligible if they have had creditable group health coverage during the look back period. Applicants with net household incomes at or below 200% FPL are subject to a six (6) month look back period. Exceptions to the look back period remain the same as specified in Section 4.4.4.2.

- Clarification: To determine WVCHIP eligibility, the State will use one income criterion only based on gross income. Families with gross incomes up to and including 250% FPL may be eligible for WVCHIP. Net income refers to gross income minus applicable Medicaid deductions. Net income is used to determine the child’s enrollment group.

- A revised budget is submitted as part of this amendment reflecting funding for the additional projected population to be covered

#### 11. STATE PLAN AMENDMENT #10

This state plan amendment provides coverage for children in families with gross incomes up to 300% FPL. It also makes necessary changes to assure covered services and other provisions are in compliance with the Children’s Health Insurance Program Reauthorization Act (specifically dental services and mental health parity) and the Patient Protection and Affordable Care Act (removal of lifetime and annual benefit limits).

Changes to Section 4: Eligibility Standards and Methodology include:

- Expansion to 300% FPL: Effective July 1, 2011 the State Plan is amended at Section 4.13 to expand coverage to children in families with household gross incomes from 250% to 300% FPL by disregarding all gross income over 200% up to and including 300% FPL income levels to meet targeted low income criteria at CFR 457.310.

- A reduction in waiting periods is described in Section 4 Eligibility Standards and Methodology [4.17; 4.3; and 4.4.4]. This change reduces the waiting period from six (6) months to three (3) months for all applicants with incomes at or below 200% FPL and from twelve (12) months to three (3) months for those applicants with incomes over 200% FPL to 300% FPL. Methods for Monitoring Substitution [Section 4.4.4.1] remain the same except for notational changes in the waiting period duration.

Section 6 Coverage Requirements for Children's Health Insurance is amended to make changes necessary to comply with provisions of the Children's Health Insurance Program Reauthorization Act of 2009. The Lifetime Benefit Limit of \$1 million dollars is eliminated, as is the \$200,000 annual limit in accordance with provisions in the Patient Protection and Affordable Care Act.

Other Specific Coverage changes in this section include:

- Mental Health Parity: Effective July 1, 2011, coverage limits for all services, both mental health and non mental health related services have been reviewed to assure compliance with the mental health parity requirements of CHIPRA, Section 502. The Actuarial Certification includes the elimination of service limits for inpatient and outpatient mental health services [6.210 and 6.2.11] as well as inpatient substance abuse treatment services and outpatient substance abuse services [6.2.18 and 6.2.19].

- Section 6.2.12 eliminates the limitation on eyeglasses or contacts lenses to enrollees over 200% FPL net income in order to assure all enrollees have the same coverage for eyeglasses or contacts up to \$125 per year effective July 1, 2010.

- Section 6.2.17 eliminates the annual limit of \$150 preventive dental services to those enrollees with incomes over 200% FPL who then have the same dental coverage as those enrollees at or below 200% FPL effective July 1, 2010.

- Section 6.2-D provides for the coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions, and specifies the periodicity schedule. The actuarial certification is attached to this amendment as Attachment #1 includes these changes effective July 1, 2010.

- Section 6.2.22 eliminates the 20 visits per year limit for physical therapy,

occupational therapy, and speech therapy services effective July 1, 2011.

- Section 6.2.24 The limitation on eye exams for enrollees over 200% FPL and above is eliminated to provide the same coverage to all enrollees for eye exams (one visit per year) and prescriptive lenses (i.e. one set per year) effective July 1, 2010.
- Section 6.2.28 Early Intervention Services provided by the state's Birth-To-Three Program under the Individuals with Disabilities in Education Act are added to coverage for children ages birth through three years who have been assessed and met medical necessity criteria for developmental delay(s). Both assessments and services must be provided from a network of early intervention service providers certified by the WV Birth-to-Three Program effective July 1, 2010.

Section 8 Cost Sharing and Payment is amended at 8.2.3 and 8.5 to reflect copayment requirements for non-preventive dental services; and at 8.7 to assure a 30-day grace period for members required to make premium payments.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

**2.2. Health Services Initiatives-** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

**Poison Treatment Advice and Prevention.** West Virginia will use CHIP HSI funds, within the 10 percent federal administrative expenditures cap allowed for states, to support the West Virginia Poison Center (WVPC).

The WVPC provides 24-hours per day, 7 days a week, emergency telephone poisoning/overdose assessment, treatment, and referral recommendations to both the public and health care professionals in WV. Emergency phone lines are staffed by nurses with additional toxicology training, Specialists in Poison Information (SPIs), who must pass a national certification examination to become Certified Specialists in Poison Information (CSPI) to maintain employment. At all times, SPIs and CSPIs are backed up by a team of Medical Toxicologists (physicians with board certification in emergency medicine and additional board certification in medical toxicology) and a Clinical Toxicologist (a fellowship-trained Doctor of Pharmacy with board certification as an applied toxicologist).

Types of poisonings/overdoses managed by the WVPC include: unintentional poisonings (e.g., accidental ingestions of drugs, cleaners, household products); therapeutic errors; drug/product misuse exposures; self-harm exposures; environmental exposures (e.g., carbon monoxide poisonings, chemical

spills); biologic exposures (e.g., snakebites, spider bites, stings, plant or mushroom ingestions); substance abuse toxicity; chronic lead poisoning; and occupational exposures (at the worksite or occupational chemicals migrating into the home).

The service is available to all citizens and health care professionals in all of WV's 55 counties. Over 16,000 exposure case records are generated each year in addition to over 5,000 information case records. Exposure cases result in approximately 19,000 follow-up calls by the Poison Specialists for continued evaluation and management recommendations. For non-English speaking residents, the WVPC has a contract with an agency that can translate over 150 languages; the WVPC can also communicate with the deaf community via telecommunications devices for the deaf and hearing impaired (TDD).

According to the US Census Bureau, 2017 American Community Survey estimates, approximately 20.5% of WV total population is under 18. 66% of WV children are in households with incomes at 300% FPL or lower. In calendar years 2016 through 2018 the WVPC reported that children under 19 averaged 60% of all case exposure records with 45% of all case exposure records involving children under age 6. CHIP funding under this HSI is targeted to cover the cost of providing WVPC services to the approximately 40% (66% of 60%) of cases that involve children under age 19 in families at or below 300% FPL.

For every \$1 spent on poison control efforts, there is a return on investment of \$18. In WV, the savings is approximately \$25 to \$30 million each year. Nationally, poison centers saved \$1.8 billion in medical costs in the United States in 2016. Costs are saved by managing poisonings at home, decreasing unnecessary ambulance rides, decreasing hospital days, and decreasing hospital transfer costs. Decreasing hospital transfer costs is especially important for children in WV due to the number of hospitals in the state that do not routinely care for pediatric patients.

The WVPC toll-free number is promoted throughout the state via poison center publications, the WVPC website, WV emergency number listings, pediatrician offices, listed in all West Virginia telephone directories.

The WVPC Director has a strong working relationship with the WV Office of Healthy Schools. Through this affiliation, students in 755 WV schools, throughout all of WV's 55 counties, receive WVPC awareness information. Public schools in WV are required to report use of naloxone or epinephrine auto-injectors and any poisonings, overdoses, or therapeutic errors to the WVPC. Other WVPC collaborations, overseen by the WVPC Community Outreach Coordinator, include: WV Birth to Three, Parents as Teachers, Help Me Grow, the Family Resource Network, and the Bureau for Children and Families through River Valley Child Development Services. The WVPC also consults with the Violence and Injury Prevention Program. The WVPC Director is a regular participant in the Emergency Medical Services for Children (EMSC) Advisory Committee.

The WVPC Community Outreach Coordinator, runs the WVPC poison prevention and outreach program. In addition to brochures on core poison prevention information, the WVPC created brochures as a result of poisoning trends seen in WV. For example, brochures aimed at children and adolescents

cover jimson weed abuse, caffeine overuse, and inhalant abuse. For smaller children, brochures covering prevention of poisonous plant exposures are popular. Brochures on poisonous snakes of WV and bites & stings are also commonly requested. The WVPC also created a “Letter to Grandparents” to warn grandparents about the risks their medications can pose for their grandchildren. Monthly and emergency press releases are used to inform the public about real-time poisoning concerns that have been identified via real-time review of emergency telephone case records. Educational materials targeted to families are disseminated widely at various settings and programs that include not only the collaborative partners identified above, but also schools, Head Start programs, daycares, local health departments, Mothers of Preschoolers (MOPS) groups, community baby showers, community based health fairs (many rural areas have large health fairs that reach many families), and mailings to public libraries and pediatrician offices.

CHIP provides \$225,000 in annual funding that is used 90% for the call center operations (\$203,000) and 10% for materials (\$22,000), with all funds targeting services for children at or below 300% FPL. WVPC has annual costs of approximately \$1.3 million. CHIP HSI funding covers around 17% of total WVPC costs and 29% of costs attributable to providing services to children under 19 (60% of \$1.3 million, or \$780,000). Further prorating WVPC costs to the 66% of WV children at or below 300% FPL, (66% of \$780,000, or \$514,000), CHIP HSI funding contributes 44% of the total WVPC serving this targeted child population.

Funding under this HSI will not supplant or match CHIP federal funds with other Federal funds, nor will it allow other Federal funds to supplant or match CHIP Federal funds. Funding under this HSI is dedicated to children 18 years of age or younger.

**“Kids First”: A Health Services Initiative.** The goal of this initiative is to assure that West Virginia children start Kindergarten healthy and ready to learn.

The Kids First Initiative is a collaborative among three state government agencies; Department of Education, Department of Administration, and Department of Health and Human Resources, that enlists the West Virginia medical community, families, and community-based supports to improve child health and early learning.

All West Virginia children entering kindergarten will receive a health screen to identify risks to healthy growth and development. The West Virginia medical community, which includes private practicing physicians, community health centers, hospital-based clinics, and local health departments, is a participating partner in Kids First. Medical clinicians will be offering wellness screenings at their service sites, or alternate school settings, using the Kids First protocol, which meets the Bright Futures, American Academy of Pediatric standards. The offering of wellness screens in children’s medical homes supports West Virginia’s efforts to encourage primary medical homes for all children.

For populations who do not receive wellness screenings in their selected medical homes, screenings will be made available by participating community medical providers on-site at Kindergarten Round-ups (enrollment). On-site school screenings will be offered to all unscreened children presenting to



Kindergarten regardless of insurance status. Caveat: WVCHIP resources will not be used to offset screening costs for children who are insured, nor will they be used to supplant school funding or resources for wellness screenings. The school is serving as an additional screening site for children who were not screened prior to Kindergarten Round-ups and is offered at the school for the convenience of parents and participating providers. No funds to providers for this project will come from schools, or their districts. Conversely, no funds from WVCHIP, Title XXI, will go to schools to cover costs of alternate service sites for wellness screenings, or for the screening services. Payments for wellness screenings for insured kids, including those covered by WVCHIP or Medicaid, will be made by the appropriate payer according to its benefit plan. WVCHIP, Title XXI Health Service Initiative (HSI) funding will pay for screening services for uninsured children only. Parents of children who are covered by private insurance are responsible to pay for the screen if the private insurance does not cover the cost for any reason. The West Virginia Office of Maternal, Child, and Family Health (OMCFH) will act as a “central depository” for provider billings of these wellness exams for uninsured children. OMCFH will access Medicaid and WVCHIP enrollment files to determine if the child was subsequently enrolled in either program. If so, the claim form for the exam will be forwarded to the appropriate Agency for payment. The remaining claim forms will then be forwarded to WVCHIP to check against commercial insurance files. If it is determined the child has commercial insurance, the claim will be returned to the provider instructing them to bill the appropriate party. WVCHIP will pay the wellness exam claims for all children identified as uninsured through this process using Title XXI HSI funding subject to the 10% administrative cap.

