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

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

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

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

_____/s/_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: Drew Snyder	Position/Title: Executive Director, MS Div. of Medicaid
Name: Janis Bond	Position/Title: Deputy Administrator, Office of Enrollment
Name: Jennifer Wentworth	Position/Title: Deputy Administrator, Office of Finance
Name: Tara Clark	Position/Title: Deputy Executive Director

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

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

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

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

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

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

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

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

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

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

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

1.3 ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR § 457.130)**1.4** Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR § 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan: Effective Date: July 1, 1998

Implementation Date: July 1, 1998

Amendment #1 submitted: August 1, 1998 Implemented January 1, 2000
Amendment #2 submitted: September 22, 1999 Implemented January 1, 2000
Amendment #3 submitted: July 6, 2000 Implemented October 1, 2000
Amendment #4 submitted: July 3, 2001 Implemented July 1, 2001
Amendment #5 submitted: September 30, 2002 Implemented January 1, 2005
Amendment #6 submitted: December 29, 2005 Implemented January 1, 2005
Amendment #7 submitted: December 6, 2010 Implemented January 1, 2010
Mental health parity requirements.

Amendment #8 submitted: September 25, 2013 Implemented July 1, 2013
Transition of the management of the Children's Health Insurance Program (CHIP) in Mississippi for the oversight of the separate health plan to the Mississippi Division of Medicaid; inclusion of covered dental benefits required by the Children's Health

Insurance Program Reauthorization Act of 2009 (CHIPRA); clarification of enrollee coverage provided in an emergency department.

Amendment #9 submitted: February 9, 2015 Implemented January 1, 2015
To reflect the change in operation of the separate CHIP health plan to two (2) contracted MCOs.

Amendment #10 submitted: January 9, 2018 Implemented: October 1, 2019
To include a Health Services Initiative offering expanded vision services to low-income children throughout the state.

Amendment #11 MS SPA 19-0011-CHIP Submitted: May 5, 2019
To demonstrate compliance with the Mental Health Parity and Addiction Equality Act (MHPAEA) final rule. Effective: July 1, 2018

Amendment #12: MS SPA 19-0012-CHIP Submitted: June 27, 2019
To include managed care requirements. Effective: July 1, 2018

Superseding Pages of MAGI CHIP State Plan Material

State: Mississippi

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
MS-13-0009 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Targeted Low-Income Children 4.4.1
		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
MS-13-0010 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
MS-13-0011 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
MS-13-0013 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5
		CS18	Non-Financial – Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR
		CS19	Non-Financial – Social Security Number	Supersedes the current section 4.1.9.1
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
		CS27	Continuous Eligibility	Supersedes the current section 4.1.8

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.

A notification letter with the draft CHIP SPA #11 was submitted to the Tribe on 3/18/2019. The Tribe had no comments.

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

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))

Demographics

According to the latest available census reports, Mississippi's population is 2,967,297 (2010 Census).

According to the U.S. Census Bureau, 22.3% of Mississippi's population is currently under 100% of the Federal Poverty Level (FPL).

30% of the families in Mississippi have children under the age of 18.

According to the 2010 Census reports, there are 849,495 (28.6%) children less than 19 years of age in the State of Mississippi.

Medicaid Eligibles

According to 2014 Medicaid Management Information Systems (MMIS) reports generated by the Mississippi Division of Medicaid, there are 362,288 Mississippi children less than 19 years of age currently enrolled in Medicaid.

CHIP

Mississippi originally implemented CHIP in July 1998 with a Medicaid expansion program for children 15 to 18 years of age at 100% of the FPL. This phase of the program ended as of October 01, 2002. To date, the State's CHIP targets all children in the state below age 19 who are below 200% FPL, not eligible for Medicaid coverage, and have no other health coverage. According to the Census Bureau's 2013 American Community Survey, there are 44,000 uninsured children in Mississippi less than 19 years of age and below 200% FPL who are not covered by Medicaid or CHIP. The goal is to assess these children for CHIP eligibility under a health coverage package. As of August 2014, 70,973 children were enrolled in CHIP.

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)

The Mississippi Division of Medicaid's CHIP CCOs will enroll non-profit providers (qualified provider) enrolled in both Mississippi Medicaid and CHIP to offer vision services to low-income children throughout the state. These services will not be reimbursed if the child has reached his/her benefit limits regarding a vision screening, eye exam and/or glasses/frames during the fiscal year. The program description and requirements of the qualified providers are as follows:

- The qualified provider will target Mississippi's low-income children by identifying Title I schools in which at least 51% of the student body qualifies to receive free or reduced price meals. In Mississippi, this includes 83% of schools statewide. The qualified provider will provide to the Division of Medicaid the list of schools where vision services will be provided. The Division of Medicaid's CHIP CCO will verify that each school on the list meets the 51% threshold for free or reduced price meals. The qualified provider will initially implement this HSI program in schools with the largest schools with the highest percentage of students eligible for free/reduced lunch (FRL) program first and then expand to additional schools in the state who meet the HSI criteria.
- The qualified provider will give all children in the targeted schools parental/guardian consent forms that require a parent/guardian's signature to opt-in or decline the services. The school will maintain a list of which children have opted-in and which children will not receive the services. Those children who do not have an opt-in consent form returned to the school will not receive the services.
- For children whose parents/guardians opt-in to receive the services, the qualified provider will perform one vision screening, one eye exam for those who fail the vision screening and, if needed, corrective lenses and frames, including replacements, as needed, on-site in a mobile eye clinic (for the eye exam) or within the school (for the vision screening and provision of glasses).
- The qualified provider will maintain an electronic medical record for each child that it serves, which will include the name of the child, services received, and other available identifying information (for example, date of birth, phone number and address) collected via the consent form. The qualified provider will submit CMS-1500 claims to the appropriate CHIP/Medicaid coordinated care organization (CCO), or the Division of Medicaid. The CHIP/Medicaid CCOs will pay the qualified provider based on negotiated, standard fees.
- The qualified provider will identify all children served aged 18 or younger who are not identified as enrolled in Medicaid fee-for-service, a Medicaid/CHIP CCO or as having private vision insurance. The qualified provider will submit these uninsured children's information including at a minimum, the child's name, date of birth, services provided and date of service to the Mississippi Division of Medicaid's CHIP CCO which will remit payment to the qualified provider for these services through CHIP HSI funding.
- The HSI will target only children/youth under the age of 19.
- The Division of Medicaid assures this HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

Mississippi estimates that approximately 2,500-3,000 children will receive services (an exam, and glasses as needed) through CHIP HSI funding on an annual basis. An updated budget is included in Section 9.10.

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

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

The Mississippi Division of Medicaid consults with the tribe by notifying the Mississippi Band of Choctaw Indians (MBCI) designees, in writing, with a description of the proposed changes and direct impact, at least thirty (30) days prior to each submission by the State of any CHIP SPA that is likely to have a direct effect on Indians, Indian Health programs, or Urban Indian Organizations (I/T/U) by email. MCBI designees are the Choctaw Health Center's Deputy Director and the Director of Financial Services.. Direct impact is defined as any Medicaid or CHIP program changes that are more restrictive for eligibility determinations, changes that reduce payment rates or payment methodologies to Indian Health Programs, Tribal Organizations, or Urban Indian Organization providers, reductions in covered services, changes in consultation policies, and CHIP proposals that may impact I/T/U providers. If no response is received from the tribe within thirty (30) days, the Mississippi Division of Medicaid will proceed with the submission to the Centers for Medicare and Medicaid Services (CMS).

If the Mississippi Division of Medicaid is not able to consult with the tribe thirty (30) days prior to a submission, a copy of the proposed submission along with the reason for the urgency will be forwarded to the tribe designee. The Tribe may waive this notification time-frame requirement in writing via e-mail. If requested, a conference call with the MCBI designee and/or other tribal representatives will be requested to review the submission and its impact on the tribe. The Mississippi Division of Medicaid will then confirm the discussion via email and request a response from the designee to ensure agreement on the submission. This documentation will be provided as part of the submission information to CMS.

The Choctaw Health Center's Deputy Health Director and Director of Financial Services were notified by e-mail on December 15, 2017, of the proposed CHIP #10 submission. An expedited submission was requested. The Tribe approved CHIP SPA #10 on 1/8/18.

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

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

The Mississippi Division of Medicaid consults with the tribe by notifying the Mississippi Band of Choctaw Indians designee, in writing, with a description of the proposed changes and direct impact, at least sixty (60) days prior to each submission by the State of any Medicaid SPA, waiver proposals, waiver extensions, waiver amendments, waiver renewals, and proposals for demonstration projects that are likely to have a direct effect on Indians, Indian Health programs, or Urban Indian Organizations (I/T/U) by email. The Director of Financial Services is the Mississippi Band of Choctaw Indians designee. Direct impact is defined as any Medicaid or CHIP program changes that are more restrictive for eligibility determinations, changes that reduce payment rates or payment methodologies to Indian Health Programs, Tribal Organizations, or Urban Indian Organization providers, reductions in covered services, changes in consultation policies, and proposals for demonstrations or waivers that may impact I/T/U providers. If no response is received from the tribe within thirty (30) days, the Mississippi Division of Medicaid will proceed with the submission to the Centers for Medicare and Medicaid Services (CMS).

If the Mississippi Division of Medicaid is not able to consult with the tribe sixty (60) days prior to a submission, a copy of the proposed submission along with the reason for the urgency will be forwarded to the tribe designee. A conference call with the designee and/or other tribal representatives will be requested to review the submission and its impact on the tribe. The Mississippi Division of Medicaid will then confirm the discussion via email and request a response from the designee to ensure agreement on the submission. This documentation will be provided as part of the submission information to CMS.

