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

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

State/Territory:_____**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)),

_____ _____
Daniel Carey, M.D., Secretary of Health and Human Resources **Date Signed**
Commonwealth of Virginia

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

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

Name: **Daniel Carey, M.D.** Title: **Secretary of Health and Human Resources**
Name: **Karen Kimsey** Title: **Director, Department of Medical Assistance Services**
Name: **Cindy Olson** Title: **CHIP Director**

*Disclosure. In accordance with the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10393 #34). The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements

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

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

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

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

Effective 09/01/02.

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. (42 CFR 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: 10/26/98; Implementation Date: 10/26/98

Amendment Effective Dates: Amend. 1: 07/01/01. Amend. 2: 12/01/01. Amend. 3: 7/01/01. Amend. 4: 09/01/02. Amend. 5: 08/01/03. Amend. 6: Withdrawn.

Amend. 7: delete ESHI premium assistance program and exempt pregnant children from waiting period 08/01/05; allow for disease management in fee-for-service program 07/01/06. Amend. 8: Changes to the CHIP State Plan to outline coverage of school services and to add language regarding private funding. Amend. 9: FAMIS MOMS to 200% FPL and MCO opt in 07/01/09; Medicaid Expansion Immigrants 04/01/09. Amend. 10: Translation for Dental Care 07/01/09; Hospice Concurrent with Treatment 03/23/10; Early Intervention and prospective payment for FQHCs and RHCs 10/01/09; Citizenship Documentation 01/01/10; Mental Health Parity and No Cost Sharing for Pregnancy-Related Assistance 07/01/10. Amend. 11: Administrative Renewal Process 10/01/10; Virginia Health Care Fund 07/01/10.

Amendment Implementation Dates: Amend. 1: 08/01/01; Amend. 2: 12/01/01; Amend. 3: 12/01/01; Amend. 4: 09/01/02; Amend. 5: 08/01/03; Amend. 6: Withdrawn; Amend. 7: 07/01/06; Amend. 8: 07/01/07, and 02/14/09 implementation date of language regarding the RWJ Grant funding and private funding; Amend. 9: 07/01/09, and Medicaid Expansion Immigrants: 04/01/09; Amend. 10: Translation for Dental Care: 07/01/09; Hospice Concurrent with Treatment: 03/23/10; Early Intervention and prospective payment for FQHCs and RHCs: 10/01/09; Citizenship Documentation: 01/01/10; and Mental Health Parity, No Cost Sharing for Pregnancy-Related Assistance, and Virginia Health Care Fund: 07/01/10. Amend. 11: Administrative Renewal Process: 10/01/10; and Virginia Health Care Fund: 07/01/10. Amend. 12: Discontinue primary care case management: 05/01/12; Expand eligibility under lawfully residing option: 07/01/12; Add coverage for early intervention case management: 10/01/11; and Discontinue Virginia Health Care Fund funding: 07/01/12. Amend. 13: Outreach Procedures 07/01/12; and Performance Plan: 07/01/12. Amend. 14: Delivery system change (Sec. 6 and 12) Behavioral Health Service Administrator: 01/01/14

List continues after table below.

Transmittal Number	SPA Group	PDF	Description	Superseded Plan Section(s)
VA-13-15 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS13	Eligibility – Targeted Low Income Children Eligibility - Deemed Newborns	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Incorporate under section 4.3

Transmittal Number	SPA Group	PDF	Description	Superseded Plan Section(s)
VA-14-0020 Effective/Implementation Date: January 1, 2015		CS15 CS10	MAGI-Based Income Methodologies Eligibility – Children Who Have Access to Public Employee Coverage	Incorporate within a separate subsection under section 4.3 Supersedes language in regard to dependents of public employees in Section 4.1.9
VA-14-0002 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
VA-14-0025 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within subsection 4.4.1
VA-13-0018 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
VA-13-19 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS23	Non-Financial Eligibility – Residency Non-Financial – Citizenship Non-Financial – Social Security Number Other Eligibility Standards	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1.1-LR Supersedes the current section 4.1.9 Supersedes the current section 4,1.6, 4.1.7, 4.1.8, 4.1.9

Transmittal Number	SPA Group	PDF	Description	Superseded Plan Section(s)
VA-13-19-01 Effective/Implementation Date: July 3, 2014		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
VA-21-0021 Effective/Implementation Date: July 1, 2021	MAGI Eligibility & Methods Non-Financial Eligibility	CS9 CS27	Coverage from Conception to Birth Continuous Eligibility	

SPA #15
Purpose of SPA: Update for SFY 2015
Effective date: 07/01/14
Implementation dates:
Remove waiting period for eligibility: 07/03/14; Allow eligibility for dependents of state employees: 01/01/15

SPA #16
Purpose of SPA: Update for SFY 2016
Effective date: 07/01/15
Implementation date:
Benefits - add Behavioral Therapy services: 07/01/16

SPA #17
Purpose of SPA: Temporary Adjustments to Enrollment and Redetermination for Individuals Living or Working in a Declared Disaster Area at the Time of a Disaster Event.
Effective date and implementation date: 01/01/17

SPA #VA-17-0012
Purpose of SPA: Update for SFY 2017
Effective date: 7/1/16
SUD amendments (not including peer supports) have an implementation date of 04/01/17.
All other items (including peer supports) have an implementation date of 07/01/17.

SPA #VA-18-0012
Purpose of SPA: Compliance with Mental Health Parity and Addiction Equity Act - Effective and implementation date 07/01/17;
Removal of Outpatient Behavioral Health Co-payments – Effective and implementation date 07/01/19

SPA #VA-19-0010
Purpose of SPA: Update for SFY 2019; Managed Care Final Rule Compliance Assurances; Technical Updates
Effective and implementation date: 07/01/18

SPA #VA-20-0001
Purpose of SPA: CHIP Disaster Relief – Temporary Waiver of Co-payments; Flexibilities Related to Processing and Renewal Requirements for State or Federally Declared Disaster Area
Effective date: 01/01/2020
Implementation date: 03/12/2020

SPA #VA-20-0015 -- PENDING
Purpose of SPA: Update for SFY2020; SUPPORT Act Section 5022 Compliance
Effective and implementation date: 10/24/19

SPA #VA-21-0010
Purpose of SPA: Health Services Initiative – Poison Control Centers
Effective and implementation date: 7/1/21

SPA #VA-21-0027
Purpose of SPA: Extend coverage for unborn children whose mothers are uninsured pregnant women up to 200% FPL not otherwise eligible for Medicaid, FAMIS MOMS, or FAMIS, regardless of immigration status requirements; Fund a Health Services Initiative to provide fee-for-service health services up to 60 days postpartum to mothers covered under the unborn child option, called FAMIS Prenatal.
Effective and implementation date: 07/01/21

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.

On April 29, 2021, prior to the submission of this SPA, a Tribal notification letter was sent to representatives of each of Virginia's seven federally recognized

Indian Tribes, as well as to contacts at the Indian Health Program (IHP) office, describing the provisions of the SPA and notifying Tribal and IHP officials of the 30-day Tribal comment period. Tribal members and IHP contacts were invited to provide input on the SPA, and contact information was provided for submitting any comments to DMAS. Virginia does not anticipate that this SPA will impact the Tribes or IHP differently than other residents of the Commonwealth.

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

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

The Virginia Health Care Foundation conducted two surveys of health access in Virginia. The latest survey was conducted in the Spring of 1997 for the year 1996 of a representative sample of 1,861 households representing 4,694 individuals. The Department of Medical Assistance Services (DMAS) used estimates derived from this survey and census data for its planning purposes rather than from the national Current Population Survey. DMAS' administrative data were used to estimate Medicaid insured children.

HEALTH INSURANCE STATUS OF VIRGINIA CHILDREN 0-18, BY POVERTY LEVEL 1996

	Insured			Uninsured			
Poverty Level	Medicaid	Private	Total Insured	Medicaid Eligible	Other Uninsured	Total Uninsured	Total Children
Under 100%	206,550	2,430	208,980	34,020	0	34,020	243,000
100% to 125%	33,450	3,570	37,020	10,980	9,000	19,980	57,000
125% to 150%	31,500	4,860	36,360	12,920	12,720	25,640	62,000
150% to 175%	37,500	9,140	46,640	22,080	17,280	39,360	86,000
175% to 200%	6,000	44,000	50,000	2,000	33,000	35,000	85,000
200% to 250%	0	57,000	57,000	0	20,000	20,000	77,000
Above 250%	0	979,000	979,000	0	40,000	40,000	1,019,000
Totals	315,000	1,100,000	1,415,000	82,000	132,000	214,000	1,629,000

DMAS assumes that insured/uninsured individuals are evenly distributed by age below 100% of poverty. Above 100% of poverty, more of the uninsured are ages 6 through 18. Virginia Medicaid covers children 0 through 5 up to 133% and covers children ages 6 through 18 up to 100% of poverty. Effective 9/01/02, Virginia's Medicaid program was expanded through Title XXI to cover additional targeted low-income children ages 6 through 18 with family income equal to or less than 133% of FPL. Effective January 1, 2014, this changed to 143% of FPL.

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)

Postpartum Services

Virginia will use additional CHIP funds, up to 10 percent of federal CHIP expenditures (after administrative costs for the CHIP populations), for other child health assistance as authorized under § 2105(a)(2) of the Act. Such assistance will provide for the payment of 60 days postpartum services, for services that are provided on a fee-for-service basis to mothers of children covered under FAMIS Prenatal, the unborn child option. The FAMIS Prenatal program's benefit package is the same as that provided under the FAMIS MOMS CHIP 1115 Demonstration, which reflects the Medicaid state plan covered benefits for pregnant women, with the exception of long-term services and supports (LTSS). Enrollees with FAMIS Prenatal coverage will be provided continuous eligibility for the entire 60-day postpartum period.

The Commonwealth assures that 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. The Commonwealth assures that it will report annually on metrics regarding how the HSI improves the health of low-income children.

Poison Control Centers

As permitted under Section 2105(a)(1)(D)(ii) of the Social Security Act and federal regulations at 42 CFR 457.10, Virginia will establish a health services initiative (HSI) that will use CHIP funds, within the 10 percent federal administrative expenditures cap allowed for states, to support Virginia's poison control centers.

Virginia is served by three poison control centers—Virginia Poison Center, Blue Ridge Poison Center, and National Capital Poison Center. Virginia's poison control centers work collaboratively to provide 24-hour, immediate response to acute and chronic poisoning. Specialists in poison information (healthcare professionals with special training in toxicology) triage and respond to poisonings and inquiries from the public and healthcare providers. Each center has board-certified clinical toxicologists immediately available to assist with complicated cases or to consult with clinicians at the bedside.

Comprehensive education programs include didactic and clinical teaching to students, resident and fellow house-staff and physicians in pediatrics, emergency medicine and other specialties; in FY2020, 522 professional education programs were delivered, and 735 healthcare students and providers received on-site training by the poison centers.

The poison control centers' community-based outreach targets caregivers of children, since children are at highest risk of unintentional poisoning. Outreach is also targeted to medically underserved areas of the Commonwealth. In FY2020, Virginia's poison centers were represented at 194 health fairs and disseminated 827,424 poison prevention materials, the majority of which targeted pediatric poisoning. Due to COVID-19, many outreach efforts transitioned to social and digital media, including 813,218 social media contacts and 11,002,766 website page encounters in FY2020. Examples of outreach campaigns specifically targeting children and underserved communities include:

- **PoisonHelp kits (poison prevention advice, poison hotline magnets, face masks) were included with Richmond Public Schools meal distribution.**
- **A poison center educator led a youth development committee for a Rural Substance Abuse Awareness Coalition that put on a virtual conference that reached 2,500 parents and youth.**
- **Centers provided targeted social media outreach to Spanish-speaking communities; the largest event, "Conversaciones en Espanol" reached 2,500 people.**
- **Centers worked with the Hanover County Cares Coalition to focus on OTC medication safety in Latinx youth.**

In 2019, Virginia's poison control centers responded to 68,000 calls for assistance, 61,700 of which were human poisoning exposures. Of these calls, 56 percent of cases involved children. Seventy-five percent of all pediatric cases were safely managed at the site of exposure, as opposed to a health care facility. If the poison center was called prior to any other action (e.g., calling 911 or self-referral to a hospital), then 90 percent of children were safely managed by the poison center, thereby preventing unnecessary emergency care. As these statistics demonstrate, most children with accidental poisoning can be safely managed by poison centers, preventing unnecessary 911 calls and emergency department visits. Prior studies indicate that up to 50 percent of callers would self-refer to an ED if a poison center was not available. According to research by the American Association of Poison Control Centers (AAPCC), poison centers save $1.8 billion annually in medical costs in the United States. Costs are saved by managing poisonings at home and reducing unnecessary ambulance rides, hospital days, and hospital transfer costs. Virginia estimates that in 2019 at least 12,000 pediatric ED visits were averted. Assuming an average cost of $1,000 (facility plus physician fee), prevention of 12,000 ED visits results in a conservative estimate of $12 million in annual savings to the Commonwealth.