Schools currently advertise Kindergarten enrollment events in local newspapers and media outlets as well as notices sent home to parents and day care centers. All of these efforts will continue with costs covered by local school districts. Promotional costs within the Kids First budget will be used for printing additional promotional materials to encourage Kids First health screens prior to kindergarten entry.

Existing state government resources will be used to bring community stakeholders together. We plan to utilize public service announcements and promotion through the annual “State of the State” address by the Governor. The West Virginia Chapter of the American Academy of Pediatrics will encourage participation by their membership. WVCHIP, Medicaid, PEIA and BlueCross BlueShield insurers and the Community Health Center Network will notify their age-eligible children through direct mailings, encouraging well-child exams.

To assure that every child eligible for government sponsored health coverage is identified, uninsured children who present at the school without having been screened will be evaluated for WVCHIP/Medicaid eligibility at Kindergarten Round-ups. School sites will offer on-line eligibility access and hard copy applications for families wishing to apply for government sponsored health services.

Parents of uninsured children who are identified with deficits by the wellness screenings will be referred to existing programs and services available in the community to address deficits utilizing the referral network established by the schools. Information will be made available by a brochure and also a document outlining a referral network will be made available online. The network will include participating medical providers that agree to offer services to families on a sliding fee scale. Parents are responsible to cover costs of any follow-up services that may be needed.

## HealthCheck In WV

The HealthCheck exam enjoys widespread acceptance by physicians, many of whom use it for all children regardless of payer source. In at least one WV county, it is already the preferred protocol to document compliance with screening requirements. The current HealthCheck document form is a single page that covers all American Academy of Pediatrics “Bright Futures” guidelines. The form has been also redesigned to allow parents to share information required by education authorities without divulging other more sensitive information, if they wish. This modification preserves family privacy without diminishing the form’s usefulness as a medical record.

## WV Kindergarten Entry

In West Virginia, kindergarten is mandatory under school law and WV’s most recent kindergarten enrollment was 21,173. Each year school districts hold kindergarten pre-enrollment orientations (“Round-ups”) in the six months preceding kindergarten entry to orient children and their families, to document children’s immunizations, and to provide those health screens as required under the state’s school law. Current estimates show that 5% (or about 1,100) of WV children entering kindergarten will not have any source of insurance coverage. Both the “Round-ups” and the actual kindergarten entry dates serve as points of entry at which schools can confirm whether or not children have had a HealthCheck exam and allow parents to provide documentation of such.

## Role of WV Public Payers

In West Virginia, three state public payers, WV Medicaid, WVCHIP, and the WV Public Employees Insurance Agency, cover more than two thirds of children in the state. All three payers cover comprehensive prevention screens that meet either the HealthCheck protocols or the requirements of comprehensive wellness exams as described in the Current Procedure Terminology found for preventive medicine under CPT codes 99381-99385 for new patients & 99391-99395 for established patients. The 3 payers will assist the initiative in these ways:

- 1) Adoption of the HealthCheck protocol as a requisite part of the medical record for billing of CPT codes by WVCHIP and the PEIA, with the HealthCheck form or an approved equivalent thereof required as documentation;
- 2) Providing initial reminder notices to parents of all age appropriate children actively enrolled to assure that a HealthCheck exam is obtained in the months prior to kindergarten entry, and to encourage them to provide the necessary physician documentation to school authorities.
- 3) Each year on or around March 1, state payers will identify to school authorities those children of qualifying age who have had a HealthCheck exam since September 1 of the prior year.
- 4) No later than June 30 each year, after each school district has held its “Round-ups,” they will identify by district those children NOT yet having presented a HealthCheck form to help assure that those children with demonstrated coverage are excluded from the estimate of children requiring a

HealthCheck exam, for kindergarten entry that year.

#### Role of Participating Providers

In order to help assure that parents of uninsured children may gain access to a variety of providers who have agreed to participate in the Kids First Initiative, including those offering sliding fee scales, the Office of Maternal Child and Family Health will assist local education authorities by providing a participating provider directory for each of the eight educational regions of the state. These directories will include providers such as primary care practices, dentists, optical services practitioners: eye, ear, nose and throat specialists and audiologists, along with 32 federally qualified community health centers operating at over 120 sites which include school based clinics which can play a key role in providing on site exams and follow-up services necessary to correct or ameliorate any conditions or deficits identified through screening exams.

As children and their parent(s) present at kindergarten orientation or “Round-ups”, four scenarios are envisioned:

- 1) The insured child has been screened and provides (or mails) a copy of the HealthCheck protocol to school authorities.
- 2) The child has insurance, but has not had a HealthCheck screen since the start of the current school year (September 1); the parent chooses to have a screening at the school and allows insurance to be billed, or the parent opts to have the child’s medical home provider perform the screen at his/her office and returns with HealthCheck documentation. The provider bills the appropriate insurance.
- 3) The child is uninsured and the parent agrees to an on-site HealthCheck exam at no cost. The family is provided a joint WVCHIP/Medicaid application and is screened for program eligibility. The appropriate program will cover costs of the exams for children subsequently enrolled as a result of this process. For those children deemed uninsured, WVCHIP Title XXI HSI funds will be used to reimburse medical providers for the exam services.
- 4) The child has insurance, but well-child exams are not covered. Parents are responsible to pay for the exam for this child. They will be referred to providers who have signed the Memorandum of Understanding with the school district offering exam services on a sliding fee scale or “pro bono.”

Any child’s family choosing not to participate in Healthcheck screening will be provided with the standard school screening as required under WV Code, also referred to as a “limited-domain” screen. No Title XXI HSI funds are used to provide “limited domain” screens, nor to reimburse schools for the use of their facilities to provide well-child exams on-site.

During the orientation, school personnel will provide copies of the joint WVCHIP/Medicaid applications and/or online application assistance when feasible. Families will also be provided with an informational brochure on the availability of health care resources in their region with special attention

to the availability of those with sliding fee scales. Families will be encouraged to establish a medical home for regular prevention.

#### Role of WV Department of Education and Local Education Authorities

- Assure that each school district has a Memorandum of Understanding (MOU) identifying its panel of providers responsible for providing HealthCheck exams for children at school sites.
- Provide regional workshops on developing the MOU in West Virginia's eight educational regions.
- Assure that participating providers educate parents about the medical home concept and its benefits for children, and assist with linking and enrolling them with one, if desired.
- Provide and coordinate data, reporting and information flow as required among WVCHIP, other state payers, the WV Department of Education's Office of Healthy Schools, and WV DHHR's HealthCheck Program.
- Under the local Memorandum of Understanding, it is the responsibility of participating providers to assist in locating services beyond their service capacity/scope or outside its own referral network. Providers will work to locate such needed services from any other provider or network within the state, and will also ask for assistance from programs operated by the state that may assist in locating these services. For example, a provider sees a child with a resulting finding that the child has a jaw misalignment making chewing difficult and that the correction of this is beyond their service capacity both within the center itself and its network, it can then turn to the statewide HealthCheck program and other programs within the Bureau for Public Health which will make inquiry to all participating providers or any other network which it finds can provide the service.
- Collect and report data for the 55 school districts on the numbers of uninsured and insured children who 1) present a documented Healthcheck exam given prior to Kindergarten Roundups and 2) those who receive a Healthcheck exam at in the school or school based clinic during each school district's Roundup period

#### Role of Commercial Payers

The state solicits commercial payers who at present reimburse for comprehensive well child exams to voluntarily assist in promoting this initiative through the issuance of reminder notices to parents and publicizing of the Kids First initiative.

For those children with commercial insurance whose coverage excludes such exams or whose use of cost sharing may discourage parents to seek such exams, referrals will be made to the same list of Kids First participating providers in their locale. All HealthCheck exam service claims provided under this initiative will be electronically cross checked for other insurance sources.

### Data Collection and Tracking

The state will establish data collection and tracking to determine the effectiveness of this initiative. Commercial payers will be solicited to share any data or quality measures concerning well child visits they can provide as part of this effort. Parents are encouraged to share copies of HealthCheck forms completed for exams furnished on-site at the school with their child's regular medical provider.

### Services Exclusion

This initiative specifically excludes consideration of any coverage for inpatient services or long-term care services or treatment of catastrophic illnesses or any follow-up services resulting from exams

**2.3-TC Tribal Consultation Requirements-** (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

[There are no federally recognized tribes in West Virginia.](#)

### Section 3. **Methods of Delivery and Utilization Controls**

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4 (Eligibility Standards and Methodology).

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the

State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

**3.1. Delivery Systems (Section 2102(a)(4)) (42 CFR 457.490; Part 457, Subpart L)**

**3.1.1 Choice of Delivery System**

**3.1.1.1** Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

- No, the State does not use a managed care delivery system for any CHIP populations.
- Yes, the State uses a managed care delivery system for all CHIP populations.
- Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed

standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))
- The State of West Virginia provides health insurance benefits through a plan managed by the Children’s Health Insurance Agency, within the Department of Health and Human Resources, using the same fiscal agent as the state Medicaid program. Pharmacy benefits are administered by a Pharmacy Benefit Manager (PBM) used by the state employees’ insurance agency. Primary care centers and school-based health centers, which provide low-income families with health care services, are also included in the provider network to assure access for children in rural areas served by these facilities, as well as emphasis on preventive services.
- All services are provided within a fee for service delivery system. All families are asked to designate a medical home for their children and are encouraged to do so through waiving of copayments for non-well visits. Families can change their choice of medical home once each year, and still retain their waived copayment status.

Guidance: Only States that use a managed care delivery system for all or some CHIP populations need to answer the remaining questions under Section 3 (starting with 3.1.1.2). If the State uses a managed care delivery system for only some of its CHIP population, the State’s responses to the following questions will only apply to those populations.

**3.1.1.2** Do any of your CHIP populations that receive services through a managed care delivery system receive any services outside of a managed care delivery system?

- No  
 Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee,

such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

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

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

- Managed care organization (MCO) (42 CFR 457.10)
  - Capitation payment
  - Describe population served:
  
- Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
  - Capitation payment
  - Other (please explain)
  - Describe population served:

Guidance: If the State uses prepaid ambulatory health plan(s) (PAHP) to exclusively provide non-emergency medical transportation (a NEMT PAHP), the State should not check the following box for that plan. Instead, complete section 3.1.3 for the NEMT PAHP.

- Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
  - Capitation payment
  - Other (please explain)
  - Describe population served:
  
- Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
  - Case management fee
  - Other (please explain)
  
- Primary care case management entity (PCCM Entity) (42 CFR 457.10)
  - Case management fee
  - Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
  - Other (please explain)



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

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

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

### 3.1.3 Nonemergency Medical Transportation PAHPs

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

- The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):
- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).