The tribe's Director of Financial Services, Donita Stephens, was notified by e-mail on January 10, 2013, of the proposed CHIP #8 submission.

While not required, the Mississippi Division of Medicaid is planning quarterly meetings with the tribe to discuss proposed Medicaid and CHIP program changes and other topics as permitted by schedules. In person meetings with the tribe have been held on July 10, 2012, October 15, 2012, March 8, 2013, and June 18, 2013. A meeting regarding CHIP and other issues was held on October 14, 2014 and December 15, 2014.

Section 3. Methods of Delivery and Utilization Controls

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

Guidance: In Section 3.1, describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

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

3.1.1 Choice of Delivery System

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

☐ No, the State does not use a managed care delivery system for any CHIP populations.

☒ Yes, the State uses a managed care delivery system for all CHIP populations.

☐ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

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

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the

State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

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

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

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

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

☒ No
☐ Yes

If yes, please describe which services are carved out of your managed care delivery system and how the State provides these services to an enrollee, such as through fee-for-service. Examples of carved out services may include transportation and dental, among others.

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

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

☒ Managed care organization (MCO) (42 CFR 457.10)
  ☒ Capitation payment
    Describe population served: Entire CHIP enrolled 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 it if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

- Reimburses CMS for an amount equal to the Federal share of the remittance, taking into account applicable differences in the Federal matching rate; and
- Submits a separate report describing the methodology used to determine the State and Federal share of the remittance with the annual report

provided to CMS that summarizes the reports received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b))

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

3.4 Enrollment

☒ The State assures that its contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities provide that the MCO, PIHP, PAHP, PCCM or PCCM entity:

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

3.4.1 Enrollment Process

3.4.1.1 ☒ The State assures that it provides informational notices to potential enrollees in an MCO, PIHP, PAHP, PCCM, or PCCM entity that includes the available managed care entities, explains how to select an entity, explains the implications of making or not making an active choice of an entity, explains the length of the enrollment period as well as the disenrollment policies, and complies with the information requirements in 42 CFR 457.1207 and accessibility standards established under 42 CFR 457.340. (42 CFR 457.1210(c))

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

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

☒ Yes
☐ No

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

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

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

3.4.2 Disenrollment

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

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

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

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

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

Guidance: Reasons for disenrollment by the MCO, PIHP, PAHP, PCCM, and PCCM entity must be specified in the contract with the State. Reasons for disenrollment may not include an adverse change in the enrollee's

health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, PCCM or PCCM entity seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b)(2))

3.4.2.5 Enrollee Requests for Disenrollment.

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

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

☒ Yes
☐ No

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

☒ The State assures that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(f)(1))

☒ The State assures that beneficiary requests to disenroll for cause will be permitted at any time by the MCO, PIHP, PAHP, PCCM or PCCM entity. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(1) and (d)(2))

☒ The State assures that beneficiary requests for disenrollment without cause will be permitted by the MCO, PIHP, PAHP, PCCM or PCCM entity at the following times:

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual

who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and

- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

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

3.5 Information Requirements for Enrollees and Potential Enrollees

3.5.1 ☒ The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.

3.5.2 ☒ The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))

3.5.3 ☒ The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.

3.5.4 ☒ The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:

- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
- Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

3.5.5 ☒ If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

- The format is readily accessible;
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;

- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

3.5.6 ☒ The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:

- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
- Making oral interpretation available in all languages and written translation available in each prevalent non-English language;
- Requiring each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services available in the prevalent non-English languages in its particular service area;
- Making interpretation services available to each potential enrollee and requiring each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee; and
- Notifying potential enrollees, and requiring each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees:
  - That oral interpretation is available for any language and written translation is available in prevalent languages;
  - That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and
  - How to access the services in 42 CFR 457.1207, cross-referencing 42 CFR 438.10(d)(5)(i) and (ii).

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

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;
- The basic features of managed care;
- Which populations are excluded from enrollment in managed care, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM

entity;

- Covered benefits including:
  - Which benefits are provided by the MCO, PIHP, or PAHP; and which, if any, benefits are provided directly by the State; and
  - For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, where and how to obtain the service;
- The provider directory and formulary information required in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h) and (i);
- Any cost-sharing for the enrollee that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan;
- The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in 42 CFR 457.1218, cross-referencing 42 CFR 438.68;
- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

3.5.8 ☒ The State assures that it will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that the State must notify all enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually.

3.5.9 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide the information specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) to all enrollees of MCOs, PIHPs, PAHPs and PCCM entities, including that:

- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider within the timeframe specified in 42 CFR 438.10(f), and
- The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in 42 CFR 438.3(i).

3.5.10 ☒ The State assures that each MCO, PIHP, PAHP and PCCM entity will provide enrollees of that MCO, PIHP, PAHP or PCCM entity an enrollee handbook that meets the requirements as applicable to the MCO, PIHP, PAHP and PCCM entity, specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(1)-(2), within a reasonable time after receiving notice of the beneficiary's enrollment, by a method consistent with 42 CFR 438.10(g)(3), and including the following items:

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:

- Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
- How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
- In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;

- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
  - What constitutes an emergency medical condition and emergency services;
  - The fact that prior authorization is not required for emergency services; and
  - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
  - The right to file grievances and appeals;
  - The requirements and timeframes for filing a grievance or appeal;
  - The availability of assistance in the filing process; and
  - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical

management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

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

3.5.12 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available a provider directory for the MCO's, PIHP's, PAHP's or PCCM entity's network providers, including for physicians (including specialists), hospitals, pharmacies, and behavioral health providers, that includes information as specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(1)-(2) and (4).

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

3.5.14 ☒ The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:
- Which medications are covered (both generic and name brand); and
- What tier each medication is on.

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

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

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

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

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

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

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

3.6 Benefits and Services

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

3.6.1 ☒ The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)

3.6.2 ☒ The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

3.6.3 ☒ The State assures that it:

- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
- Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

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

3.6.4 ☒ The State assures that each MCO, PAHP and PIHP meet the State's network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)

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

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

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

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

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

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP enrollees;
- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

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

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

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

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

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

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

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

3.6.13 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a service in an amount, duration, or scope

that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

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

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

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

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services;
- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each 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, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

- A compliance program that include all of the elements described in 42 CFR 438.608(a)(1);
- Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State;
- Provision for prompt notification to the State when it receives information

about changes in an enrollee's circumstances that may affect the enrollee's eligibility;

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

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

3.10.6 ☒ The State assures that each MCO, PIHP, or PAHP reports annually to the State on their recoveries of overpayments. (42 CFR 457.1285, cross referencing 42 CFR 438.608(d)(3))

3.10.7 ☒ The State assures that it screens and enrolls, and periodically revalidates, all network providers of MCOs, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E. This requirement also extends to PCCMs and PCCM entities to the extent that the primary care case manager is not otherwise enrolled with the State to provide services to fee-for-service beneficiaries. (42 CFR 457.1285, cross referencing 42 CFR 438.602(b)(1) and 438.608(b))

3.10.8 ☒ The State assures that it reviews the ownership and control disclosures submitted by the MCO, PIHP, PAHP, PCCM or PCCM entity, and any subcontractors. (42 CFR 457.1285, cross referencing 42 CFR 438.602(c))

3.10.9 ☒ The State assures that it confirms the identity and determines the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases. If the State finds a party that is excluded, the State promptly notifies the MCO, PIHP, PAHP, PCCM, or PCCM entity and takes action consistent with 42 CFR 438.610(c). (42 CFR 457.1285, cross referencing 42 CFR 438.602(d))

3.10.10 ☒ The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM, or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))

3.10.11 ☒ The State assures that MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities with which the State contracts are not located outside of the United States and that no claims paid by an MCO, PIHP, or PAHP to a network provider, out-of-network provider, subcontractor or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates. (42 CFR 457.1285, cross referencing to 42 CFR 438.602(i); Section 1902(a)(80) of the Social Security Act)

3.10.12 The State assures that MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities submit to the State the following data, documentation, and information:

- ☒ Encounter data in the form and manner described in 42 CFR 438.818.
- ☒ Data on the basis of which the State determines the compliance of the MCO, PIHP, or PAHP with the medical loss ratio requirement described in 42 CFR 438.8.
- ☒ Data on the basis of which the State determines that the MCO, PIHP or PAHP has made adequate provision against the risk of insolvency as required under 42 CFR 438.116.
- ☒ Documentation described in 42 CFR 438.207(b) on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR 438.206.
- ☒ Information on ownership and control described in 42 CFR 455.104 of this chapter from MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors as governed by 42 CFR 438.230.
- ☒ The annual report of overpayment recoveries as required in 42 CFR 438.608(d)(3). (42 CFR 457.1285, cross referencing 42 CFR 438.604(a))

3.10.13 The State assures that:

☒ It requires that the data, documentation, or information submitted in accordance with 42 CFR 457.1285, cross referencing 42 CFR 438.604(a), is certified in a manner that the MCO's, PIHP's, PAHP's, PCCM's, or PCCM entity's Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. (42 CFR 457.1285, cross referencing 42 CFR 438.606(a))

☒ It requires that the certification includes an attestation that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR 438.604 are accurate, complete, and truthful. (42 CFR 457.1285, cross referencing 42 CFR 438.606(b)); and

☒ It requires the MCO, PIHP, PAHP, PCCM, or PCCM entity to submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR 438.604(a) and (b). (42 CFR 457.1285, cross referencing 42 CFR 438.604(c))

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

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

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

- The documentation on which the State bases its certification that the MCO, PIHP or PAHP has complied with the State's requirements for availability and accessibility of services;
- Information on ownership and control of MCOs, PIHPs, PAHPs, PCCMs, PCCM entities, and subcontractors; and
- The results of any audits conducted under 42 CFR 438.602(e). (42 CFR 457.1285, cross-referencing to 42 CFR 438.602(g)).