According to U.S. Census Bureau American Community Survey estimates, approximately 31.5 percent of Virginia children are in households with incomes at or below 200% FPL. Applying these percentages to pediatric cases handled by Virginia's Poison Control Centers, the Centers serve an estimated 10,350 low-income children per year.

Virginia's 2020 Appropriations Act allocates a combined $2.5 million in state general funds and federal funds for the poison control centers starting in state fiscal year 2022, and directs DMAS to establish a HSI for the poison control centers to draw down CHIP federal matching funds at Virginia's enhanced FMAP, effective July 1, 2021.

Total CHIP HSI funding to the Poison Control Centers (combined federal and state) will not exceed the share of the centers' budgets that goes toward providing services to children. This maximum amount is calculated by applying the percentage of calls involving children 0-18 in the most recent year for which data is available (e.g., 56% in 2019) to the combined total budgeted expenditures for the three centers. Subject to this cap, the amount allocated in the state budget will be distributed among the three centers using the state's established methodology, i.e., based on each center's share of total statewide call volume from the most recent annual report. Only Virginia calls are included in the totals.

HSI funding is only available to the extent that funds remain under the state's 10% CHIP administrative cap after accounting for all CHIP administrative expenses. The Commonwealth assures that 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.

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.

Virginia uses a managed care delivery system for the entire CHIP population; however, children in FAMIS and pregnant individuals in the FAMIS Prenatal program are in fee-for-service during the brief initial period before they are enrolled in a managed care plan (several weeks).

Effective July 1, 2021, Virginia added FAMIS Prenatal coverage through the unborn child option for uninsured pregnant women with income from 0 to 200% FPL not otherwise eligible for Medicaid, FAMIS, or FAMIS MOMS, regardless of immigration status requirements. The unborn child option population will receive services through Medicaid managed care and fee-for-service. The CHIP Health Services Initiative (HSI) will fund postpartum services for FAMIS Prenatal participants enrolled in fee-for-service.

Effective October 1, 2009, the Commonwealth reimburses for services provided by Federally-qualified health centers (FQHCs) and rural health clinics (RHCs), applicable to CHIP, in the same manner it reimburses for services provided in the Title XIX (Medicaid) program as described in the Virginia State Plan for Medical Assistance, Attachment 4.19-B. Supplemental payments are made to FQHCs and RHCs for services reimbursed by MCOs as also described in the Virginia State Plan for Medical Assistance, Attachment 4.19-B. Coverage under the modified Medicaid look-alike component will be reimbursed on a fee-for-service basis by the Department.

The managed care organizations (MCOs) are at risk for all services provided. The plans have the discretion in reimbursing and contracting with providers and must ensure services are provided and a sufficient network exists. FAMIS rates are actuarially sound rates, and are established in a manner consistent with CMS regulations promulgated pursuant to the Balanced Budget Act of 1997. A managed care savings factor shall be applied to determine the final rates. The savings factor shall be determined annually.

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))

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.

School health services and dental services are carved out of the managed care delivery system and are provided through fee-for-service.

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:
  FAMIS children under age 19
  FAMIS Prenatal (i.e., the unborn child population)

☐ 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 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 meets the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

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

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

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

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

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

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;

- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

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

3.6.10 ☒ The State assures that each MCO, PIHP, and PAHP will be required to submit documentation to the State, at the time of entering into a contract with the State, on an annual basis, and at any time there has been a significant change to the MCO, PIHP, or PAHP's operations that would affect the adequacy of capacity and services, to demonstrate that each MCO, PIHP, and PAHP for the anticipated number of enrollees for the service area:

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

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

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

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

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

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

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

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

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

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the

enrollee;

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

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

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

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

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

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

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

3.7 Operations

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

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

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

☒ Each MCO, PIHP, or PAHP implements written policies and procedures for selection and retention of network providers (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(a));

☒ MCO, PIHP, and PAHP network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(c));

☒ MCOs, PIHPs, and PAHPs do not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification, solely on the basis of that license or certification (42 CFR 457.1208, cross referencing 42 CFR 438.12(a));

☒ If an MCO, PIHP, or PAHP declines to include individual or groups of providers in the MCO, PIHP, or PAHP's provider network, the MCO, PIHP, and PAHP gives the affected providers written notice of the reason for the decision (42 CFR 457.1208, cross referencing 42 CFR 438.12(a)); and

☒ MCOs, PIHPs, and PAHPs do not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. (42 CFR 457.1233(a), cross-referencing 42 CFR 438.214(d)).

3.7.3 The State assures that each contracted MCO, PIHP, and PAHP complies with the 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, PAHPs, 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 of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

3.12.5.3.7 ☒ The State assures that it posts the most recent copy of the annual EQR technical report on the Web site required under 42 CFR 438.10(c)(3) by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))

3.12.5.3.8 ☒ The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

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

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

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:

Please see approved template effective January 1, 2014: CS3 (Eligibility for Medicaid Expansion Program).

4.1. ☒ **Separate Program** Check all standards that will apply to the State plan. (42 CFR 457.305(a) and 457.320(a)) **Please see approved template effective January 1, 2014: CS7 (Eligibility – Targeted Low-Income Children).**

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

Please see approved template effective January 1, 2014: CS18 (Non-Financial Eligibility - Citizenship).

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:

See SPA pages CS7 and CS9 for age standards under the CHIP State Plan.

Uninsured children from birth through age 18, from >143% through 200% FPL, are served in Virginia's standalone CHIP program, Family Access to Medical Insurance Security (FAMIS).

Virginia offers the FAMIS MOMS program for pregnant women (through 60 days postpartum), through a CHIP 1115 demonstration waiver. FAMIS MOMS covers uninsured low-income pregnant women up to 200% FPL who do not qualify for Medicaid.

Effective July 1, 2021, under the unborn child option, called FAMIS Prenatal, Virginia's separate CHIP program covers uninsured pregnant women with incomes from 0-200% FPL not otherwise eligible for Medicaid, FAMIS, or FAMIS MOMS, regardless of immigration status requirements.

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):

See SPA pages CS7 and CS9 for income standards under the CHIP State Plan.

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):

Eligible persons must be Virginia residents. See approved template effective January 1, 2014: CS17 (Non-financial Eligibility – Residency).

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:

Please see approved template effective January 1, 2014: CS7 (Eligibility – Targeted Low-Income Children).

4.1.8 ☒ Duration of eligibility, not to exceed 12 months:

Effective 08-01-03, for FAMIS children from birth up to age 19, enrollment is for 12 months, unless one of the following events occurs before the annual renewal: 1) an increase in gross monthly income to above 200% FPL; 2) a child moves out of state; 3) a child turns age 19; 4) the family requests cancellation; or 5) the family reports a change and the child is determined eligible for Medicaid. Families must report the following changes before the annual renewal: 1) an increase in gross monthly income or change in family size resulting in a family income above 200% FPL or 2) an enrolled child moving out of the Commonwealth of Virginia. If none of the above changes is reported, eligibility will be renewed annually.

Please see approved template effective October 1, 2013: CS24 (Eligibility Process).

See SPA page CS27 for a description of continuous eligibility for the FAMIS Prenatal population.

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.

Children are eligible for FAMIS coverage as of the first day of the month in which a completed application is received at either the local department of social services in the locality where the child resides or electronically or telephonically through Cover Virginia. Effective 08-01-06, if a child enrolled in FAMIS is born within the three months prior to the month in which a signed application is received, coverage is effective retroactive to their date of birth if they would have met all eligibility criteria during that time.

Children are not eligible for FAMIS if (1) they are an inmate of a public institution, (2) they are an inpatient in an institution for mental disease, or (3) their parent or other authorized representative does not meet the requirements on assignment of rights to benefits or cooperation with the agency in identifying and providing information to assist the Commonwealth in pursuing any liable third party.

As of January 1, 2015, dependents of state employees able to access employer-sponsored dependent health insurance coverage under a Virginia state employee health insurance plan are eligible to enroll in FAMIS, if they otherwise qualify. See approved template effective January 1, 2015: CS10 (Eligibility – Children Who Have Access to Public Employee Coverage). The Commonwealth performed an analysis of public employee coverage costs for 2018-19, and confirms that the previously approved Hardship Exception still applies. See attachment, Hardship Exception Analysis 2018-19.

See approved templates effective January 1, 2014: CS13 (Eligibility - Deemed Newborns); CS19 (Non Financial - Social Security Number); and CS23 (Other Eligibility Standards).

Effective July 1, 2021, the Commonwealth provides coverage through the unborn child option for uninsured pregnant women with income up to and including 200% FPL who are not otherwise eligible for Medicaid, FAMIS, or FAMIS MOMS, regardless of immigration status requirements. The household for this coverage will be based on the pregnant woman, and the "unborn child" or children will be counted as if born and living with the mother in determining household size.

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

Please see approved template effective January 1, 2014: CS19 (Non-Financial - Social Security Number).

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

4.1.9.2 ☒ Continuous eligibility

See SPA page CS27 for a description of continuous eligibility for the unborn child population (i.e., FAMIS Prenatal).

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.

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 least180 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. **Please refer to CHIP 1115 Demonstration amendment**
☒ Elected for children under age **19**

Please see template CS18 (Citizenship).

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)

Prior to October 2013, Virginia had a single child health insurance application form. Effective October 1, 2013, Virginia began accepting the new MAGI single

streamlined application telephonically and electronically. This application is used for both the Medicaid and FAMIS programs.

Changes to the Medicaid and FAMIS eligibility methodology aligned with the federal open enrollment period of October 1, 2013. DMAS modified an existing contract with Xerox (now Conduent) to launch the Cover Virginia Call Center to accept the single streamlined application used to make determinations of eligibility and enrollment in all insurance affordability programs. This call center supports electronic and telephonic application and signature. The call center answers eligibility and covered services questions for the general Medicaid and FAMIS population. The Cover Virginia website (www.coverva.org) went live to provide users a self-directed eligibility screener, based on MAGI methodologies, and a link to an online application.

Beginning with renewals due in April 2014, FAMIS cases were converted monthly into the new eligibility system, renewed by the LDSS where the child resides, and maintained by the LDSS where the child resides. Steps were taken in 2014 to bring up a new Central Processing Unit function through Cover Virginia, using the state's new eligibility system for determinations of eligibility for MAGI cases. This process is monitored by co-located state staff. Cover Virginia now processes telephonic and FFM applications.

FAMIS and Medicaid cases are reviewed annually to determine continued eligibility. At the time of redetermination and/or renewal, a child found ineligible for either Medicaid or FAMIS will have his eligibility automatically determined in the other program. The ex parte renewal process is used for the majority of Medicaid and FAMIS MAGI cases. In instances where that is not possible, the family is mailed a pre-filled renewal packet with instructions to either call Cover Virginia or go to CommonHelp (state online portal) to complete their renewal or review and return the paper document to their local department of social services.

No Entitlement: In accordance with § 2102(b)(4) of the Social Security Act and § 32.1-353 of the Code of Virginia, the Family Access to Medical Insurance Security Plan shall not create any individual entitlement for payment of medical services or any right or entitlement to participation.

Beginning January 1, 2020, in the event of a federally-declared or Governor-declared disaster and at the Commonwealth's discretion:

(1) Requirements related to timely processing of applications may be temporarily waived for FAMIS applicants who reside and/or work in the State or federally-

declared disaster area.

(2) Requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for FAMIS beneficiaries who reside and/or work in a State or federally-declared disaster area.