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

### 3.2. General Managed Care Contract Provisions

- 3.2.1  The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))
- 3.2.2  The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))
- 3.2.3  The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

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

### 3.3 Rate Development Standards and Medical Loss Ratio

- 3.3.1 The State assures that its payment rates are:
- Based on public or private payment rates for comparable services for comparable populations; and
  - Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

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

- If the State is unable to meet the requirements under 42 CFR 457.1203(a), the State attests that it must establish higher rates because such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. (42 CFR 457.1203(b))
- 3.3.2  The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))
- 3.3.3  The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))
- 3.3.4  The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))
- 3.3.5 Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))
- No, the State does not require any MCO, PIHP, or PAHP to pay remittances.
  - Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.
  - Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

If the State requests some, but not all, MCOs, PIHPs, and PAHPs to pay

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

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

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

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

## **3.4 Enrollment**

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

### **3.4.1 Enrollment Process**

- 3.4.1.1**  The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an

entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

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

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

Yes

No

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

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

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

### 3.4.2 Disenrollment

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

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

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

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

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

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

**3.4.2.5 Enrollee Requests for Disenrollment.**

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

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

- Yes  
 No

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

- The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))
- The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))
- The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:
  - During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
  - At least once every 12 months thereafter;
  - If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
  - When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

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

### **3.5 Information Requirements for Enrollees and Potential Enrollees**

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

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



PCCM entity to notify its enrollees:

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

### 3.5.7

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

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

PIHP, PAHP and PCCM entity, including enrollee satisfaction.

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

provided, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 3.6 Benefits and Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**3.6.17**  The State assures that it has implemented mechanisms for identifying to MCOs, PIHPs, and PAHPs enrollees with special health care needs who are eligible for



assessment and treatment services under 42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c) and included the mechanism in the State's quality strategy.

- 3.6.18**  The State assures that each applicable MCO, PIHP, and PAHP implements the mechanisms to comprehensively assess each enrollee identified by the state as having special health care needs. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(2))
- 3.6.19**  The State assures that each MCO, PIHP, and PAHP will produce a treatment or service plan that meets the following requirements for enrollees identified with special health care needs:
- Is in accordance with applicable State quality assurance and utilization review standards;
  - Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(3))
- 3.6.20**  The State assures that each MCO, PIHP, and PAHP must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs for enrollees identified with special health care needs who need a course of treatment or regular care monitoring. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(c)(4))

### **3.7 Operations**

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

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

- 3.7.2** The State assures each contracted MCO, PIHP and PAHP will comply with the provider selection requirements in 42 CFR 457.1208 and 457.1233(a), cross-referencing 42 CFR 438.12 and 438.214, including that:
- Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));
  - MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk

populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));

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

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

- The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;
- All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable subregulatory guidance and contract provisions; and
- The subcontractor agrees to the audit provisions in 438.230(c)(3).

**3.7.4**  The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically

as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

- 3.7.5  The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))
- 3.7.6  The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)
- 3.7.7  The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)
- 3.7.8  The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the State has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004)
- 3.7.9  The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e))

### 3.8 **Beneficiary Protections**

- 3.8.1  The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))
- 3.8.2  The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))
- 3.8.3  The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:
- The MCO's, PIHP's or PAHP's debts, in the event of the entity's solvency.

(42 CFR 457.1226, cross-referencing to 42 CFR 438.106(a))

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

### 3.9 Grievances and Appeals

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

- 3.9.1  The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))
- 3.9.2  The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))
- 3.9.3  The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))
- 3.9.4. Does the state offer and arrange for an external medical review?  
 Yes  
 No

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

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

- 3.9.6**  The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))
- 3.9.7**  The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))
- 3.9.8**  The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))
- 3.9.9**  The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.
- 3.9.10**  The State assures that the notice of an adverse benefit determination explains:
- The adverse benefit determination.
  - The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
  - The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
  - The procedures for exercising the rights specified above under this assurance.
  - The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))
- 3.9.11**  The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))
- 3.9.12**  The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(a))

- 3.9.13** The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:
- Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
  - Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:
    - An appeal of a denial that is based on lack of medical necessity.
    - A grievance regarding denial of expedited resolution of an appeal.
    - A grievance or appeal that involves clinical issues.
  - All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.
  - Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
  - Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.
  - The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))
- 3.9.14**  The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))
- 3.9.15**  The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))
- 3.9.16**  The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the

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

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

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

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

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

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

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

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

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

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



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

### 3.10 Program Integrity

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

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

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

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

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

**3.10.5**

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

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

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

**3.10.13**

The State assures that:

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

**3.10.14**

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

**3.10.15**

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

**3.10.16**

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

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

accessibility of services;

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

### 3.11 Sanctions

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

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

3.11.1  The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

3.11.2  The State assures that it will impose temporary management if it finds that an MCO has repeatedly failed to meet substantive requirements of part 457 subpart L. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

3.11.3  The State assures that if it imposes temporary management on an MCO, the State allows enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to terminate enrollment. (42 CFR 457.1270, cross referencing 42 CFR 438.706(b))

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

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?  
 Yes  
 No

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

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

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

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

### 3.12 Quality Measurement and Improvement; External Quality Review

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

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

#### 3.12.1 Quality Strategy

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

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

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

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

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

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

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

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

### **3.12.2 Quality Assessment and Performance Improvement Program**

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

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

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



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

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

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

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

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

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

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

**3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness**

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

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

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

### 3.12.3 Accreditation

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

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

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

### 3.12.4 Quality Rating

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

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

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

### 3.12.5 Quality Review

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

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

### **3.12.5.1 External Quality Review Organization**

- 3.12.5.1.1**  The State assures that it contracts with at least one external quality review organization (EQRO) to conduct either EQR alone or EQR and other EQR-related activities. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(a))

- 3.12.5.1.2**  The State assures that any EQRO used by the State to comply with 42 CFR 457.1250 must meet the competence and independence requirements of 42 CFR 438.354 and, if the EQRO uses subcontractors, that the EQRO is accountable for and oversees all subcontractor functions. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.354 and 42 CFR 438.356(b) through (d))

### **3.12.5.2 External Quality Review-Related Activities**

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

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

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

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

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

### **3.12.5.3 External Quality Review Report**

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

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

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

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

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

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

- 3.12.5.3.5**  The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))
- 3.12.5.3.6**  The State assures that it finalizes the annual EQR technical report by April 30<sup>th</sup> of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))
- 3.12.5.3.7**  The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by April 30<sup>th</sup> of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))
- 3.12.5.3.8**  The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

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

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

#### Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

#### 4.0. Medicaid Expansion

4.0.1. Ages of each eligibility group and the income standard for that group:  
Ages 6 – 19 Above 108% FPL and Up to & Including 133% FPL  
Refer to form CS3

4.1.  **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0  Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

Refer to form CS18

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

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

Ages:

0 – 1 Above 158% FPL and Up to & Including 300% FPL

1 – 6 Above 141% FPL and Up to & Including 300% FPL

6 – 19 Above 133% FPL and Up to & Including 300% FPL

19+ Above 185%FPL and Up to & Including 300%FPL



Refer to forms CS7 & CS8

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

4.1.3  Income of each separate eligibility group (if applicable):

Ages:

0 – 1 Above 158% FPL and Up to & Including 300% FPL

1 – 6 Above 141% FPL and Up to & Including 300% FPL

6 – 19 Above 133% FPL and Up to & Including 300% FPL

19+ Above 185%FPL and Up to & Including 300%FPL

Refer to forms CS7 & CS8

4.1.3.1-PC  0% of the FPL (and not eligible for Medicaid) through %  
of the FPL (SHO #02-004, issued November 12, 2002)

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

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

Refer to form CS17

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

4.1.7  Access to or coverage under other health coverage:

Refer to form CS20

4.1.8  Duration of eligibility, not to exceed 12 months:

Refer to form CS27. Eligibility determination is used for continuous 12 months of enrollment for all children approved for CHIP. During this continuous 12-month eligibility period children can only be disenrolled when they reach the age of 19, moves out of state, child dies, becomes eligible for Medicaid, obtains other health insurance or approved in error and child not eligible. Members are sent notice 60 days before coverage ends informing them. Eligibility redetermination is made at the end of the 12-month continuous eligibility span.

4.1.9  Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed

newborns.

- 4.1.9.1  States should specify whether Social Security Numbers (SSN) are required.

[Refer to form CS19](#)

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

- 4.1.9.2  Continuous eligibility

[Refer to form CS27](#)

- 4.1-PW  **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option. [Refer to forms CS8, CS11, CS18, and CS20](#)

Guidance: States have the option to cover groups of “lawfully residing” children and/or pregnant women. States may elect to cover (1) “lawfully residing” children described at section 2107(e)(1)(J) of the Act; (2) “lawfully residing” pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

- 4.1- LR  **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
  - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
  - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
  - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
  - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
  - (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
  - (vi) Aliens currently in deferred action status; or
  - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;
- (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
- (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
- (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

- Elected for pregnant women.
  - Elected for children under age 19
- [Refer to form CS18](#)

**4.1.1-LR**  The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual’s initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to

verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

- 4.1-DS**  **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.
- 4.2.** **Assurances** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))
- 4.2.1.**  These standards do not discriminate on the basis of diagnosis.
- 4.2.2.**  Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.
- 4.2.3.**  These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.
- 4.2-DS** Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))
- 4.2.1-DS**  These standards do not discriminate on the basis of diagnosis.
- 4.2.2-DS**  Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3-DS**  These standards do not deny eligibility based on a child having a pre-existing medical condition.
- 4.3.** **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility

standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

Disaster Relief: At the State's discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for WVCHIP members who reside and/or work in State or Federally declared disaster areas.

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

**4.3.1. Limitation on Enrollment** Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

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

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

**4.3.2.**  Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

**4.3.3-EL Express Lane Eligibility**  Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not

apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

**4.3.3.1-EL** Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

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

**4.3.3.3-EL** List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

**4.3.3.3-EL** List the component/components of CHIP eligibility that are determined under the Express Lane.

**4.3.3.4-EL** Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

#### **4.4. Eligibility screening and coordination with other health coverage programs**

States must describe how they will assure that:

- 4.4.1.  only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.  
[There is no waiting period for children or pregnant women who are eligible under this plan. Refer to form CS20.](#)
- 4.4.2.  children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))  
[Refer to form CS24](#)
- 4.4.3.  children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))  
[Refer to form CS24](#)
- 4.4.4.  the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)  
[Refer to form CS20](#)
- 4.4.4.1.  (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))
- 4.4.5.  Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

**4.4-EL** The State should designate the option it will be using to carry out screen and enroll requirements:

- The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

- The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.
- The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

**Section 5. Outreach and Coordination**

**5.1.** (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State’s outreach efforts through Medicaid and state-only programs.