3.11 Sanctions

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

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

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

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

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

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

3.11.4 Does the State establish intermediate sanctions for PCCMs or PCCM entities?

☐ Yes
☐ No

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

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

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

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

3.12 Quality Measurement and Improvement; External Quality Review

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

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

3.12.1 Quality Strategy

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

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

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
- A description of:
  - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
  - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);

- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a "significant change" for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

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

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

3.12.1.4 ☒ The State assures that it will review and update the quality strategy as needed, but no less than once every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2))

3.12.1.5 ☒ The State assures that its review and updates to the quality strategy will include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years and the recommendations provided pursuant to 42 CFR 438.364(a)(4). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(i) and (iii).

3.12.1.6 ☒ The State assures that it will submit to CMS:

- A copy of the initial quality strategy for CMS comment and feedback prior to adopting it in final; and
- A copy of the revised strategy whenever significant changes are made to the document, or whenever significant changes occur within the State's CHIP program, including after the review and update required every 3 years. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(3))

3.12.1.7 ☒ Before submitting the strategy to CMS for review, the State assures that when it drafts or revises the State's quality strategy it will:

- Make the strategy available for public comment; and

- If the State enrolls Indians in the MCO, PIHP, or PAHP, consult with Tribes in accordance with the State's Tribal consultation policy. (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(1))

3.12.1.8 ☒ The State assures that it makes the results of the review of the quality strategy (including the effectiveness evaluation) and the final quality strategy available on the Web site required under 42 CFR 438.10(c)(3). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(c)(2)(ii) and (d))

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

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

3.12.2.1.1 ☒ The State assures that it requires that each MCO, PIHP, and PAHP establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The elements of the assessment and program include at least:

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

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

3.12.2.1.2 ☒ The State assures that each MCO, PIHP, and PAHP's performance improvement projects are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. The performance improvement projects include at least the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions based on the performance measures specified in 42 CFR 438.330(d)(2)(i); and
- Planning and initiation of activities for increasing or sustaining improvement. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(2))

Guidance: Only states with a PCCM entity whose contract with the State provides for shared savings, incentive payments or other financial reward for improved quality outcomes need to, complete the next assurance (3.12.2.1.3).

3.12.2.1.3 ☐ The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:

- Standard performance measures specified by the State;
- Mechanisms to detect both underutilization and overutilization of services; and
- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c). (42 CFR 457.1240(a) and (b), cross referencing to 42 CFR 438.330(b)(3) and (c))

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

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

3.12.2.2.1 ☒ The State assures that each MCO, PIHP, and PAHP reports on the status and results of each performance improvement project conducted by the MCO, PIHP, and PAHP to the State as required by the State, but not less than once per year. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(d)(3))

3.12.2.2.2 ☒ The State assures that it annually requires each MCO, PIHP, and PAHP to:
1) Measure and report to the State on its performance using the standard measures required by the State;
2) Submit to the State data specified by the State to calculate the MCO's, PIHP's, or PAHP's performance using the standard measures identified by the State; or
3) Perform a combination of options (1) and (2) of this assurance. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(c)(2))

3.12.2.2.3 ☒ The State assures that the State reviews, at least annually, the impact and effectiveness of the quality assessment and performance improvement program of each MCO, PIHP, PAHP and PCCM entity. The State's review must include:

- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and
- The outcomes and trended results of each MCO's, PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

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

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

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

3.12.4 Quality Rating

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

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

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

3.12.5 Quality Review

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

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

3.12.5.1 External Quality Review Organization

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

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

3.12.5.2 External Quality Review-Related Activities

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

EQR-related activities under 42 CFR 438.358(b)(1)(i) through (iii) (relating to the validation of performance improvement projects, validation of performance measures, and compliance review).

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

3.12.5.2.2 ☒ The State assures that if it elects to use nonduplication for any or all of the three mandatory EQR-related activities described at 42 CFR 438.358(b)(1)(i) – (iii), the State will document the use of nonduplication in the State's quality strategy. (42 CFR 457.1250(a), cross referencing 438.360, 438.358(b)(1)(i) through (b)(1)(iii), and 438.340)

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

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

3.12.5.2.4 ☐ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(2) (cross-referencing 42 CFR 438.358(b)(1)(ii) and (b)(1)(iii)) will be conducted on all PCCM entities, which include:

- Validation of PCCM entity performance measures required in accordance with 42 CFR 438.330(b)(2) or PCCM entity performance measures calculated by the State during the preceding 12 months; and
- A review, conducted within the previous 3-year period, to determine the PCCM entity's compliance with the standards set forth in subpart D of 42 CFR part 438 and the quality assessment and performance improvement requirements described in 42 CFR 438.330. (42 CFR 457.1250(a), cross referencing to 438.358(b)(2))

3.12.5.3 External Quality Review Report

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

3.12.5.3.1 ☒ The State assures that data obtained from the mandatory and optional, if applicable, EQR-related activities in 42 CFR 438.358 is used for the annual EQR to comply with 42 CFR 438.350 and must include, at a minimum, the elements in §438.364(a)(2)(i) through (iv). (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(a)(2))

3.12.5.3.2 ☒ The State assures that only a qualified EQRO will produce the EQR technical report (42 CFR 438.364(c)(1)).

3.12.5.3.3 ☒ The State assures that in order for the qualified EQRO to perform an annual EQR for each contracting MCO, PIHP, PAHP or PCCM entity under 42 CFR 438.350(a) that the following conditions are met:

- The EQRO has sufficient information to use in performing the review;
- The information used to carry out the review must be obtained from the EQR-related activities described in 42 CFR 438.358 and, if applicable, from a private accreditation review as described in 42 CFR 438.360;
- For each EQR-related activity (mandatory or optional), the information gathered for use in the EQR must include the elements described in 42 CFR 438.364(a)(2)(i) through (iv); and
- The information provided to the EQRO in accordance with 42 CFR 438.350(b) is obtained through methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(b) through (e))

3.12.5.3.4 ☒ The State assures that the results of the reviews performed by a qualified EQRO of each contracting MCO, PIHP, PAHP, and PCCM entity are made available as specified in 42 CFR 438.364 in an annual detailed technical report that summarizes findings on access and quality of care. The report includes at least the following items:

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR

438.310(c)(2));

- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
  - Objectives;
  - Technical methods of data collection and analysis;
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
  - Conclusions drawn from the data;
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

3.12.5.3.5 ☒ The State assures that it does not substantively revise the content of the final EQR technical report without evidence of error or omission. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(b))

3.12.5.3.6 ☒ The State assures that it finalizes the annual EQR technical report by April 30th of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(1))

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

3.12.5.3.8 ☒ The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as

participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))

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

3.12.5.3.10 ☒ 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

4.0. ☐ Medicaid Expansion

4.0.1. Ages of each eligibility group and the income standard for that group:

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

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

Social Security Administration (SSA) verification is the primary source used to verify citizenship for applying children. If citizenship cannot be successfully verified by SSA, documentation is requested for applying children. A 90-day reasonable opportunity period is granted to provide documentation, during which time benefits are granted if otherwise eligible.

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

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

Birth to age 1 – 194% FPL to 209% FPL.
Age 1 to age 6 – 133% FPL to 209% FPL.
Age 6 to age 19 – 133% FPL to 209% FPL.

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):

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):

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:

Children with coverage under other creditable health coverage at the time of application and children who are eligible for Medicaid are not eligible for CHIP.

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

Twelve (12) months from the effective date of coverage for CHIP or until the child reaches 19 years of age or otherwise loses protected eligibility under the continuous eligibility provision.

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:

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

4.1.9.2 ☒ Continuous eligibility

All CHIP and Medicaid children are granted twelve (12) continuous months of eligibility unless the child reaches age 19 or otherwise loses protected eligibility under the continuous eligibility provision.

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.

4.1- LR ☐ Lawfully Residing Option (Sections 2107(e)(1)(J) and 1993(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

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

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
(4) An alien who belongs to one of the following classes:
    (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
    (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
    (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
    (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
(vi) Aliens currently in deferred action status; or
(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☐ Elected for children under age _____.

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)) (42 CFR §, 457.350)

Eligibility for CHIP is determined in the same manner and by the same agency and staff as eligibility for Medicaid. Effective January 1, 2014, the State utilizes an alternative single, streamlined application developed by the State in accordance with section 1413(b)(1)(B) of the Patient Protection and Affordable Care Act (PPACA), as amended, and approved by the Secretary. These applications are available at community health centers, Head Start, health department clinics, other providers of care, the local DHS offices, the Mississippi Division of Medicaid website, and may be submitted via the internet website described in 42 CFR § 435.1200(f), by telephone, via mail, in person, via fax, and via email.

The State provides twelve (12) months of continuous enrollment in CHIP until the child reaches age 19 or otherwise loses protected eligibility under the continuous eligibility provision. Renewal will be conducted via administrative review based on available electronic sources. If determination is not possible based on available sources, a pre-populated renewal form will be issued to the beneficiary.

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)(4)) (42 CFR §, 457.305(b))

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

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)

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.

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. Mississippi does not impose a waiting period for enrollment in CHIP. Enrollment in CHIP is possible in the month following the month coverage terminates from other creditable coverage.

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)) (42 CFR §, 457.350(a)(2)) Each child is screened for Medicaid eligibility first and if determined ineligible and the child is uninsured, is evaluated for CHIP enrollment.

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))

Children are screened for Medicaid eligibility first and if determined ineligible (and otherwise uninsured), are evaluated for CHIP enrollment.