(3) Requirements related to timely processing changes in circumstances may be temporarily waived for FAMIS beneficiaries who reside and/or work in a State or federally declared disaster area. The Commonwealth will continue to act on changes in circumstance related to residency, death, voluntary termination of coverage, erroneous eligibility determinations, and becoming eligible for Medicaid.

(4) The Agency may provide for an extension of the reasonable opportunity period for noncitizens declaring to be in satisfactory immigration status, if the noncitizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the State or federally-declared disaster or public health emergency.

DMAS will notify CMS in the event of a declared disaster and Virginia's intent to implement one or more of these policy modifications. The CMS notification will include the intent to modify the application and/or renewal processes, the areas affected by the disaster, and the effective dates of the policy modification. The next twelve-month continuous eligibility period will begin the month after the renewal completion date.

Please see the approved template CS24 and associated attachments. See also approved templates effective January 1, 2014: CS13 (Deemed Newborns) and CS15 (MAGI-Based Income Methodologies).

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.

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.

Please see template CS24 and associated attachments.

The application asks for employer information and whether children currently have health insurance. The screening question regarding access to state employee insurance was removed in accordance with the January 2015 policy change. All applications for child health insurance coverage are screened for completeness of information, the presence of other health insurance, verification of income, and Medicaid eligibility.

Beginning January 1, 2014, children who will lose Medicaid due to changes in income at their first renewal applying MAGI standards will be provided coverage under FAMIS. See template CS14 (Eligibility – Children Ineligible for

Medicaid as a Result of the Elimination of Income Disregards). Those children with employer-sponsored or private insurance have the option to enroll in the FAMIS Select program (administered through a CHIP Section 1115 demonstration), to avoid termination at their next annual eligibility review.

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))

A single streamlined application and process facilitates eligibility determination and enrollment of children in the appropriate program, either Medicaid or FAMIS.

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)) (42 CFR 431.636(b)(4))

A single streamlined application and process facilitates eligibility determination and enrollment of children in the appropriate program, either Medicaid or FAMIS.

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)) (42 CFR 457.805)

Only uninsured children shall be eligible for FAMIS. The single streamlined application requests information on health insurance coverage the child may have.

DMAS will conduct a focused survey of applicants every five years to determine the percentage of enrollees who have dropped employer-based health insurance for enrollment in FAMIS. See template effective July 2014: CS20 (Substitution of Coverage). Assignment of rights to medical support is a condition of eligibility.

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. (42 CFR 457.810(a)-(c))

Virginia's CHIP premium assistance program, FAMIS Select, is administered through a Section 1115 demonstration.

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))

American Indian and Alaska Native children are eligible for FAMIS on the same basis as any other children in the Commonwealth, and are served statewide by Marketing and Outreach efforts. At this time Virginia has seven federally recognized Indian tribes. No cost sharing is imposed on American Indian and Alaska Native children.

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)) (42 CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility and 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):

Prior to October 1, 2013, determinations of eligibility for the state child health insurance program, the Family Access to Medical Insurance Security (FAMIS) Plan (Title XXI), were completed at a Central Processing Unit or Local Department of Social Services (LDSS). The Central Processing Unit screened applicants for Medicaid eligibility prior to completing a FAMIS eligibility determination. LDSS determines eligibility for Medicaid first and then determines FAMIS eligibility for children denied Medicaid due to excess income. Families may apply by mail, by phone, fax or web; there is no requirement for a face-to-face interview.

In addition, many community groups have trained volunteers to help parents of potential Medicaid (Title XIX) and FAMIS (Title XXI) eligible individuals by answering questions and helping to complete applications and gather verifications needed to process cases.

Effective October 1, 2013, DMAS launched the Cover Virginia Call Center. This call center accepts the new MAGI single streamlined application and signature by telephone. At the same time, the existing Central Processing Unit stopped handling new applications for FAMIS. The call center answered eligibility and covered services questions for the general Medicaid and FAMIS population. The Cover Virginia website (www.coverva.org) also went live to provide users a self-directed eligibility screener, based on MAGI methodologies, and a link to an online application.

FAMIS provides comprehensive health benefits for children from birth through age 18 who are not covered under health insurance. Effective July 3, 2014, children no longer need a four-month uninsured waiting period to be eligible for FAMIS. Effective January 1, 2015, dependents of state employees who have access to subsidized health insurance may enroll in FAMIS. The application addresses specific questions about other current health insurance coverage.

In April 2015, Cover Virginia began processing and determining eligibility for telephonic applications, again functioning as a Central Processing Unit. A family may contact Cover Virginia by phone or online to apply. Additionally, a paper application can be completed, signed, and returned via mail or fax to LDSS for determination of eligibility for Medicaid and FAMIS.

Expenditures for children who meet Medicaid eligibility criteria are claimed at the Commonwealth's regular Medicaid FMAP. Effective 9/01/02, the Commonwealth began claiming enhanced funding for optional targeted low-income children who qualify under the Medicaid expansion. Expenditures for the children determined eligible under the Family Access to Medical Insurance Security Plan are claimed at the State's enhanced FMAP.

No Entitlement: In accordance with § 2102(b)(4) of the Social Security Act (42 U.S.C. § 1397bb(b)(4)) and § 32.1-353 of the Code of Virginia, the Family Access to Medical Insurance Security Plan shall not create any individual entitlement for payment of medical services or any right or entitlement to participation.

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:

DMAS continues to work closely with its public/private contractor, the Virginia Health Care Foundation (VHCF), in coordinating local outreach efforts. Through VHCF, DMAS funds a number of community outreach organizations that provide FAMIS outreach and application assistance to families in underserved regions of the state. DMAS also provides funding to VHCF to administer the SignUpNow training workshops series, which trains community organizations and individuals who wish to assist families with the enrollment process.

Guidance: The State should describe below how its 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. (42 CFR 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) (42 CFR 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 FAMIS program coordinates with the Virginia Department of Health, including Children's Specialty Services and the Maternal and Child Health programs, with State teaching hospitals serving indigent families, and with local government health delivery programs which serve low income children. The Commonwealth's goal is to provide all targeted low-income children with an accessible and comprehensive system of care that secures a medical home for children. This coordination is directed to ensuring that FAMIS does not supplant or replace existing programs. Rather, the goal of coordination is the close cooperation between these programs to enhance the health care resources available to low income children. DMAS, the single state agency that administers the Medicaid program, also administers FAMIS. Thus, Virginia ensures that the plan is closely coordinated with Medicaid in identifying and facilitating enrollment in the respective programs.

DMAS is responsible for the coordination of outreach and education efforts for all children whether they qualify for Medicaid or for FAMIS. Community-based organizations participating in this effort inform families about the programs and assist them with applying. The Cover Virginia Call Center provides customer service, assists callers with program information, selection of a managed care organization, and referrals to other sources of care if not eligible. Public programs that have established networks serving families who would meet either FAMIS or Medicaid's income eligibility requirements are used as a resource in reaching eligible children.

In addition, through its many other committees comprised of non-agency membership (e.g., Board of Directors, Managed Care Advisory Committee, Provider Advisory Council, CHIP Advisory Committee), DMAS solicits input and advice from public and private entities on its programs.

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)) (42 CFR 457.90)

Pursuant to the 2004 amendment to § 32.1-351.2 of the Code of Virginia, DMAS has established the Children's Health Insurance Program Advisory Committee (CHIPAC). The Committee consists of no more than 20 members and shall include membership from appropriate entities, as follows: one representative of the Joint Commission on Health Care, the Department of Social Services, the Department of Health, the Department of Education, the Department of Behavioral Health and Developmental Services, the Virginia Health Care Foundation, various provider associations and children's advocacy groups; and other individuals with significant knowledge and interest in children's health insurance. The Committee may report on the current status of FAMIS and FAMIS Plus and make recommendations as deemed necessary to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources. The Committee is staffed by DMAS Policy Planning and Innovation staff.

DMAS maintains Community Outreach staff to conduct statewide outreach, oversee campaigns, attend community events, sit on coalitions, and design and print flyers, brochures, posters, and other support materials in English and Spanish. This staff also oversees content for the Cover Virginia website and FAMIS and Cover Virginia Facebook pages and Twitter accounts.

The marketing and outreach efforts promote FAMIS and Medicaid and may include the following:

***Coordination with Other State Agencies* -- Assistance is sought from other agencies, including Virginia's Department of Education, Department of Health, and Department of Social Services to promote the program to potential new enrollees. Utilizing the highly successful annual Back to School Campaign in conjunction with the Free and Reduced School Lunch Program, school systems**

are a primary vehicle for sending information home to parents about the FAMIS program. This campaign usually results in a 25% increase in applications during the month of September. In addition, State agencies are routinely educated and trained about the program, informed of any changes or new initiatives, and are provided with informational fact sheets, website links, and other materials.

***Coordination with Other Community Based Organizations* -- The Commonwealth actively encourages participation of a wide range of organizations, including, but not limited to, those organizations that target high concentrations of uninsured children. DMAS has partnered with a network of Community Based Organizations (CBO) to promote and facilitate enrollment of children in the FAMIS and Medicaid programs. DMAS will continue to build coalitions and infrastructure at the state and local level that will provide awareness and application assistance in both FAMIS and Medicaid. DMAS continues to work closely with its contractor, the Virginia Health Care Foundation, in coordinating local outreach efforts through various CBO that have expertise in providing outreach and application assistance, including translation services to reach eligible families with limited English speaking abilities. All outreach materials are available in both English and Spanish. DMAS continues to provide these organizations with the support and tools needed to reach these families.**

***Coordination with the Business Community* -- DMAS will contact Virginia businesses and business associations to request their cooperation in enrolling employees' children, sponsorship opportunities, advertising partnerships, and support of the State's child health insurance programs. These groups will be provided with materials outlining the importance and benefits of the program so that they can make informed decisions on their ability and level of participation.**

***Coordination with the Health Care Associations and Providers* -- The Commonwealth partners with health care associations and requests their cooperation in performing outreach for Virginia's child health insurance programs. Outreach information is provided to health care associations and health care providers so that they can distribute FAMIS and Medicaid information to their members.**

***Cover Virginia Call Center* -- Effective since October 2013, the Commonwealth, through a contractor, provides a call center with a toll-free number that provides general program information, assists callers with completing new and renewal applications, documents reported changes in status, provides status updates on pending applications, and helps enrollees with selecting a MCO as needed. On-line resources are available to support customer service representatives in assisting callers and making referrals to other programs. DMAS continues to**

coordinate outreach efforts in conjunction with the call center and works to develop better outreach evaluation methods. The call center provides translation services for non-English-speaking callers in 148 of the most commonly spoken languages.

***www.coverva.org* -- This web site, in tandem with the Cover Virginia Call Center, provides program information as well as information about DMAS contracted MCOs. The site is a resource for consumers, navigators, and community partners. It provides information on eligibility, training for community partners who assist with enrollment, and an online portal where partners can order materials. The site provides an online eligibility screening tool using MAGI income methodologies, and if the user is found eligible, a link to the CommonHelp application. If the user is not eligible, information on other sources of care is available, as is a link to the FFM. The site is also a source of health information for populations served by public insurance.**

***FAMIS and Cover Virginia Facebook* -- DMAS monitors and updates FAMIS and Cover Virginia Facebook and Cover Virginia Twitter accounts which were established to capitalize on social media as a method of communicating with applicants and enrollees. They serve as great tools for promoting current health-related messages to pregnant women and families with children.**

The Commonwealth has not received any gifts or in-kind contributions from the business community to support the Commonwealth's Child Health Insurance Program. Any gifts, donations, or in-kind contributions that have been provided have been given directly to the outreach efforts (as described above) or have been provided directly to the grantees providing/supporting the outreach efforts. As stated above, none of these funds are used to draw down the Title XXI federal match.

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

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

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

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

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

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

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.)

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. See instructions.

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 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 to New York, Pennsylvania, or Florida (under 457.440)

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 (Please 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)

Secretary-approved coverage through a modified Title XIX look-alike (a fee-for-service component) is the delivery system provided for newly eligible children until they are enrolled in a MCO.

Secretary-approved coverage modeled after the state employee plan provides coverage using the Key Advantage Plan. This plan is the PPO option for state employees that was offered statewide in June 2000. Several enhanced benefits are added to the plan. The services under the Key Advantage Member Handbook are briefly outlined in the checklist in § 6.2. The enhanced benefits that are provided in addition to the Key Advantage Plan are listed at the end of this checklist. This coverage is provided for children enrolled in a MCO.