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

- West Virginia seeks to enroll all eligible uncovered children in the State’s CHIP and Medicaid programs through a joint application form. The 2-page (back and front) form is accompanied by a 4-page (back and front) information guide, and return mail postage-paid envelope.
- WVCHIP maintains a website at [www.chip.wv.gov](http://www.chip.wv.gov) with an application available for downloading, responses to frequently asked questions; information updates; and a summary of benefits guide. The website also has a Spanish version of the application and directions on where to find help with translation services, if needed. Helpful information such as the current enrollment, an outreach activities calendar, and a contact list of outreach coordinators who can assist with the application is provided. It is also compliant with website requirements at Section 508 of the Rehabilitation Act (29 U.S.C.794d).
- In addition to application forms and guides, the WVCHIP maintains and distributes standard informational materials bearing the program logo including:



- Business envelope size insert with the WVCHIP toll-free number, website address and qualifying income guidelines;
- Posters promoting the availability of free/low cost insurance with the WVCHIP toll-free number and website address;
- Posters with child wellness and immunization schedules (bearing the logo, WVCHIP Call Center number, and website address)
- Posters with child wellness and immunization schedules (bearing the logo, WVCHIP Call Center number and website address) are distributed to pediatrician and family practice physician offices, clinics and other health care settings;
- A prevention brochure describing the prevention benefits available through WVCHIP coverage.

- All applications are processed through the electronic eligibility system known as “RAPIDS”, operated by the West Virginia Department of Health Human Resources (WVDHHR); this allows for all CHIP applicants to be screened for Medicaid first. In 2001, about 10,000 children were found eligible for Medicaid as a result of the screening of CHIP applications.

- On-going application distribution and application assistance occurs through the CHIP Call Center with a toll-free telephone line. Callers may request mailed applications, or assistance in completing the application with their responses filled in and mailed to them within 24 hours, Spanish and hearing impaired translation services as requested. The CHIP Call Center mails and distributes all standard program material including applications and new enrollee welcome kits with the summary plan description.

- Local WVDHHR offices located in 53 of the state’s 55 counties also provide application distribution and assistance. WVDHHR now administers the redetermination or re-enrollment applications through 2 customer call units with toll-free telephone units for quicker turn around.

Cooperative Efforts Through Other State Government Agencies:

- Through a cooperative agreement between the WVDHHR and the West Virginia Hospital Association, WVDHHR eligibility workers are outstationed in selected hospitals throughout the state to facilitate outreach and eligibility determination for both WVCHIP and Medicaid.

- Within the WVDHHR, the Office of Maternal, Child and Family Health distributes WVCHIP printed materials to the medical community as part of their outreach and community-based efforts, as do Bureau of Public Health workers.

- The Bureau of Employment Programs contacts WVCHIP for participation at workshops for laid-off workers, and “One-Stop” service centers operated by the West Virginia Workforce Investment Board also distributes WVCHIP information.

- The Department of Education has a check-off box on its free and reduced lunch application form that allows parents/guardians to indicate an interest and consent to have the joint WVCHIP/Medicaid form mailed to them. Addresses are compiled through the Department's information system which generates a centralized mailing list for all participating local county school Boards. This list is made available to the WVCHIP about two months after the beginning of the school year.
- The West Virginia State Supreme Court mandates through an administrative order that family law judges must provide WVCHIP applications and other program information to every parent of a dependent child at the first appearance before the court. This allows WV Family Courts to facilitate children's access to coverage when considering child support decisions. WVCHIP supplies copies of the joint application to all family law judges and county circuit clerks on an ongoing basis.
- As required by recent legislation passed by the West Virginia legislature, the WVCHIP Insurance Board will develop and administer a plan whereby applications for enrollment may be taken by primary care centers or other health care providers and transmitted electronically for eligibility screening.
- Members of the Governor's Health Umbrella Group planned and financed the West Virginia Healthcare Survey, a survey of over 16,000 households. Conducted by the Institute for Health Policy Research at West Virginia University, the survey results for the first report on children show that West Virginia's rate of insurance coverage from all sources for all children up through age 18 is 93.4%, considerably higher than that reported in other states. Survey sampling was able to identify numbers of uninsured children at the county level enabling better targeting of outreach efforts by WVCHIP and Medicaid.
- Each year families are encouraged to provide documentation of a HealthCheck screen at Kindergarten "Round-ups" for public school entry. Children who do not present documentation of HealthCheck screen are encouraged to have one performed at their medical home and provide documentation to the school for entry. Children presenting as having no screen and no access to health insurance to obtain a screen will be provided one under a special Health Service Initiative (HSI) using Title XXI funds to reimburse the provider. Children participating in this HSI are screened for WVCHIP/Medicaid eligibility prior to reimbursement for the exam. Children found eligible are enrolled in the appropriate program.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

- 5.1.2.** (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

**5.2.** (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

The WVCHIP Agency Office and the CHIP Call Center provide referrals to families not meeting either WVCHIP or Medicaid income limits to primary care networks which include Federally Qualified Health Clinics and Rural Health Clinics which accept payment on a sliding fee scale basis.

Both the WVCHIP Agency Office and the Call Center also refer families with specialized needs, such as dental services, special needs children, early intervention services to the Office of Maternal, Child and Family Health (OMCFH). OMCFH has provider networks and recruits providers for these specialized program areas.

**5.2-EL** The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

**5.3.** **Strategies** Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

## **Section 6. Coverage Requirements for Children's Health Insurance**

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

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

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

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

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

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

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

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

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

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

- Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:
- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
    - dental services
    - inpatient and outpatient hospital services,
    - physicians' services,
    - surgical and medical services,
    - laboratory and x-ray services,
    - well-baby and well-child care, including age-appropriate immunizations, and
    - emergency services;
  - the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
  - the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
    - coverage of prescription drugs,
    - mental health services,
    - vision services and
    - hearing services.

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

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

taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

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

A complete description of the WV Public Employees Insurance Agency Preferred Provider Benefit plan, the benchmark equivalent benefit plan, was provided as Attachment 3 of the State Plan Amendment which was effective April 1, 1999. This plan includes a lifetime benefit limit of \$1,000,000 (see page 43 of the original Attachment).

An actuarial certification which considers changes to be implemented July 1, 2002 concerning pharmacy co-payment (section 8) and annual and lifetime benefit maximums (section 6) is provided as Attachment # 1 for State Plan Amendment #4.

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

- 6.1.3.  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

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

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

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision,

hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

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

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

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

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

6.1.4.4.  Coverage that includes benchmark coverage plus additional coverage

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

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of

the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

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

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

- 6.1.4.7.  Other (Describe)

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

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

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

- 6.2.1.  Inpatient services (Section 2110(a)(1))  
Confinement in a hospital including semi-private room, special care units, confinement for detoxification, and related services and supplies during the confinement.
- 6.2.2.  Outpatient services (Section 2110(a)(2))  
Diagnostic services, therapies, laboratory, radiology, and surgeries provided in a hospital, alternative facility or physician's office are covered. Certain outpatient procedures may require pre-certification.
- 6.2.3.  Physician services (Section 2110(a)(3))



Professional services of a physician or other licensed provider for treatment of an illness, injury or medical condition. Includes outpatient and inpatient services (such as surgery, anesthesia, radiology, and office visits).

6.2.4. ☒ Surgical services (Section 2110(a)(4))

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

Diagnostic services, therapies, laboratory, radiology, and surgeries provided in a hospital outpatient setting or in an ambulatory surgical facility are covered. Immunizations are covered.

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

Prescription benefit services are covered with mandatory generic substitution, including oral contraceptives. Formulary coverage includes generic and brand drugs, with prior approval through a step therapy process for some brand drugs in some drug classes. Non-formulary drugs are at 100% cost to the participant, except where medical necessity is shown for clinical exception.

Effective January 1, 2006, program participants who are currently taking a drug that is used to treat, or is sensitive to, mental conditions, can continue to have their current prescription(s) covered even if their current medication is not on the Preferred Drug List when it is in one of the following seven drug classes:

Antipsychotics; Serotonin Selective Response Inhibitors (SSRI's); Central Nervous System Stimulants; Anticonvulsants; Sedative Hypnotics; Aliphatic Phenothiazines; and Attention Deficit Disorder Drugs.

Program participants who are newly prescribed a drug used to treat, or is sensitive to, mental conditions in one of the seven drug classes named above will have coverage from the Preferred Drug List at the time the new prescription is filled, except where there has been a demonstrated need for exception due to medical necessity.

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

These are permitted in some therapeutic classes as listed on the Preferred Drug List when accompanied by a prescription.

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

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

Pre-pregnancy family services and supplies, excluding tubal ligations and vasectomies, are covered. Oral contraceptives are included within pharmacy benefit services. Contraceptive devices and contraceptive implants will be covered under medical services.

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

Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices, and for the rental or purchase (at the Plan's discretion) of standard durable medical equipment, when prescribed by a physician. Prosthetics and durable medical equipment purchases or rentals must be pre-certified.

Eyeglasses or contact lenses are limited to \$125 per each 12-month period of eligibility for all enrollees. This amount may be increased with either prior approval and/or determined medical necessity. An actuarial certification is made for changes effective January 1, 2007 for State Plan Amendment #6. Hearing aids are covered if determined to be medically necessary with prior approval. Effective July 1, 2000, all infants at the time of birth will be screened for hearing loss. All information on children with a medically confirmed hearing loss will be reported to the Office of Maternal and Child Health by the hospital.

- 6.2.11.  Disposable medical supplies (Section 2110(a)(13))  
As medically necessary.

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

- 6.2.12.  Home and community-based health care services (Section 2110(a)(14))

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

- 6.2.13.  Nursing care services (Section 2110(a)(15))  
Skilled nursing services are covered when precertified for medical necessity.

- 6.2.14.  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))  
A physician shall provide written certification of medically necessary abortions. All services require prior approval unless a medical emergency exists endangering

the life of the mother.

- 6.2.15.  Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) Routine semi-annual exams, x-rays, and other dental services necessary to prevent disease, restore oral structures to health and function, and to treat emergency conditions. For more detail on covered dental services, see Section 6.2.-D.
- 6.2.16.  Vision screenings and services (Section 2110(a)(24))
- 6.2.17.  Hearing screenings and services (Section 2110(a)(24)) Hearing services covered to include annual exams and hearing aids when determined medically necessary and with prior approval/authorization.
- 6.2.18.  Case management services (Section 2110(a)(20)) Medical case management provided by the third-party administrator.
- 6.2.19.  Care coordination services (Section 2110(a)(21)) Provided by the third-party administrator
- 6.2.20.  Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.21.  Hospice care (Section 2110(a)(23))

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

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

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

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

under State law and operating within the scope of the license.

- 6.2.23.  Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))
- 6.2.24.  Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.25.  Medical transportation (Section 2110(a)(26))

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

- 6.2.26.  Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

- 6.2.27.  Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))
- Early Intervention Services provided by this state's Birth-To-Three (Individuals with Disabilities and Education Act) Program are covered for children ages birth through three years who have been assessed and met medical necessity criteria for developmental delay(s). Both assessments and services must be provided from a network of early intervention service providers certified by the WV Birth-to-Three Program.

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

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

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

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

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

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

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

Unchecked services are not covered under the WVCHIP State Plan. Referrals are made to other state agency programs or outside community-based programs, that may fund services with other grant sources.

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

Further diagnostic and appropriate treatment services are included when indicated by screenings and assessments.