4.4.4. ☒ The insurance provided under the State child health plan does not substitute for **c**overage

under group health plans; states should check the appropriate box. (Section 2102)(b)(3)(C)) (42 CFR § 457.805) (42 CFR § 457.810(a)-(c))

An applying child's current insurance status is self-reported at the time of application and annual review. If the CHIP CCOs discover that a claim submitted lists any other insurance coverage for an eligible CHIP child, the CCOs provide this information to the Mississippi State Office of the Division of Medicaid for further investigation. Pending the findings, CHIP eligibility may or may not be terminated.

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.

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))

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))

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):

Medicaid and CHIP are the only public health insurance programs in the State of Mississippi for children. Health services are provided in Mississippi to uninsured and Medicaid enrolled children by private physicians, 82 Mississippi County Health Department clinics operating at 110 sites, 22 federally qualified health centers (FQHC), newly-funded school health nurses, and several Indian Health Service Clinics. In addition, CHIP provides specialty care to uninsured and Medicaid enrolled children with special health care needs. The Department of Mental Health (DMH) provides mental health services to children through their Community Mental Health Clinics on a sliding scale fee arrangement based upon the patient's declared income. Program information presentations are provided on an on-going basis to schools and Head Start programs in the state, inviting families to apply for health benefits (Medicaid or CHIP). Applications, pamphlets, flyers, and posters are widely distributed.

Mississippi State Department of Health (MSDH)

This agency administers services and programs for Medicaid recipients and uninsured families and children in maternal-child health, environmental health (including lead screening for children under the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program), family planning, newborn genetic screening, well child health services, immunizations, and tuberculosis control. MSDH operates a county health department system of 110 sites, 18 regional home health offices, and 92 WIC distribution centers. MSDH partners with the Mississippi Division of Medicaid in providing targeted case management services for infants and toddlers and for EPSDT children as well as perinatal high-risk pregnancy case management services. This agency is an integral part of the outreach system for identifying Medicaid and CHIP eligible children.

Mississippi Department of Human Services (DHS)

This agency provides programs and services to needy and disadvantaged individuals and families through Temporary Assistance for Needy Families (TANF), food stamps, employment/training programs, literacy programs, childcare programs, child abuse and neglect services, foster care and adoption services, child support and medical support enforcement services, and providing care and treatment for children properly committed to the agency's custody. With offices in all 82 counties, this agency is integral in targeting and enrolling Medicaid and CHIP eligible children.

Department of Rehabilitation Services (DRS)

This agency provides rehabilitation services to eligible disabled adults and children who are on Medicaid or who are uninsured. In addition, it currently processes and renders decisions on applications for Social Security Disability and Supplemental Security Income Disability and for the State's Medicaid blind and disabled coverage groups. This agency will be integral in identifying and enrolling children eligible for Medicaid and CHIP.

Department of Mental Health (DMH)

This agency provides all services in the state for the mentally ill, emotionally disturbed, alcoholic, drug dependent and intellectually/developmentally disabled persons. These services are provided through a system of Community Mental Health Centers in eight regions of the state, several ICF-ID/DDs, and a system of acute and residential programs. These programs serve the Medicaid population, as well as the uninsured, particularly children. This agency will be integral in identifying and submitting application forms to the state agency with responsibility for determining eligibility for Medicaid and CHIP.

Mississippi Division of Medicaid (DOM)

The Mississippi Division of Medicaid provides a statewide system of medical assistance, health care, and remedial and institutional services under Titles XXI, XIX, and XVIII of the Social Security Act. In partnership with DHS, MSDH, and DMH, the Mississippi Division of Medicaid identifies and enrolls Medicaid eligible children. This partnership has been maintained and strengthened to identify and enroll CHIP eligible children. MSDH and DMH serve as providers of services to Medicaid/CHIP eligible children and to uninsured children. The Mississippi Division of Medicaid works with these agencies and a statewide coalition of other partners to identify, enroll, and retain eligible children for the Mississippi Health Benefits Program (Medicaid and CHIP). In addition, the Mississippi Division of Medicaid has expanded its school-based providers of EPSDT screening and treatment services. Through this avenue, the Medicaid agency will be able to utilize the schools to identify Medicaid eligible and CHIP eligible children. With out-stationed workers in FQHCs, disproportionate share hospitals (DSH) and MSDH Clinics, the Medicaid agency will utilize these service providers to identify Medicaid and CHIP eligible children. The Medicaid agency will increase its reliance on primary care providers (PCP) through its fee-for-services providers to disseminate information about eligibility for both Medicaid and CHIP for children through its Medical Advisory Committee.

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:

N/A

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) and 2102(c)(2) and 2102(b)(3)(E))(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 described in Section 5.2.

As discussed previously, there are no other public or private programs designed to provide creditable coverage for low-income children. The Mississippi Division of Medicaid has on-going communications with private health insurance groups, is present at their professional meetings, provides program information and updates, and has an exchange of referrals.

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.

N/A

5.3 Strategies

Outreach

Medicaid and CHIP applications and information are distributed statewide through health care providers and a statewide coalition of collaborative partners. Through these providers and collaborative partners, families are informed of the availability of coverage under Titles XIX and XXI. Outreach activities consist of efforts to identify and enroll children who are eligible for both Medicaid and CHIP. As previously discussed, Medicaid and CHIP are the only public health insurance programs for children in the state, and there is currently no private health coverage for children who cannot afford to pay for it. Thus, Medicaid and CHIP enrollment represent the only viable public alternatives for the State's children to have creditable insurance coverage in this targeted population. The State recognizes the importance of outreach to families of children likely to be eligible for assistance and to encourage them to enroll and retain their children, the State has done the following:

(a) Reduced barriers to participation by using the alternative single, streamlined application as described in PPACA.
(b) Engaged in provider education efforts because providers are a vital link to this population;
(c) Initiated cooperative efforts with MSDH , DHS, DMH, and DRS regarding public awareness of these two programs;
(d) Developed statewide coalitions to assist with the dissemination of materials and conducting a variety of outreach strategies such as health fairs and forums, development of informational fliers, posters, and other promotional items;
(e) Engaged the print and radio media as a means to educate providers;
(f) Coordinated a number of community based initiatives to educate families with potentially eligible children;
(g) Partnered with entities and programs through local and state inter-agency councils, school-based health programs, and other community organizations whose missions include services to families and children; and
(h) Out-stationed Medicaid specialists at FQHCs, Disproportionate Share Hospitals, County Health Departments, Indian reservations, and through school-based EPSDT providers. Beyond administering outreach, the State will ensure that staff at the appropriate state agencies will be well-trained to respond to inquiries from the public and provide progress reports to advocacy groups, the Legislature, and other interested parties.

Special Populations

The State works continuously with the Native American and Asian populations with the Medicaid and CHIP programs. The State has out stationed Medicaid specialists at Native Americans' Health Facilities across the state in order to identify and enroll the children in either CHIP or Medicaid. On-going communication, technical assistance, and program information are provided to the coastal Catholic Charities Refugee Center that provides services to the largest Asian population in the State.

Teens will be reached through the Mississippi Division of Medicaid's outreach partners such as Jackson Hinds Community Health Center and Children Defense Fund who go into schools to conduct outreach both for eligibility and for access to EPSDT services. The State will also rely on the MSDH clinics to help identify and enroll teens through family planning and other health outreach programs. The State has also identified public events, school, church, and community teen activities that reach teens.

The State works closely with the Mississippi School for the Deaf and the Mississippi School for the Blind to identify and enroll visually and hearing impaired children and also rely on their staff as resources for developing print and visual material for hearing impaired and audio material for vision impaired children and their families to learn about CHIP. The State also has language assistance available to help with outreach and enrollment for hearing impaired children and limited English speaking population.

The State has targeted two areas of limited English proficiency: Spanish speaking families in the Southern part of the state and Vietnamese speaking families throughout the state. The State has subscribed to a language line service to help with on-site screening and enrollment processes. The Mississippi Division of Medicaid's website is available in multiple languages.

The State works closely with children's advocacy groups to define and find solutions to various barriers to enrollment in health programs for children, including Medicaid and CHIP.

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.

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 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

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

6.1.4.1. ☐ Coverage the same as Medicaid State plan

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

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

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

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

6.1.4.7. ☐ Other (Describe)

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

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

Must be pre-certified as medically necessary and includes the following:

(1) Hospital room and board (including dietary and general nursing services).
(2) Use of operating or treatment rooms.
(3) Anesthetics and their administration.
(4) Intravenous injections and solutions.
(5) Physical therapy.
(6) Radiation therapy.
(7) Oxygen services and inhalation therapy
(8) Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms.
(9) Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs.
(10) Dressings and Supplies, sterile trays, casts, and orthopedic splints.
(11) Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and Supplies.
(12) Psychological testing when ordered by the physician and performed by a full-time employee of the hospital subject to limitations.
(13) Intensive, Coronary, and Burn Care Unit services.
(14) Occupational therapy.
Speech therapy.

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

See Physician Services and Surgical Services.

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

Include the following:

(1) In-hospital medical care.
(2) Medical care in the physician's office, enrollee’s home, or elsewhere.
(3) Surgery.
(4) Dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the program. Injury to teeth as a result of chewing or biting is not considered an Accidental Injury. Covered medical expense must be incurred as a direct result of an accidental injury to natural teeth and medical

treatment must begin within ten (10) days of the accidental injury.

(5) Administration of anesthesia.
(6) Diagnostic services, such as clinical laboratory examinations, x-ray examinations, electrocardiograms, electroencephalograms, and basal metabolism tests.
(7) Radiation therapy.
(8) Consultations.
(9) Psychiatric and psychological service for nervous and mental conditions.
(10) Physicians assisting in surgery, where appropriate.
(11) Emergency care or surgical services rendered in a practitioner's office including but not limited to surgical and medical supplies, dressings, casts, anesthetic, tetanus, serum, and x-rays.
(12) Well child assessments, including vision screening, laboratory tests and hearing screening, according to recommendations of the U.S. Preventive Service Task Force. Vision and hearing screening are to be included as part of the periodic well child assessments.
(13) Routine immunizations (according to Advisory Committee on Immunization Practices (ACIP) guidelines)-Vaccine is purchased and distributed through MSDH. The CCO will reimburse providers for the administration of the vaccine.