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

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

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

Secretary-approved coverage modeled after the state employee benefit plan in effect in June 2000, Virginia's Key Advantage State Employee Benefit Plan, is summarized in the checklist below (6.2.1 - 6.2.31). The additional coverage provided is listed separately at the bottom of the checklist.

NOTE: The FAMIS program has two separate health care services delivery systems, described immediately below and at 6.2.1.A – 6.2.31.A.

Covered Services for FAMIS Prenatal (i.e., the Unborn Child Population): Effective July 1, 2021, Virginia provides coverage through the unborn child option for uninsured pregnant persons in households with income up to 200% FPL not otherwise eligible for Medicaid, FAMIS, or FAMIS MOMS, regardless of the pregnant individual's immigration status. The FAMIS Prenatal program's coverage is the same as that provided under the FAMIS MOMS CHIP 1115 Demonstration, which reflects the Medicaid state plan covered benefits for pregnant women, with the exception of long-term services and supports (LTSS). Benefits to the "unborn child" population are delivered through the same delivery and utilization control systems as those used for FAMIS MOMS. Pregnant persons who are receiving services under FAMIS Prenatal on the basis of the "unborn child" shall continue to be eligible to receive services through the end of the month in which the 60th postpartum day occurs, regardless of any subsequent changes in household income. FAMIS Prenatal enrollees are not eligible for the FAMIS Select premium assistance program.

Through Virginia's Medicaid and CHIP managed care organizations (MCOs), DMAS utilizes bundled capitated payment arrangements for coverage of services including prenatal, labor and delivery, and postpartum services. Virginia considers all services delivered to the mother through managed care during the pregnancy through 60 days postpartum to support the health of the "unborn child" who at birth may be eligible as a targeted low-income child. Virginia's comprehensive maternal health benefits plan in Medicaid and CHIP is based on a recognition that beyond traditional limited prenatal and postpartum services, the new mother's access to full-scope health services substantially improves the newborn's access to health care. Adequately addressing the birthing person's health needs in the critical postpartum period is essential to supporting the newborn's physical, social, and emotional health.

Accordingly, DMAS claims CHIP federal financial participation (FFP) under this State Plan for managed care costs for the covered population through 60 days postpartum.

For FAMIS Prenatal participants who are not enrolled in managed care during the postpartum period, Virginia will utilize a Health Services Initiative as described in Section 2.2 to claim CHIP FFP for postpartum services paid through fee-for-service.

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

365 days per confinement; includes ancillary services.

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

Outpatient services include emergency services, surgical services, and professional provider services in a physician's office or outpatient hospital department. Facility charge for outpatient department of a hospital or hospital emergency room, separate from physician or diagnostic services.

6.2.3. ☒ Physician services (Section 2110(a)(3))

Physician services include services while admitted in the hospital, or in a physician's office, or outpatient hospital department.

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

Surgical services include services provided in Sections 6.2.1, 6.2.2, and 6.2.3.

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

Clinic services include services provided in Sections 6.2.2 and 6.2.3.

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

Covered for outpatient prescription drugs. Mandatory generic program.

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

Optional - May be covered at the discretion of the health plan.

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

Outpatient diagnostic tests, x-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab.

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

Maternity service including routine prenatal care is covered. Pre-pregnancy family services include coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives. Contraceptive drugs and devices eligible for reimbursement are oral contraceptives, Depo-Provera, cervical caps, diaphragms, intrauterine devices and transdermal implants.

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services. (Section 2110(a)(10))

Inpatient acute mental health services other than those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services.

Effective 07-01-10, medically necessary inpatient mental health services are covered for 365 days per confinement.

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

Effective 07-01-10, medically necessary outpatient mental health services (including, but not limited to those listed below) are covered without limitations.

A. Outpatient mental health services, other than services furnished in a state-operated mental hospital.

B. Effective 08-01-2003, the following community mental health services are covered under this state plan.

1. <u>Intensive in-home services to children and adolescents under age 19</u> - shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment, individual and family counseling, and communication skills (e.g., counseling to assist the

child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. Services must be directed toward the treatment of the eligible child and delivered primarily in the family's residence with the child present.

2. Therapeutic day treatment - provides evaluation, medication, education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem-solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy. The service shall be provided two or more hours per day in order to provide therapeutic interventions. One unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

3. Crisis Intervention - Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. A unit equals 15 minutes and shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

4. Case Management - Case management services for youth at risk of serious emotional disturbance and who meet the definition of Seriously Emotionally Disturbed. Case management services assist youth at risk of serious emotional disturbance and with a diagnosis of Serious Emotional Disturbance in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include: Assessment and planning, linking the individual directly to services and supports, assisting the individual directly for the purpose of locating, developing or obtaining needed service and resources,

coordinating services and service planning, enhancing community integration, making collateral contacts, follow up and monitoring, and education and counseling.

5. Behavioral Therapies - As of 07-01-16, behavioral therapies are covered. Behavioral therapies are systematic interventions provided by licensed practitioners, within their scope of practice defined under state law or regulations, to individuals younger than 19 years of age, usually in the individual's home. Behavioral therapy includes, but is not limited to, applied behavior analysis. Services are designed to enhance communication skills and decrease maladaptive patterns of behavior which, if left untreated, could lead to more complex problems and the need for a greater or a more restrictive level of care. The service goal is to ensure the individual's family is trained to effectively manage the individual's behavior in the home and community settings using behavioral modification strategies. Behavioral therapy services must be preauthorized and based on a medical necessity determination.

C. Peer Support Services - As of 07-01-17 peer support services are covered. Peer Support Services extend existing comprehensive behavioral health and substance use treatment services to help facilitate recovery from even the most serious mental health and substance use disorders. Peer support providers are self-identified individuals who are in successful and ongoing recovery from mental health and/or substance use disorders. Peer support providers shall be sufficiently trained and certified to deliver services. Peer Support Services are delivered by peers (trained/certified individuals with lived experience with mental health and/or substance use disorders) who have been successful in the recovery process and can extend the reach of treatment beyond the clinical setting into an individual's community to support and assist a member with staying engaged in the recovery process. A Peer Support service called Family Support Partners shall be provided to individuals under the age of 21 who have a mental health or substance use disorder or co-occurring mental health and substance use disorders which are the focus of the support with their caregiver.

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

Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses are covered when medically necessary with certain

limitations.

6.2.13. ☒ Disposable medical supplies. (Section 2110(a)(13))

Medically necessary disposable medical supplies provided in an inpatient or outpatient setting are covered.

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

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

Includes coverage of up to 90 visits per calendar year. Includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy.

6.2.15. ☒ Nursing care services (Section 2110(a)(15))

Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations.

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2110(a)(16))

Abortion only if necessary to save the life of the mother.

6.2.17. ☒ Dental services (Section 2110(a)(17))

Coverage includes diagnostic, preventive, primary, prosthetic and complex restorative services. Coverage does not include routine bases under restorations.

Coverage shall include full-banded orthodontics and related services to correct abnormal and correctable malocclusion for enrollees. Post-treatment stabilization retainers and follow-up visits are included in the orthodontic services. Effective 12/1/02, the benefit limits for orthodontic services increased to mirror Medicaid.

6.2.18. ☐ Vision screenings and services (Section 2110(a)(24))

6.2.19. ☐ Hearing screenings and services (Section 2110(a)(24))

6.2.20. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

Effective 7/1/10, medically necessary inpatient substance abuse treatment services are covered for 365 days per confinement. This coverage does not include services furnished in a state-operated mental hospital or in an IMD.

This coverage does not include residential services or other 24-hour therapeutically planned structural services.

6.2.21. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))

As of 4/1/17, outpatient substance abuse treatment services include outpatient, intensive outpatient, partial hospitalization, medication-assisted treatment, and case management. Peer support services (as discussed in section 6.2.11 C) are effective 7/1/17. There is no visit limit on medically necessary outpatient substance abuse treatment services (effective 7/1/10).

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

The State may elect to offer benefits for an approved, alternative treatment plan for a recipient who would otherwise require more expensive services. These services will be offered on a case-by-case basis. Effective October 1, 2011, targeted case management is provided by a certified Early Intervention Case Manager and reimbursed directly by DMAS for children from birth up to age three years who are in need of early intervention services.

6.2.23. ☐ Care coordination services (Section 2110(a)(21))

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

Medically necessary services used to treat or promote recovery from an illness or injury are covered with limitations.

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

Hospice services include a program of home and inpatient care provided directly under the direction of a licensed hospice.

Hospice care programs include palliative and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team. Hospice care services are available if the enrollee is diagnosed with a terminal illness with a life expectancy of six months or fewer. Effective 3/23/10, hospice care is available concurrently with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made.

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

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

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

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

Coverage of chiropractic and vision services with benefit limitations. Effective 12/1/02, the vision co-payments levels for each FPL decreased and levels for frames and trifocal lenses increased.

Effective 10/1/09, coverage for early intervention services was expanded to include all certified Early Intervention Professionals and Early Intervention Specialists.

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

Premiums for private health care insurance coverage are covered in the FAMIS Select program through a CHIP Section 1115

Demonstration waiver, as outlined in Section 4.4.

6.2.29. ☒ Medical transportation (Section 2110(a)(26))

Professional ambulance services under certain conditions are covered when used locally to or from a covered facility or provider's office. Ambulance services if prearranged by the Primary Care Physician and authorized by the Company if, because of enrollee's medical condition, the enrollee cannot ride safely in a car when going to the provider's office or to the outpatient department of the hospital. Ambulance services will be covered if the enrollee's condition suddenly becomes worse and must go to a local hospital's emergency room.

For coverage of ambulance services, the following three conditions must be met: (a) The trip to the facility or office must be to the nearest one recognized by the health plan administrator as having services adequate to treat the condition; (b) The services received in that facility or provider's office are covered services; and (c) If the health plan administrator requests it, the attending provider must explain why transportation could not occur in a private car or by any other less expensive means.

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

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

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

Enhanced Services Provided Beyond Secretary-approved coverage modeled after the state employee plan:

The services described above are the services included in the Key Advantage State Employee Benefit Package in effect in June 2000. FAMIS Secretary-approved coverage modeled after the state employee plan will include all of the Key Advantage benefits plus the additional benefits listed below:

1. **Well-child care from age 6 through 18 including visits, laboratory services as recommended by the American Academy**

of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP). (Well-child care from birth through age 5 is covered under Key Advantage.)

2. **The following services for special education students, when provided in a school setting pursuant to a student's Individualized Education Program (IEP), are covered under this State Plan: physical therapy, occupational therapy, and speech-language therapy; audiology; skilled nursing; psychiatric and psychological services; personal care; medical evaluations; and specialized transportation. Assessments are covered as necessary to determine special education and related services needed in the IEP. The Department of Medical Assistance Services (DMAS) reimburses Local Education Agencies (LEAs) directly for services provided pursuant to the IEP.**

3. **Blood lead testing.**

Coverage offered for Secretary-approved coverage through the fee-for-service program is summarized in the checklist below.

6.2.1.A ☒ Inpatient services (Section 2110(a)(1))

A. Payment based upon DRG shall be made for medically necessary stays in acute general care facilities within the limits of coverage prescribed with the Title XIX State Plan and state regulations.

B. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all children within the limits of coverage prescribed in the Title XIX State Plan and state regulations.

C. Payment will not be made for inpatient hospitalization for those surgical and diagnostic procedures listed on the mandatory outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions.

D. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services shall be limited to procedures that are not experimental. Transplants are covered when determined medically necessary and preauthorized.

E. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

F. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be limited to 48 hours unless additional days are medically justified. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be limited to 24 hours unless additional days are medically justified.

6.2.2.A ☒ Outpatient services (Section 2110(a)(2))

A. Outpatient hospital means preventive, diagnostic, therapeutic, rehabilitative or palliative services that are furnished to outpatients, by or under the direction of a physician or dentist, except in the case of nurse mid-wife services.

B. Are furnished by an institution that is licensed or formally approved by the Virginia Department of Health and except in the case

of medical supervision of nurse-midwife services, meets the requirements for participation in Medicare.

C. Emergency hospital services provided without limitation.

D. Coverage of outpatient observation beds. The following limits and requirements shall apply to DMAS coverage of outpatient observation beds. These services must be billed as outpatient care and may be provided for up to 23 hours. A patient stay of 24 hours or more shall require inpatient precertification and admission.