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

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

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

WVCHIP partners with the State’s HealthCheck program (EPSDT) to ensure the use of validated screening tools identified and adopted by Bright Futures and the AAP. These tools are for use in primary care settings and are included in the AAP’s Periodicity Schedule for an age specified well-child visit. HealthCheck provides education, training, and technical resources regarding the proper use of

these tools. HealthCheck is the state Medicaid's EPSDT program that also helps enrolled providers secure the validated screening and assessment tools and forms they need to complete comprehensive well child exams. This partnership assures consistent messaging and expectations with the state's Medicaid program to WV's medical providers. Bright Futures also provides access to and resources to AAP members and providers that are contained within the Periodicity Table.

WVCHIP facilitates the use of age-appropriate validated behavioral health screening tools by providing feedback directly to providers as determined necessary through desk-audits of primary care services based on randomized samples conducted quarterly. A review of medical records that indicates the lack of validated behavioral health screening tools (or any other screening tools) are communicated to the provider with an explanation and listing of validated screening tools, how to obtain those tools and training on using those tools through state partners, such as HealthCheck. The communication may include any descriptions of sanctions WVCHIP will impose should the provider not adopt the validated screening tools. These sanctions could include takeback of funds.

Similarly, WVCHIP follows the state's Office of Maternal and Child Health (OMCH) and state Medicaid's program lead to facilitate the use of validated screening tools for pregnant women. The USPSTF required screenings for pregnant women have been adopted by both these programs. The OMCH provides training and resources directly to providers in the state.

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

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

#### **6.3.2.1- BH** Psychosocial treatment

Provided for:  Mental Health  Substance Use Disorder

Includes evaluation, referral, diagnostic, therapeutic, and crisis intervention services performed on an inpatient or outpatient basis (outpatient includes physician, psychologists, licensed therapists, and counselor offices). Coverage for more than 26 visits annually is provided with prior medical necessity review. Coverage is the same for both children and pregnant women.

#### **6.3.2.2- BH** Tobacco cessation

Provided for:  Substance Use Disorder

Tobacco cessation counseling by physicians, physician assistants, nurse practitioners, and

dentists is included at no cost to the member and no prior authorization requirement. All FDA approved medications are provided within FDA guidelines. Medication is limited to two 12-week cycles per year, that may be exceeded by review for medical necessity. Coverage is the same for both children and pregnant women.

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

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

**6.3.2.3.1- BH**  Opioid Use Disorder

MAT is available for members per FDA guidelines and as prior authorized. All FDA approved medications are included in the benefit. Copayments are required for brand drugs. This list is reviewed annually and may be updated. Counseling and therapy services are also included in this benefit. Members can access these services directly without prior authorization but coverage beyond 26 visits requires prior authorization and medical necessity review in order to assess the member for any case management services that may be needed. Benefit is the same for both children and pregnant women.

**6.3.2.3.2- BH**  Alcohol Use Disorder

**6.3.2.3.3- BH**  Other

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

WV behavioral health providers typically hire peer support specialists and incorporate them into most levels of care. While there is no direct “benefit” for peer support under WVCHIP, these services are available to members through providers.

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

Behavioral health providers may offer referrals to caregiver supports based on assessment

of needs made during family therapy sessions.

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

Behavioral health providers may offer referrals to other sources of respite care based on assessment of needs made during family therapy sessions.

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

WVCHIP's UM vendor will seek provisions of services through other DHHR programs as needed, including Birth-to-Three, WV Bureau for Behavioral Health, or the Bureau for Children and Families. Also, WVCHIP will help facilitate application to the state Medicaid's IDD waiver when appropriate for members whose conditions indicate a need for these services.

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

This service is considered the same as day treatment or partial hospitalization. Intensive outpatient is a comprehensive range of services including individual counseling, group therapy, psychotherapy and/or addiction education and relapse prevention classes, weekly drug testing, and family therapy programs and after care services, depending on the program. Clients learn about impulse control, relapse prevention, cross addiction, life skills, how to plan their environment, how to sleep better and how to set themselves up for success. These programs are staffed with licensed clinical staff and trained behavioral health technicians. Psychiatrists evaluate patients weekly to monitor progress and medications and adjust treatments as necessary. Programs are generally 4 to 6 weeks long, requiring 3 to 5 days of treatment per week. Members can access these services directly without prior authorization but coverage beyond 26 visits (a visit is one day of treatment) requires prior authorization and medical necessity review in order to assess the member for any case management services that may be needed. Benefit is the same for both children and pregnant women. ASAM levels of care guidelines are applied to determine the appropriate intensity of services.

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

The National Alliance on Mental Illness (NAMI) describes psychosocial rehabilitation helps people develop the social, emotional and intellectual skills they need in order to live happily with the smallest amount of professional assistance they can manage. Psychosocial rehabilitation uses two strategies for intervention: learning coping skills so that they are more successful handling a stressful environment and developing resources



that reduce future stressors. Treatments and resources vary from case to case but can include medication management, psychological support, family counseling, vocational and independent living training, housing, job coaching, educational aide and social support.

WVCHIP provides coverage for many treatments considered “psychosocial rehabilitation” and it’s UM vendor can offer referrals for vocational and independent living training, housing, job coaching, educational aide and social supports.

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

**6.3.3- BH**  Day Treatment

Provided for:  Mental Health  Substance Use Disorder

Day treatment is considered the same as intensive outpatient or partial hospitalization. Day Treatment is a comprehensive range of services including individual counseling, group therapy, psychotherapy and/or addiction education and relapse prevention classes, weekly drug testing, and family therapy programs and after care services, depending on the program. Clients learn about impulse control, relapse prevention, cross addiction, life skills, how to plan their environment, how to sleep better and how to set themselves up for success. These programs are staffed with licensed clinical staff and trained behavioral health technicians. Psychiatrists evaluate patients weekly to monitor progress and medications and adjust treatments as necessary. Programs are generally 4 to 6 weeks long, requiring 3 to 5 days of treatment per week. Members can access these services directly without prior authorization but coverage beyond 26 visits (a visit is one day of treatment) requires prior authorization and medical necessity review in order to assess the member for any case management services that may be needed. Coverage is the same for both children and pregnant women. ASAM levels of care guidelines are applied to determine the appropriate intensity of services.

**6.3.3.1- BH**  Partial Hospitalization

Provided for:  Mental Health  Substance Use Disorder

Partial hospitalization is considered the same as day treatment and intensive outpatient services.

Partial hospitalization is a comprehensive range of services including individual counseling, group therapy, psychotherapy and/or addiction education and relapse prevention classes, weekly drug testing, and family therapy programs and after care services, depending on the program. Clients learn about impulse control, relapse prevention, cross addiction, life skills, how to plan their environment, how to sleep better and how to set themselves up for

success. These programs are staffed with licensed clinical staff and trained behavioral health technicians. Psychiatrists evaluate patients weekly to monitor progress and medications and adjust treatments as necessary. Programs are generally 4 to 6 weeks long, requiring 3 to 5 days of treatment per week. Members can access these services directly without prior authorization but coverage beyond 26 visits (a visit is one day of treatment) requires prior authorization and medical necessity review in order to assess the member for any case management services that may be needed. Coverage is the same for both children and pregnant women. ASAM levels of care guidelines are applied to determine the appropriate intensity of services.

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

Provided for:  Mental Health  Substance Use Disorder

All inpatient hospital admissions, except deliveries, require prior authorization for medical necessity. Requests for prior authorizations of emergency admissions must be submitted within 48 hours of the admission to be evaluated retro-actively for any necessary case management services or post-discharge needs. Coverage is the same for both children and pregnant women.

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

**6.3.4.1- BH**  Residential Treatment

Provided for:  Mental Health  Substance Use Disorder

Residential treatment for mental health and substance use conditions are covered as long as medically necessary and after the member has exhausted alternative community based and less intensive services in the CHIP state plan, such as psychosocial treatment, intensive outpatient treatment and/or partial hospitalization, with little to no relief of symptoms. Members may receive residential services in either a residential treatment facility or a hospital setting depending on what setting is more clinically appropriate. For example, a hospital setting has a higher intensity level, such as 24/7 monitoring, compared to a slightly lower level of monitoring in a residential treatment facility. Regardless of the type of setting that residential treatment is provided in, the state considers it to be inpatient care (see Section 6.3.4 above), and the subset of services provided are the same, such as access to a treatment team (that includes the resident, family members, and a multidisciplinary team of providers), group and individual therapies, behavior management, and medication monitoring. Residential treatment services are subject to prior authorization, but there are no hard limits. The state does not

have a waiting list for these services. Coverage is the same for both children and pregnant women.

**6.3.4.2- BH**  Detoxification  
Provided for:  Substance Use Disorder

Detoxification services are covered. Services include counseling, individual and group therapies. Medications and inpatient detox are covered as prescribed and ordered by a physician. Medications are covered within FDA guidelines. All inpatient hospital admissions, except deliveries, require prior authorization. Coverage is the same for both children and pregnant women.

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

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

Includes evaluation, referral, diagnostic, therapeutic, and crisis intervention services performed on an inpatient or outpatient basis (outpatient includes physician offices). Coverage for more than 26 visits is provided with prior medical necessity review. Coverage is the same for both children and pregnant women.

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

Includes evaluation, referral, diagnostic, therapeutic, and emergency services performed on an inpatient or outpatient basis (outpatient includes physician offices). Coverage for more than 26 visits is provided with prior medical necessity review. Coverage is the same for both children and pregnant women. Children’s mobile crisis services response teams are provided by the WVDHHR Bureau for Behavioral Health at family request and WVCHIP covers services resulting from these interventions (ie, hospitalizations, therapies, etc.) as otherwise included in its benefit. The Bureau for Behavioral Health also provides “Children’s Mental Health Wraparound Services” to families to help identify any other agency or community services available for any services that are not included in WVCHIP benefits.

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

Includes evaluation, referral, diagnostic, therapeutic, and crisis intervention services performed on an inpatient or outpatient basis (outpatient includes physician offices).

Coverage for more than 26 visits is provided with prior medical necessity review.

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

These services are typically handled by the treating provider's office. Also, care coordination services are covered when requested as part of another covered benefit. Case management services include care coordination services.

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

Intensive wraparound services are provided by the WV DHHR Bureau for Behavioral Health.

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

Care transition services are provided as necessary. WVCHIP's nurse works directly with members, their families, and healthcare providers to transition care to settings that are included in the benefit. Transitions usually occur when a member newly enrolled in WVCHIP is in an episode of care (course of treatment) that is not typically covered under the plan.

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

WVCHIP's UM vendor provides case management services upon referral through the prior authorization processes, WVCHIP, or member request. The timeframe to follow the member in CM is determined by the reason of the referral. A phone call is made to the member or guardian to obtain Consent to follow in CM. An Initial Assessment is obtained to discuss the needs of the member is physically, mentally, and follow the social deterrents of health. The UM vendor will give the member information r/t transportation; food banks; in network providers; education materials; etc. per member request which is individualized. The member is followed at least monthly via phone call or more as necessary depending on the member needs.

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

## 6.4- BH Assessment Tools

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

- ASAM Criteria (American Society Addiction Medicine)
  - Mental Health
  - Substance Use Disorders

**\*NOTE:** by checking both MH and SUD we mean the Dually Diagnosed population; or singular SUD; ASAM Criteria – Defines criteria for 6 levels of care/placement options; Use of the “ASAM CONTINUUM” assessment leads to match up to one of the 6 Levels of Care; SUD programs across the State and funded by WV DHHR Bureau for Behavioral Health are required to use the ASAM criteria with the bio-psychosocial “ASAM Continuum”; MH – Specific Assessments not required.