Exclusions and limitations include: the CCOs may require prior authorization and physician's prescription and/or order for outpatient services.

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

Certain surgeries must be pre-certified as medically necessary.

Benefits are provided for the following covered medical expenses furnished to the enrollee by an Ambulatory Surgical Facility:

(1) Services consisting of routine pre-operative laboratory procedures directly related to the surgical procedure.
(2) Pre-operative preparation.
(3) Use of facility (operating rooms, recovery rooms, and all surgical equipment).
(4) Anesthesia, drugs and surgical Supplies.

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

Covered as medical services (refer to 6.2.3.).

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))
Prior authorization is required for selected drugs. A preferred drugs list will be implemented with provisions for medically necessary exceptions.

The following drugs and medical supplies, if medically necessary, U.S. Food and Drug Administration (FDA) approved, non-experimental drugs prescribed by a licensed practitioner, and prescribed for the medical treatment of illness and/or injuries, are covered:

(1) Legend drugs.

(2) Compounded medication of which at least one ingredient is a legend drug.
(3) Disposable diabetic supplies, including, but not limited to, insulin needles/syringes, blood/urine glucose/acetone testing agents.
(4) Insulin.
(5) Fluoride supplements.

The following are excluded:

(1) Anabolic steroids.
(2) Drugs when used for weight loss.
(3) Charges for the administration or injection of any drug.
(4) Drugs when used to promote fertility.
(5) Over-the-counter (OTC) items except those specifically listed as covered.
(6) Drugs used for cosmetic purposes or hair growth, including, but not limited to anti-wrinkle agents, drugs used to treat alopecia, and pigmenting/depigmenting agents.
(7) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed as covered.
(8) Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature.
(9) Drugs that are investigational or approved drugs used for investigational purposes.
(10) Refills in excess of the number specified by the practitioner or any refills dispensed more than one (1) year after the date of practitioner's original prescription.

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

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

Certain diagnostic tests must be pre-certified.

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

Exclusions include: infertility treatments, reproductive services other than prenatal care, labor and delivery, and care related to diseases illnesses or abnormalities related to the reproductive system.

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))

(1) Benefits for Covered Medical Expenses are paid for medically necessary inpatient psychiatric treatment of an enrollee.
(2) Benefits for covered medical expenses are provided for Partial Hospitalization.
(3) Certification of medical necessity by the Insurer's Utilization Review Program is required for admissions to a hospital.

Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse.

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)

Benefits for Covered Medical Expenses for treatment of nervous and mental conditions on an outpatient basis. Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse

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))

Rental of Durable Medical Equipment is covered for temporary therapeutic use; provided, however, at the Insurer's discretion, the purchase price of such equipment may be allowed. To be Durable Medical Equipment, an item must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose; (3) generally not useful to a person in the absence of illness, injury or disease; and (4) appropriate for use in the enrollee's home.

Prosthetic or Orthotic Devices necessary for the alleviation or correction of conditions arising from accidental injury, illness, or congenital abnormalities are covered services. Benefits are available for the initial placement, fitting, and purchase of Prosthetic or Orthotic devices that require a prescription by a physician and for the repair or replacement when medically necessary. Shoes are not covered except for the following: (1) a surgical boot which is part of an upright brace, (2) one pair of mismatched shoes annually in instances where a foot size disparity is greater than two sizes, and (3) a custom fabricated shoe in the case of a significant foot deformity.

Eyeglasses (limited to one (1) per year) and hearing aids (limited to one (1) every three (3) years) are covered services.

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

Supplies provided under the Plan, which are medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling an enrollee to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease, and are appropriate for use in the enrollee's home.

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

Services and supplies required for the administration of Home Infusion Therapy regimen must be (1) medically necessary for the treatment of the disease; (2) ordered by a practitioner; (3) as determined by the Insurer's Utilization Review Program capable of safe administration in the home; (4) provided by a licensed Home Infusion Therapy provider coordinated and pre-certified by the Insurer's Utilization Review Program; (5) ordinarily in lieu of inpatient hospital therapy; and (6) more cost effective than inpatient therapy.

Benefits for home health nursing services must be approved by the Insurer's Utilization Review Program in lieu of hospitalization. Benefits for nursing services are limited to ten

thousand dollars and zero cents ($10,000.00) annually.

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

Benefits include nursing services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered and supervised by a practitioner and when the services rendered require the technical skills of an RN or LPN.

Benefits are provided for covered medical expense when performed by a nurse practitioner practicing within the scope of his or her license at the time and place service is rendered.

Benefits for private duty nursing services are provided for an illness or injury that the Insurer's Utilization Review Program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital's nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services. Benefits are also provided for nursing services in the home for illness or injury that the Insurer's Utilization Review Program determines to require the skills of an RN or LPN. Benefits for nursing services provided in an enrollee's home must be approved by the Insurer's Utilization Review Program in lieu of hospitalization. Benefits for nursing services are limited to ten thousand dollars and zero cents ($10,000.00) annually. (This limit does not apply to nurse practitioner services.)

No nursing benefits are provided for:

(1) Services of a nurse who ordinarily lives in the child's home or is a member of the child's family;
(2) Services of an aide, orderly or sitter; or
(3) Nursing services provided in a Personal Care Facility.

Benefits are provided for confinement in a skilled nursing facility for up to sixty (60) days per benefit period, subject to utilization management requirements.

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)

Benefits are allowed for elective abortion only when documented to be medically necessary in order to preserve the life or physical health of the mother.

6.2.17. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

Covered dental services are limited to two thousand dollars and zero cents ($2,000.00) each calendar year (CY).

(1) Benefits are provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD), as indicated below:

a. Bitewing X-rays - as needed, but no more frequently than once every six (6) months;

b. Complete Mouth X-ray and Panoramic X-ray - as needed, but no more frequently than once every twenty-four (24) months;
c. Prophylaxis - one every six (6) months; must be separated by six (6) full months;
d. Fluoride Treatment - limited to one each six (6) month period;
e. Space Maintainers - limited to permanent teeth through age 15 years; and
f. Sealants - covered up to age 14 years, every thirty-six (36) months.

(2) Benefits are provided for restorative, endodontic, periodontic, and surgical dental services, as indicated below:

a. Amalgam, Silicate, Sedative and Composite Resin Fillings including the replacement of an existing restoration;
b. Stainless steel crowns to posterior and anterior teeth;
c. Porcelain crowns to anterior teeth only;
d. Simple extraction;
e. Extraction of an impacted tooth;
f. Pulpotomy, pulpectomy, and root canal; and
g. Gingivectomy, gingivoplasty and gingival curettage.

Other Dental Services (The calendar year maximum does not apply to these services.)

(1) Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled child is covered under the Program. Injury to teeth as a result of chewing or biting is not considered an accidental injury.
(2) Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the enrolled child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. These services must be pre-certified.
(3) No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions. Diagnosis and surgical treatment for temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a practitioner or dentist, is subject to a lifetime maximum benefit of five thousand dollars and zero cents ($5,000.00) per member. This lifetime maximum will apply regardless of whether the temporomandibular/craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.

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

Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol abuse, drug abuse, or a combination of alcohol and drug abuse, as follows:

(1) Benefits for covered medical expenses are provided for medically necessary inpatient stabilization and residential substance abuse treatment.

(2) Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol abuse, drug abuse, or a combination of alcohol and drug abuse.
(3) Certification of medical necessity by the Insurer's Utilization Review Program is required for admissions to a hospital or residential treatment center.
(4) Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

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

(1) Benefits are provided for covered medical expenses for medically necessary Intensified Outpatient Programs in a hospital, an approved licensed alcohol abuse or chemical dependency facility, or an approved drug abuse treatment facility.
(2) Benefits are provided for covered medical expenses for substance abuse treatment while not confined as a hospital inpatient.
(3) Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

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

Medical Case Management may be performed by the Utilization Review Program for those children who have a catastrophic or chronic condition. Through medical case management, the Utilization Review Program may elect to (but is not required to) extend covered benefits beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and supplies which are not otherwise covered. The decision to provide extended or alternative benefits is made on a case-by-case basis to covered children who meet the Utilization Review Program's criteria then in effect. Any decision regarding the provision of extended or alternative benefits is made by the Utilization Review Program.

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

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

Benefits are provided for physical therapy services specified in a plan of treatment prescribed by the enrollee's practitioner and provided by a licensed physical therapist.

Benefits are provided for medically necessary occupational therapy services prescribed by the enrollee's practitioner and specified in a treatment plan. Occupational therapy services must be provided by a licensed occupational therapist.

Benefits are provided for medically necessary speech therapy services prescribed by the enrollee's practitioner and specified in a treatment plan. Speech therapy is not covered for maintenance speech, delayed language development, or articulation disorders.

Benefits are provided for an annual hearing examination, if indicated by the results of a hearing screening.

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

Benefits are provided for inpatient and home hospice services, subject to utilization management requirements. Benefits for hospice services are limited to an overall lifetime maximum of fifteen thousand dollars and zero cents ($15,000.00).

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

Benefits are provided for general anesthesia service when requested by the attending physician and performed by an anesthesiologist or a certified registered nurse anesthetist practicing within the scope of his or her license at the time and place service is rendered.

Transplant Benefits:

(1) Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies:

(i) The enrollee or provider obtains prior approval from the Insurer's Utilization Management Program; and
(ii) The condition is life-threatening; and
(iii) Such transplant for that condition is the subject of an ongoing phase III clinical trial; and
(iv) Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and
(v) The enrollee is a suitable candidate for the transplant under the medical protocols used by the Insurer's Utilization Management Program.