6.2.3.A ☒ Physician services (Section 2110(a)(3))

A. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere. Elective surgery as defined by the Program is surgery that is not medically necessary to restore or materially improve a body function. Elective and cosmetic surgical procedures are not covered unless performed for physiological reasons and require prior approval by DMAS.

B. Routine physicals and immunizations are not covered except when the services are provided under the EPSDT Program and when a well child examination is performed in a private physician's office for a foster child of the local social services department on specific referral from those departments.

C. Consistent with the Omnibus Budget Reconciliation Act of 1989 §6403, medically necessary psychiatric services shall be covered when prior authorized by DMAS for individuals younger than 19 years of age when the need for such services has been identified through an EPSDT screen.

D. Physician visits to inpatient hospital patients are limited to medically necessary days of inpatient hospitalization.

E. Psychological testing and psychotherapy by clinical psychologists licensed by the State Board of Medicine.

F. Reimbursement will not be provided for physician services performed in the inpatient setting for those surgical or diagnostic procedures listed on the mandatory outpatient surgery list unless the service is medically justified or meets one of the exceptions.

G. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Experimental or investigational procedures are not covered.

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

A. Medical surgical services - Medically necessary surgical services are covered. Elective surgery is defined as procedures not medically necessary to restore or materially improve a body function. Elective and cosmetic surgical procedures are not covered unless performed for physiological reasons and require preauthorization.

B. See physician services above for organ transplantation. Breast reconstruction/prostheses following mastectomy and breast reduction may be covered if preauthorized following the medically necessary complete or partial removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorized for all medically necessary indications. Such procedures shall be considered non-cosmetic.

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

Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are provided to outpatients by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients and are furnished by or under the direction of a physician or dentist.

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

A. Drugs for which Federal Financial Participation is not available pursuant to the requirements of §1927 of the Social Security Act shall not be covered. Legend drugs, with the exception of the drugs or classes of drugs provided for in Supplement 5 of the Medicaid State Plan are covered. Coverage of drugs used for weight loss requires prior authorization. Prescriptions for recipients for specific multiple source drugs shall be filled with generic drug products unless the physician or other practitioners so licensed and certified to prescribe drugs certifies "brand necessary." The number of refills shall be limited pursuant to the Drug Control Act, *Code of Virginia* Title §54.1-3411.

B. Coverage includes home infusion therapy which is covered consistent with limits and requirements set out within home health services.

C. Effective June 1, 2004, pursuant to § 1927 of the Act and 42 CFR § 440.230, the Department shall require the prior authorization of legend drugs when both institutionalized and non-institutionalized FAMIS enrollees are prescribed high numbers of legend drugs. Over-

the-counter drugs and legend drug refills shall not count as a unique prescription for the purposes of prior authorization as it relates to the threshold program.

Prior authorization shall be required for non-institutionalized FAMIS enrollees whose current volume of prescriptions meet the identified threshold limits as defined by the agency's guidance documents for pharmacy utilization review, limitations, and the prior authorization program. All recipients subject to these prior authorization limits shall be given advance notice of such limits and shall be advised of their rights to appeal. Such appeals shall be considered and responded to pursuant to
12 VAC 30-110-10 et. seq.

Prior authorization shall consist of prospective and retrospective drug therapy review by a licensed pharmacist to ensure that all predetermined clinically appropriate criteria, as established by the department, have been met before the prescription may be dispensed. Prior authorization shall be obtained through a call center staffed with appropriate clinicians, or through written or electronic communications (e.g., faxes, mail). Responses by telephone or other telecommunications device within 24 hours of a request for prior authorization shall be provided. The dispensing of 72-hour emergency supplies of the prescribed drug may be permitted and dispensing fees shall be paid to the pharmacy for such emergency supply.

Exclusion of protected institutions from pharmacy threshold prior authorization: For the purposes of threshold prior authorization, nursing facility residents do not include residents of the Commonwealth's mental retardation training centers. For the purposes of threshold prior authorization, non-institutionalized recipients do not include recipients of services at Hiram Davis Medical Center.

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

Non-legend drugs shall be covered for insulin, syringes and needles, and diabetic test strips and family planning supplies. Designated non-legend drugs which are prescribed by licensed prescribers to be used as less expensive therapeutic alternatives to covered legend drugs are also covered. Designated categories of non-legend drugs for recipients in nursing homes are covered.

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

Services must be ordered or prescribed and directed or performed within the scope of a license of the practitioner of the healing arts.

Effective 08-01-03, prior authorization of the following specific high-cost non-emergency outpatient procedures is required: Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT) Scans and Positron Emission Tomography (PET) Scans.

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

A. Family planning services and supplies for individuals of child-bearing age must be ordered or prescribed and directed or performed within the scope of the license of a practitioner of the healing arts. Family planning services shall be defined as those services which delay or prevent pregnancy. Such services shall not include services to treat infertility or services to promote fertility.

B. Pregnancy-related and postpartum services shall be covered for any medical condition that may complicate pregnancy if otherwise covered under the Title XXI state plan. Enhanced prenatal care services include nutrition, patient education, homemaker services, blood glucose meters (including test strips).

6.2.10.A ☒ Inpatient mental health services, other than services described in 6.2.20, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

Inpatient mental health services will be offered in general acute care hospitals. Inpatient acute mental health services other than those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services. Effective 07-01-10, medically necessary inpatient mental health services are covered for 365 days per confinement. Effective 12-01-13, these services are managed by the contracted BHSA.

6.2.11.A ☒ Outpatient mental health services, other than services described in 6.2.21, but including services furnished in a state-operated mental hospital and

including community-based services (Section 2110(a)(11))

Effective 07-01-10, medically necessary outpatient mental health services (including, but not limited to those listed below) are covered without limitations. Outpatient mental health services are managed by the contracted BHSA.

Consistent with the Omnibus Budget Reconciliation Act of 1989 §6403, medically necessary psychiatric services shall be covered for individuals younger than 19 year of age when the need for such services has been identified through an EPSDT screen.

Community Mental Health Services:

1. Intensive in-home services to children and adolescents under age 19 - Shall be time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. These services provide crisis treatment, individual and family counseling, and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem-solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response. Services must be directed toward the treatment of the eligible child and delivered primarily in the residence with the child present.

2. Therapeutic day treatment for children and adolescents - Provides evaluation, medication, education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem-solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy. The service shall be provided two or more hours per day in order to provide therapeutic interventions. One unit of service is defined as a minimum of two hours but less than three hours in a given day. Two units of service shall be defined as a minimum of three but less than five hours in a given day. Three units of service shall be defined as five or more hours of service in a given day.

3. Day Treatment / Partial Hospitalization - Day treatment / partial hospitalization services shall be provided in sessions of two or more consecutive hours per day, which may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These

services include the major diagnostic, medical, psychiatric, psychosocial and psychoeducational treatment modalities designed for individuals who require coordinated, intensive, comprehensive, and multidisciplinary treatment but who do not require inpatient treatment.

4. Psychosocial Rehabilitation - Psychosocial rehabilitation shall be provided at least two or more hours per day to groups of individuals in a nonresidential setting. These services include assessment, education to teach the patient about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment.

5. Crisis Intervention - Crisis intervention shall provide immediate mental health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing acute psychiatric dysfunction requiring immediate clinical attention. A unit equals 15 minutes and shall include assessing the crisis situation, providing short-term counseling designed to stabilize the individual, providing access to further immediate assessment and follow-up, and linking the individual and family with ongoing care to prevent future crises. Crisis intervention services may include office visits, home visits, preadmission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

6. Mental Health Crisis Stabilization - Crisis stabilization services for non-hospitalized individuals shall provide direct mental health care to individuals experiencing an acute psychiatric crisis which may jeopardize their current community living situation.

7. Mental Health Support - Mental health support services shall be defined as training and supports to enable individuals to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. These services may be authorized for six consecutive months. This program shall provides the following services: training in or reinforcement of functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition.

8. Intensive Community Treatment - Medical psychotherapy, psychiatric assessment, medication management, and case management activities offered to outpatients outside the clinic, hospital, or office setting for individuals who are best served in the community.

9. Case Management - Case management services for youth at risk of serious emotional disturbance and who meet the definition of Seriously Emotionally Disturbed. Case management services assist youth at risk of serious emotional disturbance and with a diagnosis of Serious Emotional Disturbance in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include: Assessment and planning, linking the individual directly to services and supports, assisting the individual directly for the purpose of locating, developing or obtaining needed service and resources, coordinating services and service planning, enhancing community integration, making collateral contacts, follow up and monitoring, and education and counseling.

10. Behavioral Therapies - As of 07-01-16, behavioral therapies are covered. Behavioral therapies are systematic interventions provided by licensed practitioners within their scope of practice, defined under state law or regulations, to individuals younger than 19 years of age, usually in the individual's home. Behavioral therapy includes, but is not limited to, applied behavior analysis. Services are designed to enhance communication skills and decrease maladaptive patterns of behavior which, if left untreated, could lead to more complex problems and the need for a greater or a more restrictive level of care. The service goal is to ensure the individual's family is trained to effectively manage the individual's behavior in the home and community settings using behavioral modification strategies. Behavioral therapy services must be preauthorized and based on a medical necessity determination.

6.2.12.A ☒ 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))

Durable medical equipment, hearing aids, and eyeglasses are covered when medically necessary with certain limitations. Prosthetic devices for the replacement of missing arms, legs and breasts and the provision of any internal (implant) body part shall be covered.

Prosthetic devices (artificial arms and legs, and their necessary supportive attachments; implants and breasts) are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional license. This service when provided by an authorized vendor must be medically necessary and preauthorized for the minimum applicable component necessary for the activities of daily living.

6.2.13.A ☒ Disposable medical supplies (Section 2110(a)(13))

Medical supplies, equipment and appliances suitable for use in the home. All medically necessary medical supplies, equipment, and appliances are covered for recipients. Unusual amounts, types and duration of usage must be authorized by DMAS. When cost-effective, payment may be made for rental of the equipment in lieu of purchase. Prosthetics which are preauthorized shall be covered. Supplies, equipment that are not covered are: space conditioning equipment, equipment and supplies for any hospital or nursing facility resident, except for ventilators and associated supplies for nursing facility residents; furniture or appliances not defined as medical equipment; items that are only for the recipient's comfort and convenience.

6.2.14.A ☒ Home and community-based health care services (See instructions) (Section 2110(a)(14))

A. Home Health Services: Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area. Effective 08-01-2003, home health services are limited to five visits without prior authorization in each state fiscal year. Service extensions beyond the initial five visits must be prior-authorized. Limits are per recipient, regardless of the number of providers rendering services. If services beyond these limitations are determined by the physician to be required, then the provider shall request prior authorization from DMAS for additional services.

B. Home Health Aide services provided by a home health agency. Home health aides must function under the supervision of a professional nurse. Home health aides must meet the federal certification requirements. Patient may receive up to 32 visits annually.

6.2.15.A ☒ Nursing care services (See instructions) (Section 2110(a)(15))

Intermittent or part-time nursing service provided by a home health agency; Nurse mid-wife services allowed under licensure

requirements of Virginia and federal law; skilled nursing services provided in schools to special education students.

Private duty nursing services are not covered.

6.2.16.A ☒ Abortion only if necessary to save the life of mother or if the pregnancy is the result of an act of rape or incest. (Section 2110(a)(16)

Abortion only if necessary to save the life of the mother.

6.2.17.A ☒ Dental services (Section 2110(a)(17))

A. Routine diagnostic, preventive or restorative procedures necessary for oral health provided by or under the direct supervision of a dentist in accordance with the State Dental Practice Act.

B. Initial, periodic and emergency examinations; required radiography necessary to develop a treatment plan; patient education; dental prophylaxis; fluoride treatments; routine amalgam and composite restorations; stainless steel crowns, prefabricated steel post, temporary (polycarbonate crowns) and stainless steel bands; crown recementation; pulp capping; sedative fillings; therapeutic apical closure; topical palliative treatment for dental pain; removal of foreign body; simple extractions; root recovery; incision and drainage of abscess; surgical exposure of the tooth to aid eruption; sequestrectomy for osteomyelitis; and oral antral fistula closure are dental services covered without preauthorization.