- InterQual
  - Mental Health
  - Substance Use Disorders

- MCG Care Guidelines
  - Mental Health
  - Substance Use Disorders

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

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

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

Bureau for Behavioral Health requires use of CANS for Expanded School Mental Health Programs, Children’s Mental Health Wraparound program, Children’s Mobile Crisis Response; Bureau for Children and Families requires CANS in their “Safe at Home WV” program

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

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

WVCHIP requires the ABAS-II or III (functional assessment) for members seeking Applied Behavior Analysis services; Psychiatric Evaluation or Psychological Evaluation is required every 2 years with use of the “Severity Scale” to determine levels of function per DSM5 requirements.

Other (please describe)  
 Mental Health  Substance Use Disorders

No specific criteria or tools are required  
 Mental Health  Substance Use Disorders

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

**6.4.2- BH**  Please describe the state’s strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

WVCHIP partners with other WVDHHR bureaus and programs that concentrate on state level directors identifying clinical “best practice” treatments within their scope of responsibilities. Those partners keep behavioral health specialized providers up to date on clinical guidelines or education on use of “best practice” treatment modalities. Those programs facilitate trainings with certifications. For example, the Bureau for Behavioral Health’s focus on “trauma informed” treatment. Trauma-based screening tools become a part of the program’s “clinical best practice” when a child or adult is exhibiting psychiatric symptoms or school deficits. The Bureau’s grant funded clinical programs will then require a program to be a “trauma-based women’s SUD treatment program” to be awarded funding through that agency. WVCHIP partners with sister agencies within the WVDHHR by recognizing those validated assessment tools for treatments by emphasizing the same in the WVCHIP benefit.

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

All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to

ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

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

**6.2.1-DC**  **State Specific Dental Benefit Package.** The State assures dental services represented by the following categories of common dental terminology (CDT<sup>1</sup>) 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<sup>2</sup> codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

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

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

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

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

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

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



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

- International Classification of Disease (ICD)
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- State guidelines
- Other (Describe: \_\_\_\_\_ )

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

- Yes
- No

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

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

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

- Yes
- No

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

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

**6.2.2.2- MHPAEA** EPSDT benefits are provided to the following:

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

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

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

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

- All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions (Section 1905(r)).
- All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan (Section 1905(r)).
- All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions

discovered by the screening services, whether or not such services are covered under the Medicaid State plan (Section 1905(r)(5)).

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

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

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

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

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

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

### **Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations**

**Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements §457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For**

**example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.**

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

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

**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.

The state sorted all medical/surgical and MH/SUD claims into one of four classifications (inpatient, outpatient, emergency, and Rx) to conduct its parity analysis.

- 1) Inpatient: Facility claims where member was confined to a hospital as evidenced by room and board record.
- 2) Outpatient: Services were further classified into office visits and other outpatient services.
  - a) Outpatient-Office Visits: Professional claims regardless of place of service.
  - b) Outpatient-Other: Facility claims for services not performed in the Emergency Department and no evidence of an inpatient admission.
- 3) Emergency Care: Facility claim for service performed in an emergency room that did not have an associated hospital admission.
- 4) Prescription Drugs: Claims for drugs that require a prescription billed to the Pharmacy Benefit Manager (PBM). This does not include drugs provided in outpatient or inpatient facilities nor physician administered drugs.

Claims were further categorized by the member's enrollment group (Gold, Blue, and Premium) indicating different cost-sharing levels based on family income.

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

Yes

No

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

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

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

**6.2.3.2 MHPAEA** The State assures that:

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

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

### **Annual and Aggregate Lifetime Limits**

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

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

Aggregate lifetime dollar limit is applied

Aggregate annual dollar limit is applied

No dollar limit is applied

**Guidance: If there are no aggregate lifetime or annual dollar limit on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.**

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

Yes (Type(s) of limit: \_\_\_\_\_ )

No

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

**6.2.4.3 – MHPAEA.** States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (457.496(c)).

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

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

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

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

Less than 1/3

At least 1/3 and less than 2/3

At least 2/3

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

Less than 1/3

At least 1/3 and less than 2/3

At least 2/3

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

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

**6.2.4.3.2.1- MHPAEA** If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (§§457.496(c)(4)(i)(B); 457.496(c)(4)(ii)):

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

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

**6.2.4.3.2.2- MHPAEA** If at least 2/3 of all medical/surgical benefits are

subject to an annual or lifetime limit, the State assures either of the following (§457.496(c)(2)(i); (§457.496(c)(2)(ii)):

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

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

### Quantitative Treatment Limitations

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

Yes (Specify:            )

No

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

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

Yes

No

**Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.**

**6.2.5.2- MHPAEA** Within each classification of benefits in which the State applies a type of



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

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

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

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

- Yes
- No

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

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

health or substance use disorder benefits, the State assures:

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

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

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

## Non-Quantitative Treatment Limitations

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

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

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

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

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

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

Yes

No

**6.2.6.2.2- MHPAEA** If yes, please assure the following:

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

### **Availability of Plan Information**

**6.2.7- MHPAEA** The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services.

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

State

Managed Care entities

Both

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

State

Managed Care entities

Both

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

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

**6.3.2.**  The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

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

**6.4.1.**  **Cost Effective Coverage-** Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

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

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

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

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

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

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

- 6.4.2.1. Purchase of family coverage is cost-effective. The State’s cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.
- 6.4.2.2. The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))
- 6.4.2.3. The State assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

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

- Yes
- No

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

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

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

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

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

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

**6.4.3.2.3-PA** If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

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

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

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

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

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

resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

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

Yes  
 No

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

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

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

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

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

## **Section 7. Quality and Appropriateness of Care**

**Guidance:** Methods for Evaluating and Monitoring Quality- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement



purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

**Tools for Evaluating and Monitoring Quality-** Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

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

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using,

for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

- 7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

The West Virginia Children's Health Insurance Program utilizes the Public Employees Insurance Agency's claims processing and utilization management contractor, Wells Fargo, to provide comprehensive quality assurance addressing:

- Appropriateness of care
- Quality of care
- Compliance with immunization schedules; tracking of well-baby and well-child exams
- Provision of case management services to children with special needs
- Exclusion from the WVCHIP provider network of those providers barred from participation in Medicare/Medicaid

Claims Review: From the claims processing standpoint quality and appropriateness of care review, several sources are utilized: Unbundling code review is integrated into the Wells Fargo claims system. This alerts the Claims Examiner as to whether the procedure is coded correctly.

For each claims examiner, a standard set of policies is in place to alert the examiner as to whether a claim needs to be sent to the nurse for review. Wells Fargo also utilizes an over limit review by the nurse for all claims in excess of \$10,000 for inpatient treatment and in excess of \$7,500 for outpatient procedures.

Clinical Review: Wells Fargo performs provider reviews for utilization activities as well as health care patterns. Guidelines and resources provide case managers with evidence and outcome-based tools that ensure the delivery of high quality care in the most appropriate setting. Great West Health Management Guidelines, are the tools utilized to assess quality and appropriateness of care based on national standards. Registered nurses (RN=s) and physician advisors obtain the clinical information from the treating physician using Great West as a guideline and then utilize their medical expertise on a case-by-case basis to determine what is appropriate. If a RN finds the proposed treatment does not fall within the guidelines, the case is then referred to a physician advisor.

WVCHIP will pursue the above objectives through a variety of strategies, including:

- Identification of children with special needs through the pre-certification process, claims review and self-identification by parents and guardians in response to literature sent through the benefit

welcome kit

- Tracking of complaint data received by the toll-free number, the WVCHIP central office, and the contract agencies
- An annual satisfaction survey of parents/guardians
- Through discussions with the health care community via provider workshops, newsletters and periodic contacts with their association representatives
- Through consumer education utilizing newsletters to beneficiary families, information dissemination with outreach workers and public relations activities

On a monthly basis, WVCHIP will receive utilization management reports detailing the top diagnostic categories of CHIP beneficiaries from its third-party administrator for utilization management services, which will better position the program to track trends and facilitate the development of appropriate intervention strategies.

WVCHIP will have access to comparative data. Not only will this data enable the program to better assess its standing in relation to national trends, but it will permit a broader discussion on innovative approaches used elsewhere.

7.1.1.  Quality standards  
The same tools in place for the benchmark-equivalent plan will be used for WVCHIP.

7.1.2.  Performance measurement  
The same tools in place for the benchmark-equivalent plan will be used for WVCHIP.

7.1.2 (a)  CHIPRA Quality Core Set

7.1.2 (b)  Other

7.1.3.  Information strategies

7.1.4.  Quality improvement strategies

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

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

(42CFR 457.495)

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

- Well Child Visits measured for birth through six years of age.
- Well Child Adolescent visits 6 years to 19 years.
- Access to Primary Care Visits measured for children ages 1 to 19 years who had visits coded to primary care services only.
- Dental Visits measured for children ages 2 to 18 who had a dental check-up coded to preventive dental services only.
- Vision Visits measured for children of all ages who received vision services from a physician or ophthalmologist coded for preventive vision services only.
- WVCHIP added the following preventive measures in its 2010 Annual Report:
  - Childhood immunizations for 2 year-olds
  - Adolescent immunizations for 13 years-olds
  - BMI – Nutrition and counseling for ages 2 – 17 years

WVCHIP reports annually on these measures, both in its Annual Framework Report and in the WVCHIP Annual Report submitted to the WV Legislature each year.

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

WVCHIP's utilization manager reviews inpatient stays of WVCHIP children for medical appropriateness.

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

WVCHIP reports HEDIS measures annually on the appropriate treatment of three chronic conditions:

Proper Use of Asthma Medications

- Reports children with persistent asthma enrolled for the prior year and the current annual report period who were prescribed appropriate medication.

Diabetic Care

- Reports the number of children enrolled an entire year with Type 1 and 2 diabetes shown to have had a blood (HbA1c) test; a serum cholesterol level screening; and in eye exam are a screen for kidney disease.

Emotional/Behavioral Conditions

- Follow-up after hospitalization for mental illness – 6 years and older
- Follow-up care for children prescribed ADHD medications

Families are notified of the availability of case management services upon enrollment through their copy of the WVCHIP Summary Plan Description.

Medical case management cases are also identified at the time of pre-admission certification and at all subsequent continued stay reviews Specialists identify potential case management cases as quickly as possible.

Diagnoses identified through the utilization management system that warrant review for chronic, high-cost, or special needs consideration will be referred to an individual case manager who will coordinate care as appropriate. Flagged diagnoses may reflect such conditions as:

- Asthma
- Cerebral Palsy
- Diabetes
- Seizure Disorders
- Leukemia
- Sickle Cell Anemia
- Emotional/Behavioral Conditions

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

The third party administrator assures that all decisions for prior authorizing health services are made within 14 days of receipt of a request for the services.

**Section 8. Cost-Sharing and Payment**

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

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

**8.1.1.**  Yes

8.1.2.  No, skip to question 8.8.

8.1.1-PW  Yes

8.1.2-PW  No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

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

Disaster Relief: At the State's discretion, copayments and/or monthly premiums may be waived for WVCHIP members who reside and/or work in State or Federally declared disaster areas.