(2) In addition to regular benefits, benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ transplant procedure.
(3) Benefits are provided for transportation costs of recipient and two other individuals to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of two individuals at the site of transplant surgery. Reasonable and necessary expenses for transportation, meals, and lodging of two other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to ten thousand dollars and zero cents ($10,000.00).
(4) If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient:
(i) The following expenses are covered:
1) A search for matching tissue, bone marrow or organ
2) Donor's transportation
3) Charges for removal, withdrawal and preservation, and
4) Donor's hospitalization.
(ii) When only the recipient is enrolled in the Program, the donor is entitled to donor

coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the recipient's contract.

(iii) When both the recipient and the donor are enrolled in the Program, the donor is entitled to benefits under the donor's contract.

(iv) When only the donor is a CHIP participant, the donor is not entitled to donor coverage benefits. No benefits are provided to the non-member transplant recipient.

(v) If any organ or tissue is sold rather than donated to the enrollee, no benefits are payable for the purchase price of such organ or tissue;

Manipulative therapy is a covered medical expense but benefits shall not exceed two thousand dollars and zero cents ($2,000.00) annually.

Benefits are provided for medically necessary services and supplies required for the treatment of injury or disease of the eye which fall within the legal scope of practice of a licensed optometrist. Benefits are provided for annual routine eye examinations, eyeglasses, and the fitting of eyeglasses.

Benefits are provided for diabetes self-management training and education, including medical nutrition therapy, for the treatment of diabetes, subject to a limitation of two hundred fifty dollars and zero cents ($250.00) per benefit period.

6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

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

Professional ambulance services to the nearest hospital, which is equipped to handle the enrollee's condition in connection with covered hospital inpatient, care; or when related to and within seventy-two (72) hours after accidental bodily injury or medical emergency whether or not inpatient care is required.

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

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

Limitations and Exclusions:

a. For convalescent, custodial, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a physician for an enrollee who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither shall benefits be provided if the enrollee was admitted to a hospital for his or her own convenience or the convenience of his or her physician, or that the care or treatment provided did not relate to the condition for which the enrolled child was hospitalized,

or that the hospital stay was excessive for the nature of the injury or illness, it being the intent to provide benefits only for the services required in relation to the condition for which the enrolled child was hospitalized and then only during such time as such services are medically necessary.

b. For cosmetic purposes, except for correction of defects incurred by the enrollee while covered under the Program through traumatic injuries or disease requiring surgery.
c. For sex therapy or marriage or family counseling.
d. For custodial care, including sitters and companions.
e. For equipment that has a non-therapeutic use (such as humidifiers, air conditioners or filters, whirlpools, wigs, vacuum cleaners, fitness supplies, etc.).
f. For procedures, which are Experimental/Investigative in nature.
g. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment for subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
h. For services and supplies related to infertility, artificial insemination, intrauterine insemination and in vitro fertilization regardless of any claim to be medically necessary.
i. For services which the Insurer's Utilization Review Program determines are not medically necessary for treatment of injury or illness.
j. For services provided under any federal, state, or governmental plan or law including but not limited to Medicare except when so required by federal law.
k. For nursing or personal care facility services i.e., extended care facility, nursing home, or personal care home, except as specifically described elsewhere.
l. For treatment or care for obesity or weight control including diet treatment, gastric or intestinal bypass or stapling, or related procedures regardless of any claim of medical necessity or degree of obesity.
m. For inpatient rehabilitative services consisting of the combined use of medical, social, educational or vocational services, or any such services designed to enable enrollees disabled by disease or injury to achieve functional ability, except for acute short-term care in a hospital or rehabilitation hospital as approved by the Insurer's Utilization Review Program.
n. For outpatient rehabilitative services consisting of pulmonary rehabilitation, or the combined use of medical, social, educational or vocational services, or any such services designed to enable enrollees disabled by disease or injury to achieve functional ability, except for physical, occupational, or speech therapy services specified in a plan of treatment prescribed by the enrollee's physician and provided by a licensed therapist.
o. For care rendered by a provider, (physician or other provider) who is related to the covered enrollee by blood or marriage or who regularly resides in the enrolled child's household.
p. For services rendered by a provider not practicing within the scope of his license at the time and place service is rendered.
q. For treatment related to sex transformations regardless of claim of medical necessity or for sexual function, sexual dysfunction or inadequacies not related to organic disease.
r. For reversal of sterilization regardless of claim of medical necessity.
s. For elective abortion unless documented to be medically necessary in order to preserve the life or physical health of the mother.

t. For charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim.
u. For travel, whether or not recommended by a physician, except as provided for under Transplant Benefits.
v. Because of diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
w. For treatment of any injury arising out of or in the course of employment or any sickness entitling the enrollee to benefits under any Workers' Compensation or Employer Liability Law.
x. For any injury growing out of a wrongful act or omission of another party for which injury that party or some other party makes settlement or is legally responsible; provided, however, that if the enrollee is unable to recover from the responsible party, benefits shall be provided.
y. For refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea.

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

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

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

Mississippi CHIP Plan Covered Services. De

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

schedule:

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

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

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)Page - 11 – State Health Official

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

6.2-DS ☐ **Supplemental Dental Coverage- The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.**

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

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

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

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

6.4.1. ☐ **Cost Effective Coverage**- Payment may be made to a State in excess of the 10%

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 (42 CFR § 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)) (42 CFR § 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)) (42 CFR § 457.1005(b))

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

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

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

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

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

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010)A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all

targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☐ Yes
☒ No

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Yes
☒ No

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

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

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

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

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

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 (Describe:)

☐ Other (Describe:)

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

☒ Yes

☐ No

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

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act)provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance

with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

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

☐Yes

☒No

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

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

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐All children covered under the State child health plan.

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

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

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 becompleted 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.

Benefit Classification	Standards Used
Inpatient	Inpatient benefits are applied per the benefit plan to a registered inpatient bed patient in a hospital.
Outpatient	Outpatient benefits are applied per the benefit plan to a patient who is not a registered inpatient bed patient of a hospital.
Pharmacy	Pharmacy benefits are applied per the benefit plan and evidence based clinical criteria for use of medication, regardless of behavioral health or medical diagnosis.
Emergency	Services covered in connection with a medical condition that occur suddenly and without warning with symptoms which are so acute and severe as to require immediate medical attention.

6.2.3.1.1 MHPAEA The State assures that:

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

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

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

☒Yes

☐No

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

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

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

6.2.3.2 MHPAEA The State assures that:

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

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

Annual and Aggregate Lifetime Dollar Limits

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

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

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☒ No dollar limit is applied

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

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

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

☐ Yes (Type(s) of limit:

☐ No

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

6.2.4.3- MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)).The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR

457.496(c)(3))

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

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

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

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

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

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (42 CFR 457.496(c)(1)).Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits,please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either anannual 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 (42 CFR 457.496(c)(4)(i)(B)); (42 CFR

457.496(c)(4)(ii)):

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

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

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

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

Quantitative Treatment Limitations

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

☐ Yes (Specify:)

☒ No

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

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

☐Yes

☐No

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

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

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

Guidance: Please include the state's methodology and resultsas anattachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to "substantially all"(defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐Yes

☐No

Guidance: If the State does not apply a type of QTL to substantially all

medical/surgical benefits in a given classification of benefits,the State may *not* impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- **MHPAEA** For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B).The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

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

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

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- **MHPAEA** The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4));(42 CFR 457.496(d)(5))

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

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

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

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

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

☒Yes

☐No

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

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

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

Availability of Plan Information

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

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

☐ State

☒ Managed Care entities

☐ Both

☐ Other

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

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

☐ State

☒ Managed Care entities

☐ Both

☐ Other

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

Section 7. Quality and Appropriateness of Care

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

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

7.1.1. ☐ Quality standards

7.1.2. ☒ Performance measurement

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

7.1.3. ☐ Information strategies

7.1.4. ☐ Quality improvement strategies

2102(a)(7)(B))

7.2. **Describe the methods used, including monitoring, to assure: (Section 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)) (42 CFR § 457.495(a))

The State establishes minimum requirements based on CHIPRA Quality Core Set and utilizes mandatory reporting requirements placed on the CCOs to monitor the number and rate of well-baby, well-child, well-adolescent visits and immunization rates by age group. The State establishes sanctions for noncompliance.

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

In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the CCOs shall meet the geographic access standards for all Members set forth in Table below.

Provider Type	Urban	Rural
PCPs	Two (2) within fifteen (15) miles	Two (2) within thirty (30) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles

Provider Type	Urban	Rural
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Emergency Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within thirty (30) minutes or thirty (30) miles
Urgent Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	Not Applicable
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within thirty (30) minutes or thirty (30) miles	One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within sixty (60) minutes or sixty (60) miles
Dialysis Providers	One (1) within sixty (60) minutes or sixty (60) miles	One within ninety (90) minutes or ninety (90) miles

The Mississippi Division of Medicaid shall specify the urban and rural designation of counties within Mississippi. All travel times are maximums for the amount of time it takes a Member, using usual travel means in a direct route to travel from their home to the Provider.

If the CCOs are unable to identify a sufficient number of Providers located within an area to meet the geographic access standards, or are unable to identify a sufficient number of Providers within a Provider type or specialty, the CCOs will submit documentation to the Mississippi Division of Medicaid verifying the lack of Providers. The Mississippi Division of Medicaid may approve exceptions to the geographic access standards in such cases.