C. All covered dental services not referenced above require preauthorization by DMAS. The following services are also covered through preauthorization: medically necessary full banded orthodontics, tooth guidance appliances, complete and partial dentures, surgical preparation (alveoloplasty) for prosthetics, single permanent crowns and bridges.

D. Routine bases under restorations and inhalation analgesia are not covered.

E. Examinations prophylaxis, fluoride treatment (one each six months); space maintenance appliance; bitewing x-ray - two films each 12 months; routine amalgam and composite restorations once each three years; dentures once each five years; extractions, orthodontics, tooth guidance appliances, permanent crowns and bridges, endodontics, patient education and sealants - one time.

F. Limited oral surgery procedures, as defined and covered by Medicare when preauthorized.

G. Provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

6.2.18.A ☒ Vision screenings and services (Section 2110(a)(24))

6.2.19.A ☒ Hearing screenings and services (Section 2110(a)(24))

6.2.20.A ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

Effective 12-01-13 these services are managed by the contracted BHSA.

Residential treatment for pregnant women. The treatment facility shall not be an institution for mental disease.

6.2.21.A ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))

Group and individual counseling, outpatient, intensive outpatient, partial hospitalization, and case management services are covered for members with a documented substance use diagnosis as of 4-1-17. Peer support services (as discussed in section 6.2.11.C) were added on 7/1/2017. Services must be rendered by a certified or licensed provider. Effective 12-01-13 these services are managed by the contracted BHSA.

6.2.22.A ☒ Case management services (Section 2110(a)(20))

Targeted case management for high risk pregnant women and infants up to age 2; individuals with mental retardation; children with serious emotional disturbance and youth at risk for serious emotional disturbance; and children with behavioral disorder or emotional disturbances who are referred to treatment foster care by the Family Assessment and Planning Team of Comprehensive Services Act for Youth and Family. Effective October 1, 2011, targeted case management is provided by a certified Early Intervention Case Manager and reimbursed directly by DMAS for children from birth up to age three years who are in need of early intervention services.

6.2.23.A ☐ Care coordination services (Section 2110(a)(21))

May be a component of another service.

6.2.24.A ☒ Physical therapy, occupational therapy, and services for individuals with

speech, hearing, and language disorders (Section 2110(a)(22))

Effective 08-01-03, home health and outpatient rehabilitation services are limited to five visits for each rehabilitative therapy without prior authorization in each state fiscal year. Service extensions beyond the initial five visits must be prior-authorized.

A. Under home health, physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility covered as ordered by a physician in consultation with a physical therapist who has been licensed by the Board of Medicine. Limits shall apply per recipient regardless of the number of providers rendering services. Annually shall be defined as July 1 through June 30 for each recipient. If the physician determines that additional services are needed, the provider shall request prior authorization.

B. Physical therapy and related services:

1. Services for individuals requiring physical therapy are provided only as an element of hospital inpatient or outpatient services, nursing facility service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitation services.

2. The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine or a physical therapy assistant who is licensed by the Board of Medicine and under the supervision of a qualified physical therapist who makes an onsite supervisory visit at least once every 30 days. This visit shall not be reimbursable.

C. Occupational therapy: Services for individuals requiring occupational therapy are provided only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, or when otherwise included as an authorized service by a provider who provides rehabilitation services. Services shall meet all of the following conditions: services shall be directly and specifically related to an active written plan of care designed by a physician after consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board; shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a qualified occupational therapist. The amount, frequency and

duration of the services shall be reasonable.

D. Services for individuals with speech, hearing and language disorders. Services must be provided by or under the supervision of a speech pathologist or an audiologist only as an element of hospital inpatient or outpatient service, nursing facility service, home health service, or when otherwise included as an authorized service by a cost provider who provides rehabilitative services. Services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Speech/Language Pathology, or, if exempt from state licensure, meets the requirements in 42 CFR 405.1719(c). The services shall be of a level of complexity and sophistication or the patient's condition be of a nature that the services can only be performed by or under the direction of a qualified speech-language pathologist. The amount, frequency and duration of the services shall be reasonable.

6.2.25.A ☒ Hospice care (Section 2110(a)(23))

Hospice care services described in the Title XIX state plan for medical assistance. Effective 3/23/10, hospice care is available concurrently with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made.

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

Consistent with the Omnibus Budget Reconciliation Act of 1989 §6403, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services means the following services: screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Social Security Act §1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services and which are medically necessary, whether or not such services are covered under the Virginia Title XIX State Plan subject to the requirements and limits of Title XXI.

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

A. Intensive physical rehabilitation in facilities certified as rehabilitative hospitals or rehabilitation hospitals which meet the requirements to be excluded from the Medicare PPS system and in CORFs. An intensive physical rehabilitation program provides intensive skilled rehabilitation, nursing, physical therapy, occupational therapy, and speech therapy, cognitive rehabilitation, prosthetic-orthotic services, psychology, social work, and therapeutic recreation.

B. Optometrist: Diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians, as allowed by the Code of VA and by regulations of the Boards of Medicine and of Optometry, are covered. Routine refractions are limited to once in 24 months except as may be authorized by DMAS.

C. Podiatrists: Covered podiatry services are defined as reasonable and necessary diagnostic, medical, or surgical treatment of disease, injury, or defects of the human foot. These services must be within the scope of the license of the podiatrists' profession and defined by State law. The following services are not covered: preventive health care, including routine foot care; treatment of structural misalignment not requiring surgery; cutting or removal of corns, warts, or calluses; experimental procedures; acupuncture.

D. Nursing facility services in a Medicaid certified facility (other than in an IMD).

E. Nurse-midwife services: defined as those services allowed under the licensure requirements of the state statute and as specified in the Social Security Act.

F. Effective 10/1/09, coverage for early intervention services was expanded to include all certified Early Intervention Professionals and Early Intervention Specialists.

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

6.2.29.A ☒ Medical transportation (Section 2110(a)(26))

Transportation services are provided to ensure that recipients have necessary access to and from providers of all covered medical services. Transportation to both emergency and nonemergency services is covered.

6.2.30.A ☐ Enabling services (such as transportation, translation, and outreach services

(See instructions) (Section 2110(a)(27))

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

The following services for special education students, when provided in a school setting pursuant to a student's Individualized Education Program (IEP), are covered under this State Plan: physical therapy, occupational therapy, and speech-language therapy; audiology; skilled nursing; psychiatric and psychological services; personal care; medical evaluations; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings; and specialized transportation. Assessments are covered as necessary to determine special education and related services needed in the IEP. The Department of Medical Assistance Services (DMAS) reimburses Local Education Agencies (LEAs) directly for services provided pursuant to the IEP.

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

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

☒ **International Classification of Disease (ICD)**

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines

☒ Other (Describe): **Conditions noted in ICD-10-CM, Chapter 5, "Mental, Behavioral, and Neurodevelopmental Disorders" are classified under MH/SUD with the following exceptions: The conditions listed in subchapter 1, "Mental disorders due to known physiological conditions" (F01 to F09) are categorized as MED/SURG; the conditions listed in subchapter 8, "Intellectual disabilities" (F70 to F79) are categorized as MED/SURG; and the conditions listed in subchapter 9, "Pervasive and specific developmental disorders" (F80-F89) are categorized as MED/SURG.**

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

☒ **Yes**

☐ No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

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

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

☐ Yes

☒ **No**

FAMIS children access the EPSDT benefit during the time they are temporarily in fee-for-service prior to being enrolled in a MCO. FAMIS children in managed care do not receive the EPSDT benefit; therefore DMAS is not seeking deemed parity on the basis of EPSDT for its separate CHIP population.

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

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐ All children covered under the State child health plan.

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

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

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

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

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

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

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

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

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

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

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

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

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

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

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

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR

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

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

Inpatient: **All covered services or items (including medications) provided to a member when a physician (or other qualified provider as applicable) has written an order/certification for a >24-hour admission to a facility.**

Outpatient: **All covered services or items (including medications) provided to a member in a setting that does not require a physician (or other qualified provider as applicable) order/certification for a >24-hour admission, and does not meet the definition of emergency care.**

Emergency Care: **All covered services or items (including medications) provided in an emergency department setting or to stabilize an emergency/crisis, when provided in a setting other than an inpatient setting.**

Pharmacy/Prescription Drugs: **Covered medications, drugs, and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy.**

6.2.3.1.1 MHPAEA The State assures that:

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

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

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

☐ **Yes**

☒ **No**

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

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

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

6.2.3.2 MHPAEA The State assures that:

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

Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

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

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☒ **No dollar limit is applied**

Guidance: A monetary coverage limit that applies to *all* CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or

substance use disorder benefits, please go to section 6.2.5- MHPAEA.

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

☐ Yes (Type(s) of limit:)

☒ **No**

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

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

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

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

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

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

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

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

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

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

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

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

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

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

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

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

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

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

Quantitative Treatment Limitations

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

☐ Yes (Specify:)

☒ **No**

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

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

☐ Yes

☐ No

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

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the 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. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

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

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

Guidance: Examples of NQTLs include medical management standards to limit or

exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

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

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

☐ Yes

☒ **No**

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

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

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

Availability of Plan Information

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

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

☐ State

☐ Managed Care entities

☒ **Both**

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 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). *Previously 8.6.* Please describe:

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% 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)

The families of targeted low-income children who have access to health insurance through their employer may be eligible for premium assistance for the purchase of their employer-sponsored health insurance if certain conditions are met. However, the goal of FAMIS Select is to provide coverage for eligible children under their parents' employer-sponsored plan. Any coverage of individuals not eligible for FAMIS is incidental.

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))

Section 7. Quality and Appropriateness of Care

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

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

The Commonwealth will use numerous methods to assure that FAMIS enrollees receive quality services that are appropriate to their needs. These methods may include the following:

- **Verification that contracted managed care organizations (MCOs) develop and maintain quality assurance and quality improvement programs.**
- **Verification that contracted MCOs have sufficient network providers and procedures to ensure that children have access to routine, urgent, and emergency services.**
- **Verification that contracted MCOs maintain a member complaint system and provide access to a grievance process to appeal a plan action.**

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

7.1.1. ☒ Quality standards

Contracted MCOs are required to follow standards established by the Commonwealth in the development and maintenance of their quality improvement programs.

7.1.2. ☒ Performance measurement

7.1.2(a) ☒ **CHIPRA Quality Core Set**
7.1.2(b) ☒ **Other**

A. Submission of a quality improvement plan.
B. Adherence to NCQA, JCAHO, or other nationally recognized accrediting organization.
C. Results of HEDIS or other.

D. CAHPS Survey.
E. Clinical focus studies.

7.1.3. ☒ Information strategies

Each managed care organization will establish a system to monitor compliance with access standards set forth by DMAS and a data management system to meet DMAS data collection requirements. DMAS annually requires managed care organizations to report the percentage of children who received all expected well child visits according to the benefits schedule, during the period that each child was enrolled, and the percentage of two-year-old children who have received each immunization specified in the most current ACIP recommendations.

7.1.4. ☒ Quality improvement strategies

Health insurers may perform the following:

A. Documentation of current MCHIP quality certification or documentation of a comparable accreditation.
B. Develop and maintain a Quality Improvement Program (QIP) which meets standards and reporting requirements set out by the Commonwealth.
C. Cooperate and show compliance with the DMAS Quality Improvement Program, which may require calculation and reporting of performance measures and the implementation of performance improvement projects as well as cooperate with DMAS or a designated agent in conducting quality reviews. Managed care organizations are required to have a written utilization management (UM) program that reflects the National Committee for Quality Assurance standards to include mechanisms to detect underutilization and/or overutilization of care. Managed care organizations must show implementation of an approved system to monitor and address complaints and grievances.

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

Each MCO will meet the requirements by the contract with DMAS to ensure

access to well-baby care, well adolescent care, and childhood immunizations. By contract MCOs are responsible for arranging and administering covered services to enrollees and ensuring that the delivery system provides available, accessible and adequate numbers of facilities, locations and personnel for the provision of covered services. The MCO provides or otherwise arranges care by providers specializing in early childhood and youth services. MCOs provide services as established by recognized clinically approved guidelines for standards of care. MCOs ensure that immunizations are rendered in accordance with the most current Advisory Committee on Immunization Practices (ACIP) or the American Academy of Pediatrics Advisory Committee recommendations.