8.2.1.  Premiums:

YES – Pregnant women and children in families with incomes >211% FPL based on net income are charged a monthly premium. There is a two-tier premium structure: families with one enrolled child and families with two or more enrolled children. Pregnant women will pay \$35 per month in premium. Eligible pregnant women have no other cost share under the plan. See table below.

WVCHIP Premiums		
Enrolled Children per household	Monthly Premium	Annual Premium Cost
1	\$35.00	\$420.00
2 or More	\$71.00	\$852.00
Pregnant Women	\$35.00	\$420.00

Non-payment of premiums does not result in loss of CHIP eligibility.

8.2.2.  Deductibles:

8.2.3.  Coinsurance or copayments:

As described below.

There are no copayments for pregnancy or maternity related services. There are no copayments for pregnant women covered under WVCHIP.

#### Copayments Under WVCHIP's Plan

##### A) Pharmacy Benefits Copayments

All WVCHIP families participate in a two tier copayment structure for pharmacy benefits under the Plan. Copays are assessed according to family net (i.e. gross income minus Medicaid deductions described in Section 4.3.) income level as follows:

ABOVE 200% FPL net income:

\$0 for generic prescription drugs

\$15 for formulary brand drugs

(As amended 1/1/2007)

ABOVE 150% FPL net income:

\$0 for generic prescription drugs

\$10.00 for formulary brand drugs

(As amended 1/1/2006)

BELOW 150% FPL net income:

\$0 for generic prescription drugs

\$5.00 for formulary brand drugs

(As amended 1/1/2006)

##### B) Non-Well Visit Copayments

#### Non Well Physician Visits Schedule

All enrollees who do not designate a medical home pay a graduated copayment for non-well physician visits as follows:

Enrollees at and under 150% FPL net income levels: \$5.00 per visit  
(waived when visit is to enrollee's designated medical home)

Enrollees above 150% FPL net income levels: \$15.00 per visit

(waived when visit is to enrollee's designated medical home)

Enrollees above 200% FPL net income levels: \$20.00 per visit  
(waived when visits are to enrollee's designated medical home)

C) Other Medical Benefit Copayments Schedule for Enrollees Above 150% FPL Net Income Levels

Inpatient Service	\$25.00 per admission
Outpatient Service	\$25.00 per procedure
Emergency Room	\$35.00 per visit (waived when admitted)
Dental Services	\$25.00 per non-preventive procedures capped at \$100 per year per member or \$150 per year per family; applies to enrollees with net incomes over 200% FPL
Vision Services	\$0
Preventive Services	\$0

MAXIMUM COPAYMENT LIMITS FOR FAMILIES AT AND UNDER 200% FPL NET INCOMES

Maximum limits for all pharmacy and medical copayments imposed by the Plan are set as follows:

One Child Family: \$100 prescription maximum; \$150 medical maximum  
Two Child Family: \$200 prescription maximum; \$300 medical maximum  
Three or More Child Family: \$300 prescription maximum; \$450 medical maximum

MAXIMUM COPAYMENT LIMITS FOR FAMILIES ABOVE 200% FPL NET INCOMES

Maximum limits for all pharmacy and medical copayments imposed by the Plan are set as follows:

One Child Family: \$150 prescription maximum; \$200 medical maximum  
Two Child Family: \$250 prescription maximum; \$400 medical maximum  
Three or More Child Family: \$350 prescription maximum; \$600 medical maximum

8.2.4.  Other:

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



457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS  Premiums:

8.2.2-DS  Deductibles:

8.2.3-DS  Coinsurance or copayments:

8.2.4-DS  Other:

- 8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))  
The State informs the public and individuals of cost sharing amounts and any changes to these amounts, including cumulative maximums, through its application form, printed posters available in clinics and other outreach sites, on its website at [www.chip.wv.gov](http://www.chip.wv.gov), and to individual participants who receive a Summary Plan Description (SPD) on enrolling and at the time of re-enrollment. Plan participants are notified at least 30 days in advance of proposed changes to cost sharing and asked for comments. Comments are reviewed by the Children’s Health Insurance Board prior to approving proposed changes

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

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

8.4.1.  Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2.  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3  No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.4.1- MHPAEA  There is no separate accumulation of cumulative financial requirements, as defined in §457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits (§457.496(d)(3)(iii)).

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

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

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

Yes (Specify: Copayments are required for brand drugs, multi-source drugs, non-medical home visits, inpatient visits, outpatient surgeries, ER services, and some dental services.)

No

**Guidance: If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.**

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

Yes

No

**Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.**

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

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

**Guidance: Please include the state's methodology as an attachment to the State**

**child health plan.**

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

Yes

No

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

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

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

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

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

**8.5.** Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family’s income for the length of the child’s eligibility

period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

The State (WV) assures that the total cost of premiums and copayments (as described in Sections 8.2.1. and 8.2.3. respectively) do not exceed 5% of a family’s total annual income as shown in the tables below:

A) Single Child Family Annual Premium/Copayment Maximum Cost  
(as a % of family income levels)

Family Size	At or Under 200% FPL			Over 200% FPL				
	Max. Copay	Income	Exp %	Annual Premium	Max. Copay	Total Exp	Income	Exp %
2	\$250	\$29,420	0.8%	\$420	\$450	\$870	\$44,130	1.9%
3	\$250	\$37,060	0.7%	\$420	\$450	\$870	\$55,590	1.6%
4	\$250	\$44,700	0.6%	\$420	\$450	\$870	\$67,050	1.3%

B) Two Child Family Annual Premium/Copayment Maximum Cost  
(as a % of family income levels)

Family Size	At or Under 200% FPL			Over 200% FPL				
	Max. Copay	Income	Exp %	Annual Premium	Max. Copay	Total Exp	Income	Exp %
3	\$500	\$37,060	1.3%	\$852	\$800	\$1,652	\$55,590	2.9%
4	\$500	\$44,700	1.1%	\$852	\$800	\$1,652	\$67,050	2.5%
5	\$500	\$52,340	0.9%	\$852	\$800	\$1,652	\$78,510	2.1%

C) Three or More Child Family Annual Premium/Copayment Maximum Cost  
(as a % of family income levels)

Family Size	At or Under 200% FPL			Over 200% FPL				
	Max. Copay	Income	Exp %	Annual Premium	Max. Copay	Total Exp	Income	Exp %
4	\$750	\$44,700	1.7%	\$852	\$1,100	\$1,952	\$67,050	2.9%
5	\$750	\$52,340	1.4%	\$852	\$1,100	\$1,952	\$78,510	2.5%
6	\$750	\$59,980	1.3%	\$852	\$1,100	\$1,952	\$89,970	2.2%

D) Pregnant Women’s Coverage >211% FPL - \$35 per month premium; no copayments

Pregnant Women	Under 211% FPL	Over 211% FPL				
	No cost-share	Annual	Max	Total		

		Premium	Copay	Exp.	Income	Exp. %
		\$420	\$0	\$420	\$44,130	0.9%

The State assures that families are exempt from cost sharing upon reaching the maximum co-pays through processes administered by separate medical and pharmacy benefit managers:

Medical Plan Process

The claims processing systems used by WVCHIP’s third party administrator (TPA) tracks co-payments as claims are processed by accumulating co-payment amounts on a per patient basis. For families with more than one child, individual children are linked to the family group through a number assigned to the parent/guardian in order to track the family cap. Should a provider attempt to collect a co-payment when the parent/guardian knows the cap has been met, the provider may verify the accumulated amount from an available “fax back” system in which the provider calls a toll-free number. After entering the patient’s ID number, a form with the applicable co-payment is faxed to the provider. Another option is that, upon reaching the maximum, the parent/guardian may use their Explanation of Benefits form, generated by the TPA, to show a provider that their co-pay cap has been met. WVCHIP’s TPA assures that medical and dental claims which are procedure code specific to well-baby, well child, and preventive dental visits, or other preventive services such as immunizations, have no copayments through its claims billing system. The claims processor maintains a separate subgroup file for those enrollees at and under 150% net FPL to assure that copayments amount no higher than those permitted under 457.555 are allowed. WVCHIP also assures that its members are aware of this through its program materials.

Prescription Plan Process

The Pharmacy Benefit Manager similarly tracks co-pays through an electronic Point of Sale (POS) system, which is accumulated as each prescription is filled. Upon reaching the cap, the message is conveyed to individual pharmacies through the POS that no co-pay is due, and none is collected.

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

WVCHIP will notify applicants that membership in designated tribes excludes families from cost sharing. Applications can be obtained through a toll-free telephone line for the WVCHIP Call Center or Helpline. Although West Virginia does not have any designated tribes, the Call Center will maintain a list of designated tribes in case applicants do not know if their tribe is a designated tribe. Applicants so choosing to identify themselves as members of a designated tribe will then be issued a card indicating they are exempt from co-pays. When beneficiaries disclose designated tribal membership, it will be accepted

unless it is questionable.

- 8.7.** Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))  
See form CS21

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

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

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

- 8.7.1.1.**  State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- 8.7.1.2.**  The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
- 8.7.1.3.**  In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- 8.7.1.4**  The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

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

- 8.8.1.**  No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2.**  No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3.**  No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this

obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

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

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

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

## **Section 9. Strategic Objectives and Performance Goals and Plan Administration**

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))
1. Expand eligibility to uninsured children from birth through age 18 years whose incomes exceed the limit for Medicaid eligibility up to and including 250% FPL gross household income limit.
  2. Identify previously uninsured children from birth through age 18 years who are potentially eligible for West Virginia's Title XXI Program through ongoing and new outreach activities.
  3. Children who are enrolled in West Virginia's Title XXI Program will have a designated source of primary health care.
  4. West Virginia's Title XXI Program will result in the improved health of children enrolled in the program by focusing on preventive measures as well as the management of chronic diseases or conditions.

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

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

Performance Goal/Objective 1:

Title XXI benefits will be utilized by the current 24,000+ enrollees as well as the additional children found eligible under the expansion to the 300% FPL gross income limit. Existing data systems and processes will be leveraged for the processing of program applications, recipient information, service utilization, billing, and provider information.

Performance Goal/Objective 2:

WVCHIP has an annual plan for ongoing outreach efforts and for new initiatives that are to be implemented each year. Outreach activities such as those specified in Section 2.2.2. will be in place.

Performance Goal/Objective 3:

All children who are eligible for West Virginia's Title XXI program will have sufficient access to primary care providers that are willing to operate as medical homes.

Performance Goal/Objective 4:

WVCHIP will promote the concept of Patient-Centered Medical Homes in written guidelines to its consumers and in participation in statewide planning activities with other payers as it relates to this concept.

Performance Goal/Objective 5:

Over time, West Virginia will show increased access and usage of health care services by children from birth through age 18 through HEDIS data and utilization measures. This data will reflect increases in well-child visits and other preventive and access measures until optimum levels are reached. Other outcome data will be developed as necessary to track quality and/or access.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that



State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))
- Performance Goal 1 is measured by comparing annual Title XIX and Title XXI enrollment levels to population levels of eligible children using available CPS data.
  - Performance Goal 2 is measured by the review of ongoing monthly enrollment and re-enrollment reporting data comparing the current six months to the prior six months and 12 months and revising outreach activity annually based on these data..
  - Performance Goal 3 is measured by medical home selection data quarterly and annually.
  - Performance Goal 4 is a qualitative goal that will be assessed through written reports of its activities until there is implementation activity that leads to more measurable goals.
  - Performance Goals 3 and 4 also use an annual review of 7 different HEDIS measures as reported in the Annual Framework Report to assess access and the progress of medical homes toward a true integrated model.