The CCOs must pay for services covered under the contract on an out-of-network basis for the Member if the CCOs' Provider Network is unable to provide such services within the geographic access standards. The CCOs shall ensure that the cost to the Member is no greater than it would be if the services were furnished within the network. Services must be provided and paid for in an adequate and timely manner, as defined by the

Mississippi Division of Medicaid, and for as long as the CCOs are unable to provide them.

The CCOs shall submit a Network Geographic Access Assessment (GeoAccess) Report on a quarterly basis to the Mississippi Division of Medicaid demonstrating compliance with these requirements.

The CCOs are also contractually required to provide coverage to members on a 24-hours-per-day, 7-days-per-week basis. The CCOs must have written policies and procedures describing how members and providers can contact the CCOs to receive individual instruction or referral for treatment of an emergency or urgent medical problem and to receive instructions concerning how to access benefits when either in an area where network providers are not available and/or are not reasonably accessible. The policies and procedures must be made available in an accessible and understandable format upon request. Direct contact with qualified clinical staff must be made available to members through a toll-free nurse triage hotline telephone number.

Emergency services must be available at all times and provided upon arrival at the emergency room, or in the physician's office. If the physician or emergency room staff determines that the condition is not an emergency medical condition, the member may be referred back to his/her physician for treatment after they are stabilized.

Coverage of emergency medical services are not subject to prior authorization requirements, but the CCOs may include a requirement that notice be given to the CCOs of use of non-participating providers for emergency services. Such notice requirements shall provide at least a 48-hour time frame after the emergency for notice to be given to the CCOs by the member and/or the emergency provider. Utilization of and payments to non-participating providers may, at the CCOs option be limited to the treatment of emergency medical conditions, including medically necessary services rendered to the member until such time as he/she can be safely transported to a network provider service location.

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)) (42 CFR § 457.495(c))

The CCOs provide case management services for children with complex, often high cost, medical conditions. If care is not available in-network, approval is given to access care on an out-of-network basis.

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 fourteen (14) days after the receipt of a request for services. (Section 2102(a)(7)) (42 CFR § 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

The CCOs' decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient and federal regulations. These decisions are determined within the fourteen (14) day time frame for medical requests. For health

services, the State uses health insurance law, not the Medicaid fair hearing process since CHIP is a health insurance plan.

Contractor must make standard authorization decisions and provide notice within three (3) calendar days and/or two (2) business days per Minimum Standards for Utilization Review Agents issued by MSDH following receipt of the request for services. If Contractor requires additional medical information in order to make a decision, Contractor will notify the requesting provider of additional medical information needed and Contractor must allow three (3) calendar days and/or two (2) business for the requesting provider to submit the medical information. If Contractor does not receive the additional medical information, Contractor shall make a second attempt to notify the requestor of the additional medical information needed and Contractor must allow one (1) business day or three (3) calendar days) for the requestor to submit medical information to Contractor.

Once all information is received from the provider, if Contractor cannot make a decision, the three (3) calendar day and/or two (2) business day period may be extended up to fourteen (14) additional calendar days upon request of the Member or the provider to Contractor, or if Contractor justifies to the Mississippi Division of Medicaid a need for additional information and how the extension is in the Member's best interest. The extension request to the Mississippi Division of Medicaid applies only after Contractor has received all necessary medical information to render a decision and Contractor requires additional calendar days to make a decision. Contractor must provide to the Mississippi Division of Medicaid the reason(s) justifying the additional calendar days needed to render a decision. The Mississippi Division of Medicaid will evaluate Contractor's extension request and notify Contractor of decision within three (3) calendar days and/or two (2) business days of receiving Contractor's request for extension.

Contractor must expedite authorization for services when the provider indicates or Contractor determines that following the standard authorization decision time frame could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Contractor must provide an Expedited Authorization Decision notice no later than twenty-four (24) hours after receipt of the expedited authorization request. This twenty-four (24) hour period may be extended up to fourteen (14) additional calendar days upon request of the Member, provider, or Contractor. Contractor must justify to the Mississippi Division of Medicaid a need for additional information and how the extension is in the Member's best interest. The extension request to the Mississippi Division of Medicaid applies only after Contractor has received all necessary medical information to render a decision and Contractor requires additional calendar days to make a decision. Contractor must provide to the Mississippi Division of Medicaid the reason(s) justifying the additional calendar days needed to render a decision. The Mississippi Division of Medicaid will evaluate Contractor's extension request and notify Contractor of decision within three (3) calendar days and/or two (2) business days of receiving Contractor's request for extension.

Section 8. Cost-Sharing and Payment

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

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

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

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

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

8.2.1. Premiums: None

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments:

Requirement	≤150% FPL	151%-175% FPL	176% - 209% FPL
Per doctor visit	None	$5.00	$5.00
Per ER visit	None	$15.00	$15.00
Out-of-Pocket Maximum	N/A	$800.00	$950.00

8.2.4. Other:

No cost sharing is applied to preventive services, including immunizations, well child care, routine preventive and diagnostic dental services, routine dental fillings, routine eye examinations, eyeglasses, or hearing aids.

There is no cost sharing for American Indian/Alaska Native children.

Effective 11/1/19, copayments will not be charged on outpatient mental health/substance use disorder (SUD) visits.

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

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

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

All cost-sharing requirements are described in the member booklet(s). Individual participants are notified of cost sharing responsibilities through their member booklets. The individual identification card also indicates cost sharing amounts and cumulative maximum. The CCOs maintain the cost sharing accounting for the participant. When a participant has met his/her out of pocket maximum, the CCOs send a letter to the participant indicating that no further co-payments should be made for the remainder of the calendar year. The participant is instructed to present this letter when future health services are sought, or request the provider to contact the CCOs regarding this issue.

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

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.4.1- MHPAEA ☒There is no separate accumulation of cumulative financial requirements, as defined in 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))

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: inpatient, outpatient, prescription drugs, emergency room)

☒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, theState 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 and results of the parity analysis 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)) (42 CFR § 457.560(b) and 457.505(e))

The CCO providing coverage tracks each family's out-of-pocket expenses. If a family's annual aggregate cost-sharing amount reaches the out-of-pocket amount noted in Section 8.2.4 (which is below 5% of the family's annual income) the family will receive notification that no further cost sharing is required for the remainder of the year. This notification can be used by the family to document to health care providers that no co-payments are to be collected for services provided.

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)) (42 CFR § 457.535)

There is no cost sharing for American Indian/Alaska Native children. These children are classified separately so that there is no cost sharing applied regardless of income.

Through the application process, the applicant self-declares his/her race and ethnicity. The Mississippi Division of Medicaid, the agency responsible for eligibility determination, notifies the CCO of an American Indian/Alaska Native enrollee through a specific code in the enrollment data transfer process. The Mississippi Division of Medicaid currently assigns out-stationed Medicaid specialists to take applications at the Indian Reservation.

The CCOs enroll American Indian/Alaska Native children in a separate contract type, which has no cost sharing requirements, regardless of poverty category. The member booklet sent to these participants explains that there is no out-of-pocket expenses for covered services.

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

Families are not dis-enrolled due to non-payment of co-payments. (Member booklet explains that a provider may refuse service if unpaid)

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

- ☐ 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.
- ☐ 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. (42 CFR § 457.570(b))
- ☐ In the instance mentioned above, that the State will facilitate enrolling the child in

Medicaid or adjust the child's cost-sharing category as appropriate. (42 CFR § 457.570(b))

☐ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42 CFR § 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)) (42 CFR § 457.220)

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

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42 CFR § 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)) (42 CFR § 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)) (42 CFR § 457.475)

8.8.5. ☒ 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)) (42 CFR § 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

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)) (42 CFR § 457.710(b))

1. The infrastructure of the Mississippi Medicaid agency will be able to accommodate all critical facets of outreach and eligibility determination for the Title XXI program.
2. Previously uninsured children who will potentially be eligible for Mississippi's Title XXI program will be identified through ongoing outreach activities involving other state agencies, social/healthcare providers, schools, Head Start, community/faith-based organizations, and advocates.
3. Low income children who were previously without health insurance coverage will have health insurance coverage through Mississippi's Title XXI program.
4. Children enrolled in CHIP will have adequate access to primary care, inpatient care, and pharmacy services.
5. Children enrolled in CHIP will receive appropriate preventive and primary care services.
6. Families of CHIP enrollees will be surveyed annually regarding their satisfaction with the services provided under the Program.

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

Performance Goal for Objective 1:

The capacity within the Mississippi Division of Medicaid was appropriately expanded or modified to conduct outreach, enrollment and eligibility determination activities as needed to enroll uninsured eligible children. These areas include data systems modification, eligibility determinations, enrollment, participation information, health service utilization, billing, health status, provider information, personnel, (eligibility workers, administrative and support staff), staff training, publications and documents.

Performance Goals for Objective 2:

(1) The Medicaid agency has re-evaluated its existing outreach activities and developed materials for wide-spread dissemination throughout the state as needed;
(2) The State will define ways to identify and enroll the State's ethnic minorities e.g., Native Americans, Asian Americans, Hispanics;
(3) It is not anticipated that the State will need to increase the number of eligibility workers initially. As of January 1, 2005, the Mississippi Division of Medicaid assumed the responsibility of eligibility determination for MHB. The State expanded the twenty-five regional offices to thirty and deployed over four hundred Medicaid specialists to the thirty regional Medicaid offices as well as over two hundred outstation sites, and
(4) Potentially eligible children for Medicaid and CHIP are identified through the school lunch program and Head Start.

Performance Goals for Objective 3:

By January 1, 2015, at least 65,000 children between 100% and 209% FPL will be enrolled in

CHIP or Medicaid.

Performance Goal for Objective 4:

At least 85% of children enrolled in CHIP will have access to a primary care physician within 15 miles in urban/suburban areas and 25 miles in rural areas.

At least 85% of children enrolled in CHIP will have access to a hospital within 25 miles in urban/suburban areas and 45 miles in rural areas.