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))

MCOs are required to demonstrate their ability to monitor network capacity throughout their service area for routine, urgent, and emergency care. The Commonwealth establishes standards and reporting requirements for access to routine, urgent, and emergency care. Each health plan is solely responsible for arranging for and administering covered services to enrollees and ensuring that its delivery system provides available, accessible, and adequate numbers of facilities, locations, and personnel for the provision of covered services. The health plan must include in its network or otherwise arrange care by providers specializing in early childhood and youth services.

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

The State monitors complaints received by DMAS, the Call Center, or MCOs with regard to access to care.

Children with special health care needs are not considered a separate population or as a special population under the FAMIS State Plan. MCOs provide access to all covered services, including specialty services, to any child regardless of the medical condition. Each MCO must have, at a minimum, complex care management programs that focus on improving the health status of members diagnosed with the following conditions: respiratory conditions such as asthma, heart disease, diabetes, co-occurring mental health/behavioral health conditions, and cancer.

Each MCO must arrange to provide care according to established appointment standards and meet requirements determined by the contract for monitoring and reporting access to services, timeliness of services, and appropriateness of services for all enrollees including those with chronic, complex or serious medical conditions. The MCO is responsible for the provision of services regardless if a medical condition and/or diagnosis was present prior to being assigned the enrollee; thus the MCO will manage all pre-existing conditions. MCOs cover and pay for services furnished in facilities or by practitioners outside the plan's network if the needed medical services or necessary supplementary resources are not available in the plan's network.

MCOs are not permitted to refuse an assignment or disenroll a patient or otherwise discriminate against a patient based on physical or mental disability or type of illness or condition.

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)) (42 CFR 457.495(d))

Prior authorization of health decisions is made in accordance with State law, consistent with the standards set by the regulations governing managed care health insurance plans.

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

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

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

8.1.1. ☒ Yes

Cost sharing as described below applies to FAMIS children. Cost sharing does not apply to the FAMIS Prenatal population.

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 and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

None. Effective April 15, 2002, Virginia temporarily suspended premiums until further notice. Effective September 1, 2002, the FAMIS program no longer charges premiums.

8.2.2. Deductibles:

None.

8.2.3. Coinsurance or copayments:

Co-payments shall not be imposed on any of the children covered under the Secretary-approved coverage offered through fee-for-service.

In Secretary-approved coverage modeled after the state employee plan, no co-payments are required for well-baby and well-child and other preventive services. Effective 7/1/10, no co-payments are required for pregnancy-related services. Effective 7/1/19, no co-payments are required for outpatient mental health and substance use disorder services.

In the event of a federally declared or Governor-declared disaster and at the Commonwealth's discretion, the Commonwealth may temporarily waive co-payments for FAMIS beneficiaries who reside and/or work in the State or federally declared disaster area.

Copayments for Secretary-approved coverage modeled after the state employee plan are:

Description of Service	≤ 150% FPL	> 150% FPL
Outpatient	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient	$15 per admission	$25 per admission
Non-Emergency use of Emergency Room	$10 per visit	$25 per visit
Poverty Levels	**≤ 150% FPL**	**> 150% FPL**
Maximum Yearly Co-Payment Limit Per Family	$180	$350

Income levels are provided as a percentage of Federal Poverty Level (FPL) based on gross income.

Total cost-sharing for each year (or 12-month eligibility period) is limited to: (1) for a family with an annual income equal to or less than 150% of the FPL, the lesser of (a) 2.5% of a family's income, and (b) $180.00; and (2) for a family with an annual income greater than 150% of the FPL, the lesser of (a) 5% of a family's income, and (b) $350.00.

The co-payment and coinsurance maximums are set at thresholds that are

well below the maximum allowable per CMS for families with annual incomes equal to or below 150% of FPL and for those with annual incomes above 150% of FPL. The maximum yearly co-payment limit for families in FAMIS with annual incomes at or below 150% FPL is $180.00 per year. Families enrolled in FAMIS and receiving benefits through FAMIS contracted health plans are advised of the amount of maximum allowable cost-sharing that they may be responsible for during the year. Families are required to submit documentation to DMAS or its contractor, showing that the co-payment cap is met for the year. Once the cap is met, DMAS or its contractor will issue a new card excluding families from paying additional co-pays.

Enrollees are not held liable for any additional costs, beyond the standard co-payment amount, for emergency services furnished outside of the individual's managed care network. Only one co-payment charge is imposed for a single office visit.

The proposed cost sharing caps to be applied toward copayments and/or coinsurance ($180 and $350) were included in the Plan document.

No cost-sharing will be charged to American Indians and Alaska Natives.

8.2.4. Other

None.

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)) (42 CFR 457.505(b))

The public is notified of FAMIS' cost-sharing requirements, including differences based on income and plans, in the outreach and enrollment materials including:

- **The DMAS and Cover Virginia websites;**
- **FAMIS Member Handbook;**
- **Managed care organization member handbooks; and**
- **Outreach grantees.**
- **The public also has the opportunity to become involved during the regulatory process. Implementing regulations must go through a mandatory 60-day comment period consistent with the Code of Virginia.**
- **The Children's Health Insurance Program Advisory Committee (CHIPAC) provides an opportunity for public education and input.**

Effective April 15, 2002, Virginia temporarily suspended premiums until further notice. FAMIS families were notified by letter, informing them of the suspension of premiums and copies of such letters were posted on the DMAS web site. Effective September 1, 2002, the FAMIS program no longer charges premiums.

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)) (42 CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 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)) (42 CFR 457.515(f))

8.4.1- MHPAEA ☒ **There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 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. (42 CFR 457.496(d)(3)(ii)(A)) **Not applicable.**

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 by 42 CFR 457.560 (42 CFR 457.496(d)(3)(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: <u>inpatient, emergency, pharmacy</u>)**

☐ No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. 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.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

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 portion 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-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 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? (42 CFR 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. (42 CFR 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 42 CFR 457.496(d)(3)(i)(B)) 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. (42 CFR 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 predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))**

Guidance: If there is no single level of a type of 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 predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

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))

Virginia has structured the cost sharing levels to make it highly unlikely that any family will exceed the allowable cost sharing.

Virginia ensures that the annual aggregate cost sharing for all FAMIS enrollees in a family does not exceed 5% of a family's income as required by §2103(e)(3)(b) of Title XXI. Co-payments are capped at levels that are extremely unlikely to

exceed the upper limit. Total cost-sharing for each year (or 12-month eligibility period) is limited to: for a family with an annual income equal to or less than 150% of the FPL, the lesser of (a) 2.5% of a family's income or (b) $180; and for a family with an annual income greater than 150% of FPL, the lesser of (c) 5% of the family's income or (d) $350. In 2018, the federal poverty level for a family of one is $12,140: 5% of that amount is $607 and 2.5% of that amount is $304. Virginia's cost-sharing caps are well below these amounts and are designed not to exceed 2.5% or 5% of a family's income, respectively.

As mentioned earlier, families under the Secretary-approved coverage offered through the fee-for-service program are not subject to any cost-sharing.

Families are required to submit documentation to DMAS or its contractor, showing that the co-payment limit is met for the year. Once the cap is met, the managed care organization will issue a new card excluding families from paying additional co-pays.

Finally, Title XXI requires that cost-sharing for families with incomes below 150 percent of FPL not exceed an amount that is "nominal" under Medicaid law, with appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable. The maximum co-payment for a service costing over $50 is $3 under Medicaid law and was established in 1978. Virginia's co-payment for families under 150% of FPL is $2, which is well below the $3 federal cap.

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)

No cost-sharing will be charged to American Indians and Alaska Natives. The application form requests information regarding race, ethnicity, and AI/AN status on each child for whom application for child health insurance is made. The applicant's statement on the application form is sufficient to exempt an AI/AN child from any cost-sharing obligations. The FAMIS automated eligibility determination system codes the case records for children listed on the application form as Alaska Natives or American Indians and the automated record will exempt such children from any cost-sharing obligations.

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

Not applicable.

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act which 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 Please 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)) **Virginia's program does not have premiums.**

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, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under this

title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

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

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

Abortion only if necessary to save the life of the mother.

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

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

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))

Objective One: To reduce the number of uninsured children.
Objective Two: To improve the health care status of children.
Objective Three: To conduct effective outreach to encourage enrollment in health insurance plans.

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

See Section 9.3.

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))

With the FAMIS program well established after 10 years, Virginia re-assessed the performance goals for the program. While program managers continue to monitor enrollment on a monthly basis, a decision was made to focus on quality measures rather than enrollment targets.

All of Virginia's Medicaid/CHIP managed care organizations (MCOs) are required to be accredited by the National Committee for Quality Assurance (NCQA). As such, they must calculate Healthcare Effectiveness Data and Information Set (HEDIS) scores on an annual basis. These measures of care are calculated using technical specifications set forth by the NCQA. In addition, each MCO is required to conduct the CAHPS Child Survey annually. Virginia contracts with the same MCOs for Medicaid and FAMIS services. All performance measures are monitored based on the combined Medicaid-CHIP population:

- **Childhood Immunization Status (Combo 2) and each vaccine reported separately as well**
- **Childhood Immunization Status (Combo 3) and each vaccine reported separately as well**
- **Lead Screening in Children**
- **Well-Child Visits in the First 15 Months of Life and each number of visits listed separately**

- **Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life**
- **Adolescent Well-Care Visit**
- **Children and Adolescent access to primary care practitioners**
- **Asthma – Medication Management (all age categories set forth by the HEDIS technical specifications)**

The Children's Health Insurance Program Advisory Committee (CHIPAC) continues to monitor progress on the following measures, based on HEDIS specifications, and make recommendations for improvement:

- **Well Child Visits for child and adolescent age groups**
- **Immunizations at 2 years of age for combinations 2 and 3**

The DMAS agency strategic plan was modified to include performance measures and goals for the CHIP population for the 2016-2018 biennium, beginning July 1, 2016, using NCQA's HEDIS technical specifications:

- **Percentage of adolescents in managed care with at least one comprehensive well-visit per year – Annually**
- **Percentage of two-year-olds in managed care who are fully immunized – Annually**
- **Number of Medicaid/FAMIS enrolled children who received at least one dental service – Quarterly**

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 (HEDIS)
9.3.7.2. ☒ Well child care (HEDIS)
9.3.7.3. ☒ Adolescent well visits (HEDIS)
9.3.7.4. ☒ Satisfaction with care (CAHPS)
9.3.7.5. ☒ Mental health (HEDIS)
9.3.7.6. ☒ Dental care (EPSDT)
9.3.7.7. ☒ Other, please list:

Lead screening (HEDIS)
Asthma (HEDIS)

9.3.8. ☐ Performance measures for special targeted populations.

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

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

DMAS complies with subsection 10.1 in assessing the operation of FAMIS and submitting a report to the Secretary by January 1 following the end of the fiscal year. This includes the reduction in the number of uninsured low-income children and the results of the program assessment.

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 of audit. (Section 2107(b)(3)) (42CFR 457.720)

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

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

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

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

The public has the opportunity for involvement in major changes to the FAMIS program through the legislative process of the Virginia General Assembly. The public also has the opportunity to become involved in administrative policies during the regulatory process. Implementing regulations must go through a mandatory 60-day comment period consistent with the Code of Virginia.

Another method for insuring ongoing public involvement is the Children's Health Insurance Program Advisory Committee (CHIPAC). CHIPAC is composed of representatives from public and private organizations and other individuals with significant knowledge of and interest in children's health insurance. The Committee meets quarterly to assess policies, operations, and outreach efforts. Meetings are open to the public and include a public comment period. The Committee may offer recommendations regarding policies, the coordination of regional and local outreach activities, and procedures for streamlining and simplifying the application process, brochures, other printed materials, forms, and applicant correspondence.

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. (Section 2107(c)) (42CFR 457.120(c))

At this time, Virginia has seven federally recognized Indian tribes. DMAS participates with CMS representatives and Tribal leaders in an annual face-to-face tribal consultation. During this meeting, the state's development and implementation of pertinent components of the CHIP State Plan are discussed.