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

- 9.3.1.  The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2.  The reduction in the percentage of uninsured children.
- 9.3.3.  The increase in the percentage of children with a usual source of care.
- 9.3.4.  The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5.  HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6.  Other child appropriate measurement set. List or describe the set used.
- 9.3.7.  If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1.  Immunizations
  - 9.3.7.2.  Well childcare
  - 9.3.7.3.  Adolescent well visits

- 9.3.7.4.  Satisfaction with care
- 9.3.7.5.  Mental health
- 9.3.7.6.  Dental care
- 9.3.7.7.  Other, list:

9.3.8.  Performance measures for special targeted populations.

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

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

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

Under State law, West Virginia must provide to the State Legislature, on at least a quarterly basis, statistical data on the Children’s Health Insurance Program which will reflect the total number of children enrolled as a result of the expansion, breakdown by age, the average annual cost of coverage per recipient, and the total cost of these services by provider .

West Virginia will also produce reports on a quarterly basis outlining the number of well-child visits, immunizations, emergency visits, and mental health visits. These services will be broken down by provider specialty and will be compared to access standards for the overall Medicaid child population.

State-adopted legislation (W.Va. Code §9-4A-2b) requires that a report be made to the Governor and the State Legislature regarding outreach activities and the quality and effectiveness of the health care delivered to children in the program. Satisfaction surveys and health status indicators are required. Statistical profiles of the families served shall be included.

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

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

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

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

9.8.1.  Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2.  Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3.  Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4.  Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

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

WVCHIP Insurance Board meetings are held approximately four times a year. WVCHIP provides notice of Board meetings according to State law through the Secretary of State's Office. During each Board meeting, time is allotted for public comment and inquiry.

Comments are solicited in writing from interested and affected persons.

The WVCHIP state plan amendments are placed in each of the DHHR County offices inviting public comment. Public notice of the state plan amendments will be posted in local Social Security offices.

In addition, press releases are sent to all major daily newspapers in the State.

Providers are notified of plan changes through a quarterly newsletter published by the Public Employees Insurance Agency, the state health insurance agency.

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

West Virginia has no Federal or State recognized tribes. Public hearings and WVCHIP Board meetings are open to all Native American and advocacy organizations, and these groups are included in advance notice of public meetings and invited to participate in the ongoing design of the program.

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

West Virginia has no Federal or State recognized tribes. Public hearings and WVCHIP Board meetings are open to all Native American and advocacy organizations, and these groups are included in advance notice of public meetings and invited to participate in the ongoing design of the program.

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

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

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
  
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.

- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

This SUPPORT Act SPA is not expected to have any impact on WVCHIP’s budget as these services are already covered in the benefit.

### CHIP Budget

STATE: WV	FFY Budget
<b>Federal Fiscal Year</b>	
State’s enhanced FMAP rate	
<b>Benefit Costs</b>	
Insurance payments	
Managed care	
<u>per member/per month rate</u>	
Fee for Service	
<b>Total Benefit Costs</b>	
(Offsetting beneficiary cost sharing payments)	
<b>Net Benefit Costs</b>	
<b>Cost of Proposed SPA Changes – Benefit</b>	
<b>Administration Costs</b>	
Personnel	
General administration	
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	
Other	
<b>Total Administration Costs</b>	
10% Administrative Cap	
<b>Cost of Proposed SPA Changes</b>	
Federal Share	
State Share	
<b>Total Costs of Approved CHIP Plan</b>	

**NOTE: Include the costs associated with the current SPA.**

**The Source of State Share Funds: State general appropriations****Section 10. Annual Reports and Evaluations**

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at <http://www.nashp.org>. Per the title XXI statute at Section 2108(a), states must submit reports by January 1<sup>st</sup> to be compliant with requirements.

- 10.1. Annual Reports.** The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)
- 10.1.1.**  The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and
- 10.2.**  The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))
- 10.3.**  The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.
- 10.3-DC**  The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

**Section 11. Program Integrity (Section 2101(a))**

- Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.
- 11.1.**  The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that

are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

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

- 11.2.1.  42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2.  Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3.  Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4.  Section 1128A (relating to civil monetary penalties)
- 11.2.5.  Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6.  Section 1128E (relating to the National health care fraud and abuse data collection program)

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

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

**12.1. Eligibility and Enrollment Matters-** Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant’s rights when the State is using the Express Lane option when determining eligibility.  
[All WVCHIP applicants and participants have the right of appeal through the same fair hearing process that is utilized by Medicaid participants for eligibility and enrollment matters.](#)

Guidance: “Health services matters” refers to grievances relating to the provision of health care.

**12.2. Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.  
[WVCHIP has a Program Specific Review Process for health services matters that assures the participant’s right of appeal. Plan participants are informed of the appeals process through written materials describing the program and covered benefits \(the Summary Plan Description\) that each participant receives upon enrollment. In addition, written notice of the appeals process is provided to affected individuals within 5 days of decisions subject to review. These written materials inform participants that they may appeal any health service matter involving the delay, denial, reduction, suspension or](#)

termination of a covered service, including a determination of the type or level of services, or a failure to approve or furnish or provide payment for health services in a timely manner.

EXCEPTION: Plan participants are informed that 1) Matters pertaining to eligibility or enrollment are exempt from review through this process. Nor 2) Any matter or issue which can only be remedied through a change in provisions through the State Plan, Federal or State laws requiring a) an automatic change in eligibility or enrollment or b) a change in coverage as described in this benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

Step 1: INFORMAL FACT FINDING

Plan participants may initiate appeals regarding claims or service denial by contacting the appropriate third party administrator through a toll-free number to verify whether or not a mistake has been made. All appeals must be initiated within 60 days of the participants' learning of the health services matter at issue.

Step 2: WRITTEN RESPONSE BY THE THIRD PARTY ADMINISTRATOR

Plan participants who disagree with the determination made by the third party administrator at the first step may then appeal in writing within 60 days of the participant's learning of the health services matter at issue, to the appropriate third party administrator by explaining what the problem is and why they disagree with the first step determination. The third party administrator must respond by either reprocessing the claim for payment issues (if that is the resolution) or sending a letter to the plan participant explaining what actions they are prepared to take or the basis for their action. For all complete case files, a written or processed claim, or Explanation of Benefits statement response will be made within 30 days. The case file is considered complete when the participant has provided documentation pertaining to the health services matter at issue, but not longer than 90 days (except by mutual agreement of the parties).

Step 3: REVIEW BY WVCHIP'S EXECUTIVE DIRECTOR

For issues not resolved at the second step, the third step is to appeal in writing within 60 days of receiving the written decision of the third party administrator to the Executive Director of the West Virginia CHIP.

Plan participants are asked to provide written statements of facts, issues, letters, explanation of benefits and all other information pertinent to the case. Participants may represent themselves or have an authorized representative at each step. The Director will render a written decision to the insured or his/her authorized representative, taking into account all materials presented at the third step, and explain the reason, and whether the original disposition of the claim/denial to be either upheld or modified. For all complete



case files, response is made within 30 days. For issues of appeal regarding clinical/medical matters, the Executive Director may consider a physician review by the Medical Director. The Medical Director is the same individual who serves as Medical Director for the Public Employees Insurance Agency.

For those cases involving emergency conditions where the standard time frame could seriously jeopardize the enrollee's life or health or ability to retain or regain maximum function, an expedited review may take place within 72 hours (or up to a maximum of 14 days, if the enrollee requests an extension). After initiating the first step appeal, participants may go directly to the third step for resolution if necessary.

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

WVCHIP does not participate in premium assistance programs.

### **Key for Newly Incorporated Templates**

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

**CMS Regional Offices**

<b>CMS Regional Offices</b>	<b>States</b>		<b>Associate Regional Administrator</b>	<b>Regional Office Address</b>
Region 1- Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal <a href="mailto:richard.mcgreal@cms.hhs.gov">richard.mcgreal@cms.hhs.gov</a>	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2- New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez <a href="mailto:michael.melendez@cms.hhs.gov">michael.melendez@cms.hhs.gov</a>	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3- Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher <a href="mailto:ted.gallagher@cms.hhs.gov">ted.gallagher@cms.hhs.gov</a>	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4- Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze <a href="mailto:jackie.glaze@cms.hhs.gov">jackie.glaze@cms.hhs.gov</a>	Atlanta Federal Center 4 <sup>th</sup> Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5- Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson <a href="mailto:verlon.johnson@cms.hhs.gov">verlon.johnson@cms.hhs.gov</a>	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6- Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks <a href="mailto:bill.brooks@cms.hhs.gov">bill.brooks@cms.hhs.gov</a>	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7- Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott <a href="mailto:james.scott1@cms.hhs.gov">james.scott1@cms.hhs.gov</a>	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8- Denver	Colorado Montana North Dakota Dakota	South Dakota Utah Wyoming	Richard Allen <a href="mailto:richard.allen@cms.hhs.gov">richard.allen@cms.hhs.gov</a>	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9- San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle <a href="mailto:gloria.nagle@cms.hhs.gov">gloria.nagle@cms.hhs.gov</a>	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103

Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly <a href="mailto:carol.peverly@cms.hhs.gov">carol.peverly@cms.hhs.gov</a>	2001 Sixth Avenue MS RX-43 Seattle, WA 98121
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## **GLOSSARY**

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term ‘child health assistance’ means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and pre-pregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
  - a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
  - b. performed under the general supervision or at the direction of a physician, or
  - c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

**TARGETED LOW-INCOME CHILD DEFINED-** For purposes of this title--

1. **IN GENERAL-** Subject to paragraph (2), the term ‘targeted low-income child’ means a child--
  - a. who has been determined eligible by the State for child health assistance under the State plan;
  - b. (i) who is a low-income child, or  
(ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
  - c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. **CHILDREN EXCLUDED-** Such term does not include--
  - a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
  - b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. **SPECIAL RULE-** A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. **MEDICAID APPLICABLE INCOME LEVEL-** The term ‘Medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical

assistance under Section 1902(1)(2) for the age of such child.

5. **TARGETED LOW-INCOME PREGNANT WOMAN.**—The term ‘targeted low-income pregnant woman’ means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

**ADDITIONAL DEFINITIONS-** For purposes of this title:

1. **CHILD-** The term ‘child’ means an individual under 19 years of age.
2. **CREDITABLE HEALTH COVERAGE-** The term ‘creditable health coverage’ has the meaning given the term ‘creditable coverage’ under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. **GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC-** The terms ‘group health plan’, ‘group health insurance coverage’, and ‘health insurance coverage’ have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. **LOW-INCOME CHILD -** The term ‘low-income child’ means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. **POVERTY LINE DEFINED-** The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. **PREEXISTING CONDITION EXCLUSION-** The term ‘preexisting condition exclusion’ has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. **STATE CHILD HEALTH PLAN; PLAN-** Unless the context otherwise requires, the terms ‘State child health plan’ and ‘plan’ mean a State child health plan approved under Section 2106.
8. **UNINSURED CHILD-** The term ‘uninsured child’ means a child that does not have creditable health coverage.