At least 85% of children enrolled in CHIP will have access to a pharmacy within 15 miles in urban/suburban areas and 25 miles in rural areas.

Performance Goal for Objective 5:

At least 85% of children 2 years of age enrolled in CHIP will have received all appropriate immunizations.

At least 85% of CHIP enrollees who were 2 to 6 years of age will have received at least one (1) preventive or primary care visit during the year.

Performance Goals for Objective 6:

At least 90% of families responding to the member satisfaction survey will express satisfaction with customer service and provider access.

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)) (42 CFR § 457.710(d))

The State has contracted with an analytics engine which provides expanded, age specific utilization data that will be used in monitoring the enrollment of the established performance goals for CHIP population. The CCOs will provide encounter data to the State's fiscal agent so that the analytics vendor can produce required reports and provide the data to the Mississippi Division of Medicaid for further analysis through the decision support system.

The fiscal agent and analytics engine will be able to measure and track the following Healthcare Effectiveness Data and Information Set (HEDIS) performance measures for the targeted CHIP population:

(a) Well child visits in the 3rd, 4th, 5th, and 6th years of life;
(b) Use of appropriate medications for children with asthma;
(c) Children's access to primary care practitioners;
(d) Drug utilization;
(e) Inpatient utilization – general hospital/acute care;
(f) Mental health utilization; and
(g) Annual dental visits.

Objective 1:

Eligibility and enrollment are evaluated on an ongoing basis. Reports from Envision, the Mississippi Division of Medicaid's patient information management system, on the number of applications approved, both pending and denied are reviewed on a monthly basis and appropriate interventions are implemented as indicated. The activities of each Medicaid specialist are monitored to determine maximum worker caseload.

Objective 2:

Through state, community, and advocacy networks, outreach activities are coordinated and evaluated. Recommendations from an internal survey and from the Outreach and Assessment and focus groups conducted by an outside consultant will be implemented as appropriate and further evaluated. Successful activities with targeted populations will be duplicated. The State will further define and refine its outreach strategies as more specific data is made available from a planned study of the uninsured children in Mississippi.

Objective 3:

Enrollment is measured by the Mississippi Division of Medicaid, which provides eligibility determination services for both Medicaid and CHIP.

Objective 4:

Access is measured by the CCOs using GeoAccess software applied to the CHIP enrollment file and network provider file.

Utilization of preventive and primary care services is measured through the State's decision support system supported by the fiscal agent. The CCOs provide encounter data to the fiscal agent, and loads the data into the decision support system, which provides standard reports, as well as the ability to produce ad hoc reports.

Objective 6:

Satisfaction is measured by the CCOs through an annual member satisfaction survey.
Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

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

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

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

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

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

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

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

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

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)) (42 CFR § 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)) (42 CFR § 457.750)

The Medicaid agency uses the same staff to evaluate and assess CHIP quality of care~~.~~

There are reliable state-wide or comparable sub-group measures of morbidity of the Medicaid population to measure the effectiveness of the coverage of individuals enrolled in this proposed expansion.

In CHIP, the CCOs submit encounter data to the fiscal agent. The system generates standard reports and enables ad hoc reporting.

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)) (42 CFR § 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. (42 CFR § 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)) (42 CFR § 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)) (42 CFR § 457.120(a) and (b))

The process of design and implementation of CHIP was open to allow input and participation from various interested and affected parties. Initial decisions were reached during the 1998 Legislative session in which Legislators received input from recipients, providers, advocates, the business community, medical care industry, and religious and political leaders. Phase I of CHIP was set forth in statute, together with a Commission to design Phase II. Phase I CHIP was publicized in the routine manner through the State of Mississippi's Administrative Procedures Act. The CHIP Commission was appointed, according to state statute, to develop proposals regarding benefits, funding, and eligibility of children. The CHIP Commission meetings were open to the public, as were the meetings of the three subcommittees established to develop recommendations with respect to structure, benefits and eligibility and outreach. Public hearings were held in four locations across the state, and an advance notice of these meetings was published in both the newspaper with statewide distribution as well as local papers. In addition, the Mississippi Division of Medicaid authored news releases, editorials, and public service announcements on educational television and public radio. To date, information about and application for the State's CHIP is available on the Internet at the Mississippi Division of Medicaid's web page http://www.medicaid.ms.gov. The Mississippi Division of Medicaid has established statewide coalitions not only to assist with dissemination of MHB applications and materials but also to funnel families' experiences and concerns to the Mississippi Division of Medicaid. Finally, the Mississippi Division of Medicaid has maintained an extensive mailing list, and all materials and updates developed are distributed ongoing to all included therein.

This application will be published in the routine manner through the State's Administrative Procedures Act.

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

The Mississippi Division of Medicaid consults with the tribe by notifying the Mississippi Band of Choctaw Indians designee, in writing with a description of the proposed change and direct impact, at least sixty (60) days prior to each submission by the State of any Medicaid SPA, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health programs, or Urban Indian Organizations (I/T/U) by email. The Deputy Health Director is the Mississippi Band of Choctaw Indians designee. Direct impact is defined as any Medicaid or CHIP program changes that are more restrictive for eligibility determinations, changes that reduce payment rates or payment methodologies to Indian Health Programs, Tribal Organizations, or Urban Indian Organization providers, reductions in covered services, changes in consultation policies, and proposals for demonstrations or waivers that may impact I/T/U providers. If no response is received from the tribe within thirty (30) days, the Mississippi Division of Medicaid will proceed with the submission to the Centers for Medicare and Medicaid Services (CMS).

If the Mississippi Division of Medicaid is not able to consult with the tribe sixty (60) days prior to a submission, a copy of the proposed submission along with the reason for the urgency will be forwarded to the MBCI designee. A conference call with the designee and/or other tribal representatives will be requested to review the submission and its impact on the tribe. The Mississippi Division of Medicaid will then confirm the discussion via email and request a response from the designee to ensure agreement on the submission. This documentation will be provided as part of the submission information to CMS.

9.9.2

For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR § 457.65(b) through (d).9.9.2 Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option

9.10. Provide a 1-year projected budget. Budget submitted with MS SPA 18-0010-CHIP, effective 10/01/2019.

	Federal Fiscal Year 2020 Oct - Sept Projected Costs
Enhanced FMAP rate	**95.39%**
Benefit Costs	
Insurance payments	
Managed care	156,220,634
per member/per month rate @ # of eligibles	277.59 PM/PM – 49,600 eligibles
Risk Assessment State Share Only ($3)	
Fee for Service	2,700,000
Total Benefit Costs	**158,920,634**
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	158,920,634
Administration Costs	
Personnel	3,242,025
General administration	300,000
Contractors/Brokers (e.g., enrollment contractors)	-
Claims Processing	
Outreach/marketing costs	
Other	
Health Services Initiative	288,000
Total Administration Costs	3,830,025
10% Administrative Cost Ceiling	17,657,848
Federal Share (multiplied by enhanced-FMAP rate)	155,247,854
State Share	7,502,8050
TOTAL PROGRAM COSTS	**162,750,659**

Note: The Federal Fiscal Year (FFY) runs from October 1st through September 30th.

Section 10. Annual Reports and Evaluations

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)) (42 CFR § 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. (42 CFR § 457.710(e))

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

10.3-DC ☒ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

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

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

12.1. Eligibility and Enrollment Matters- Describe the review process for eligibility and enrollment matters that complies with 42 CFR § 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

Mississippi has established written criteria for the determination of eligibility and for fair and equitable treatment, including the opportunity for recipients who have been adversely affected to be heard. The State will administer the due process notification of adverse action relative to Title XIX. This process includes an opportunity for a fair hearing handled independently of the regional office eligibility. Recipients may resolve any enrollment and eligibility matters, including terminations, or related issues through this method. All enrollees receive written information about the grievance and appeal procedures that are available to them.

12.2. Health Services Matters- Describe the review process for health services matters that comply with 42 CFR § 457.1120.

Denials related to health care services are appealed to the CCOs. The final level of appeal is to an independent review entity external to the CCOs. All levels of review must be completed within the required ninety (90) day period.

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

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices				
CMS Regional Offices	**States**		**Associate Regional Administrator**	**Regional Office Address**
Region 1- Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2- New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3- Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4- Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5- Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6- Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7- Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
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GLOSSARY

Adapted directly from SEC. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term `child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is
    a. Prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,

b. Performed under the general supervision or at the direction of a physician, or
c. Furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

24. Premiums for private health care insurance coverage.
25. Medical transportation.
26. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
27. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title—

1. IN GENERAL- Subject to paragraph (2), the term `targeted low-income child' means a child—

   a. who has been determined eligible by the State for child health assistance under the State plan;
   b. (i) who is a low-income child, or
      (ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
   c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).

2. CHILDREN EXCLUDED- Such term does not include—

   a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
   b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

3. SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. MEDICAID APPLICABLE INCOME LEVEL- The term `Medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under Section 1902(l)(2) for the age of such child.
5. TARGETED LOW-INCOME PREGNANT WOMAN.—The term ‘targeted low-income pregnant woman’ means an individual—‘‘(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; ‘‘(B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and ‘‘(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. CHILD- The term `child' means an individual under 19 years of age.
2. CREDITABLE HEALTH COVERAGE- The term `creditable health coverage' has the meaning given the term `creditable coverage' under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms `group health plan', `group health insurance coverage', and `health insurance coverage' have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. LOW-INCOME CHILD - The term `low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. POVERTY LINE DEFINED- The term `poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. PREEXISTING CONDITION EXCLUSION- The term `preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms `State child health plan' and `plan' mean a State child health plan approved under Section 2106.
8. UNINSURED CHILD- The term `uninsured child' means a child that does not have creditable health coverage.