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

FAMIS MCO coverage has expanded incrementally over the years since 2000 in conjunction with the expansion of Medicaid MCOs. Prior to each expansion, notification was sent by letter to all affected members, and a Medicaid Memorandum was sent to all providers. This Memorandum was also posted on the DMAS website.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. 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 sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

CHIP Budget Plan

	Federal Fiscal Year Costs – FFY 2021	Federal Fiscal Year Costs – FFY 2022
Enhanced FMAP rate	**69.34%**	**65.00%**
Benefit Costs		
Insurance payments		
Managed care	$367,268,603	$398,707,941
per member/per month rate @ # of eligible	$203.15 @ 150,650 avg elig/mo	$215.70 @ 154,038 avg elig/mo
Fee for Service	$77,417,685	$81,774,108
Total Benefit Costs	**$444,686,288**	**$480,482,049**
(Offsetting beneficiary cost sharing payments)	$0	$0
Net Benefit Costs	**$444,686,288**	**$480,482,049**
Administration Costs		
Personnel	$2,822,841	$3,037,786
General administration	$625,221	$672,828
Contractors/Brokers (e.g., enrollment contractors)	$19,664,576	$21,161,936
Claims Processing	$6,137,094	$6,604,403
Outreach/marketing costs	$510,521	$549,394
Health Services Initiatives	$871,756	$5,528,873
Other	$0	$0
Total Administration Costs	**$30,632,008**	**$37,555,221**
10% Administrative Cost Ceiling	$49,409,588	$53,386,894
Federal Share (multiplied by enh-FMAP rate)	**$329,585,706**	**$336,724,226**
State Share	$145,732,590	$181,313,044
TOTAL PROGRAM COSTS	**$475,318,296**	**$518,037,270**

Funding:

State funding comes from state General Funds and the Family Access to Medical Insurance Security (FAMIS) Plan Trust Fund.

The 1997 General Assembly established the Virginia Children's Medical Security

Insurance Plan (CMSIP) Trust Fund in anticipation that a children's health insurance program would be enacted by the 1998 General Assembly. The fund was renamed the FAMIS Plan Trust Fund in legislation enacted in 2000. The Assembly directed that the Fund be used to pay, in part, the Commonwealth's share of expenditures under the children's health insurance program. Income to the Fund is derived from increased health insurance premium tax revenue. In 1997, the Commonwealth repealed a partial tax exemption enjoyed by the Blue Cross and Blue Shield Companies, which no longer provide insurance of last resort as a result of HIPAA reforms. Payments into the Trust Fund are approximately $14 million a year. The remainder of the Commonwealth's share is paid from state General Funds.

Section 10. **Annual Reports and Evaluations (Section 2108)**

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

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

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

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

Section 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 items 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.

Eligibility and Enrollment Matters

12.1 Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

For reviews involving adverse eligibility actions taken by the Department of Medical Assistance Services (DMAS), the Department of Social Services (DSS), or the Central Processing Unit (CPU), the following procedures shall apply.

1. **DMAS, the DSS, and/or the CPU must send written notification of adverse actions affecting an individual's request for or receipt of FAMIS coverage. Adverse actions include:**
   a. **Denial of eligibility;**
   b. **Failure to make a timely determination;**
   c. **Suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.**

2. **The written notification must include the reasons for the determination, an explanation of rights to request a review and how to request a review, the standard and expedited time frames for review, and the circumstances under which enrollment may continue pending review. The notice must be sent to applicants/enrollees within 10 days after the date of denial or at least 10 days prior to suspension or termination of enrollment.**

3. **To be considered timely, a request for review shall be received by DMAS no later than 30 calendar days from the date of the notice of adverse action.**

4. **A review shall not be granted if the sole basis for the adverse determination is a state or federal provision requiring an automatic change in eligibility or enrollment that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.**

5. **A request for review shall be heard and decided by an agent of DMAS who has not been directly involved in the adverse action under review.**

6. **All applicants/enrollees shall have the right to have personal and medical information and records maintained as confidential.**

7. All applicants/enrollees shall have an opportunity to:

a) Represent themselves or have representation of their choosing during the review process;
b) Timely review their files and other applicable information relevant to review of the decision;
c) Fully participate in the review process, including an opportunity to present supplemental information during the review process; and
d) Receive continued coverage if the enrollee requests a review prior to the effective date of the suspension or termination of the enrollment.

8. If an expedited review decision is not mandated, a request for review shall result in a written final decision within 90 calendar days of receipt of the request for review unless the applicant, enrollee, or authorized representative requests or causes a delay. An expedited review decision will be mandated whenever the State receives, from the managed care organization or the primary health provider, information indicating that taking the time for a standard resolution of the review request could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. If an expedited review decision is mandated, then a request for review shall result in a written final decision within 3 business days after the State receives, from the managed care organization or the primary health provider, the case record and information indicating that taking the time for a standard resolution of the review request could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, unless the applicant, enrollee, or authorized representative requests or causes a delay.

Health Services Matters

12.2 Please describe the review process for health services matters that complies with 42 CFR 457.1120. "Health services matters" refers to grievances relating to the provision of health care.

For reviews involving health services matters for FAMIS enrollees receiving services through Managed Care Organizations (MCOs), the following procedures shall apply.

1. The MCO shall provide a written notification within 10 days after a decision is made and provide the opportunity for external review whenever an enrollee's request for covered services is delayed, denied, reduced, suspended, or terminated, in whole or in part including a determination about the type or level of services; or whenever there has been the failure to approve, furnish or provide

payment for health services in a timely manner.

2. **Written notification must include the reasons for the determination, an explanation of rights to request a review and how to request a review, and the standard and expedited time frames for review. In addition, it shall inform the enrollee about his or her opportunity to file a grievance or a request for review with the MCO, and include the phone number and name of the contact person at the MCO's office.**

3. **The MCO shall comply with the Department's hearing process, no more or less, and in the same manner as is required for all other FAMIS evidentiary hearings.**

4. **The MCO shall have written policies and procedures which describe the informal and formal grievance and review process and how it operates, and the process must be in compliance with federal and State regulations. The procedures must provide for prompt resolution of the issue and involve the participation of individuals with the authority to require corrective action.**

5. **A review shall not be granted if the sole basis for the adverse determination is a state or federal provision requiring an automatic change that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.**

6. **The MCO shall offer an internal grievance review procedure. The MCO shall issue grievance decisions within fourteen (14) days from the date of initial receipt of the grievance and after all pertinent information has been received. The decision must be in writing and shall include but not be limited to:**

   a. **The decision reached by the MCO;**
   b. **The reasons for the decision;**
   c. **The policies or procedures which provide the basis for the decision; and**
   d. **A clear explanation of further review rights and the time frame for filing a request for review.**

7. **The enrollee may request an external review of any formal grievance decision by the MCO. An external review organization shall manage the external review procedure. The external review organization provides an independent external review, because the external review organization is the State or a contractor other than the contractor responsible for the matter subject to external review. If an enrollee wishes to file an appeal with the external review organization, the appeal must be filed within 30 days of the enrollee's receipt of notice of the final decision from the MCO.**

8. **The MCO shall provide to the external review organization all information necessary for any enrollee appeal within the time frame established by the**

Department.

9. **All applicants/enrollees shall have the right to have personal and medical information and records maintained as confidential.**

10. **All applicants/enrollees shall have an opportunity to:**

    a. **Represent themselves or have representation of their choosing during the review process;**
    b. **Timely review their files and other applicable information relevant to review of the decision;**
    c. **Fully participate in the review process, whether the review is in person or in writing, including an opportunity to present supplemental information during the review process; and**
    d. **Receive continued coverage if the enrollee requests a review prior to the effective date of the reduction or termination of services or payment for services.**

11. **Unless an expedited review decision is mandated, the external review organization shall complete the external review process and issue a decision within ninety (90) calendar days of the date an enrollee requests an internal review. If the enrollee's physician or health plan determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, then the external review organization must complete the external review process and issue a decision within seventy-two (72) hours of the time an enrollee requests external review.**

12. **The MCO shall comply with the external review decision. The external review organization's decision in these matters shall be final and shall not be subject to appeal by the MCO.**

13. **The external review organization's decision must be in writing and shall include but not be limited to:**

    a. **The decision reached by the external review organization;**
    b. **The reasons for the decision;**
    c. **The policies or procedures which provide the basis for the decision.**

For reviews involving health services matters for FAMIS enrollees receiving services through fee-for-service, the following procedures shall apply.

1. **The State or its contractor shall provide a written notification within 10 days**

after a decision is made and provide the opportunity for external review whenever an enrollee's request for covered services is delayed, denied, reduced, suspended, or terminated, in whole or in part including a determination about the type or level of services; or whenever there has been the failure to approve, furnish or provide payment for health services in a timely manner.

2. **Written notification must include the reasons for the determination, an explanation of rights to request a review and how to request a review, and the standard and expedited time frames for review.**

3. **A review shall not be granted if the sole basis for the adverse determination is a state or federal provision requiring an automatic change that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.**

4. **The external review must be conducted by the State or a contractor other than the contractor responsible for the matter subject to external review.**

5. **If an enrollee wishes to request an external review, the request must be filed within 30 days of the enrollee's receipt of notice of the final decision from the State or its contractor.**

6. **All applicants/enrollees shall have the right to have personal and medical information and records maintained as confidential.**

7. **All applicants/enrollees shall have an opportunity to:**
   a. **Represent themselves or have representation of their choosing during the review process;**
   b. **Timely review their files and other applicable information relevant to review of the decision;**
   c. **Fully participate in the review process, whether the review is in person or in writing, including an opportunity to present supplemental information during the review process; and**
   d. **Receive continued coverage if the enrollee requests a review prior to the effective date of the reduction or termination of services or payment for services.**

8. **Unless an expedited review decision is mandated, the external review process shall be completed and a written decision shall be issued within ninety (90) calendar days of the date an enrollee requests an external review, unless the applicant, enrollee, or authorized representative requests or causes a delay. If the enrollee's physician or health plan determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or**

ability to attain, maintain, or regain maximum function, then the external review process must be completed and a written decision must be issued within seventy-two (72) hours of the time an enrollee requests external review, unless the applicant, enrollee, or authorized representative requests or causes a delay.

For reviews involving behavioral health services matters for FAMIS enrollees receiving services through the contracted BHSA, the following procedures shall apply.

1. **The BHSA shall provide a written notification within 10 days after a decision is made and provide the opportunity for external review whenever an enrollee's request for covered services is delayed, denied, reduced, suspended, or terminated, in whole or in part including a determination about the type or level of services; or whenever there has been the failure to approve, furnish or provide payment for health services in a timely manner.**

2. **Written notification must include the reasons for the determination, an explanation of rights to request a review and how to request a review, and the standard and expedited time frames for review. In addition, it shall inform the enrollee about his or her opportunity to file a grievance or a request for review with the BHSA, and include the phone number and name of the contact person at the BHSA's office.**

3. **The BHSA shall have written policies and procedures which describe the informal and formal grievance and review process and how it operates, and the process must be in compliance with federal and State regulations. The BHSA shall issue grievance decisions within thirty (30) days from the date of initial receipt of the grievance.**

4. **A review shall not be granted if the sole basis for the adverse determination is a state or federal provision requiring an automatic change that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.**

5. **FAMIS members have the right to appeal most adverse actions by the BHSA contractor directly to the Department. The contractor shall notify the members of their right to appeal to the Department. If an enrollee wishes to file an appeal with the Department, the appeal must be filed within 30 days of the enrollee's receipt of notice of the decision from the BHSA contractor.**

6. **The BHSA shall provide to the Department all information necessary for any enrollee appeal within the time frame established by the Department.**

7. **All applicants/enrollees shall have the right to have personal and medical information and records maintained as confidential.**

8. All applicants/enrollees shall have an opportunity to:

a. Represent themselves or have representation of their choosing during the review process;
b. Timely review their files and other applicable information relevant to review of the decision;
c. Fully participate in the review process, whether the review is in person or in writing, including an opportunity to present supplemental information during the review process; and
d. Receive continued coverage if the enrollee requests a review prior to the effective date of the reduction or termination of services or payment for services.

9. The Department shall complete the review process and issue a decision within ninety (90) calendar days of the date an enrollee's request. An expedited review must be completed within seventy-two (72) hours of the request.

10. The Department's decision must be in writing and shall include but not be limited to: the decision reached by the Department; the reasons for the decision; and, the policies or procedures which provide the basis for the decision.

11. The BHSA shall comply with the Department's decision.

12.3 Premium Assistance Programs - If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please 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.

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