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: California
(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))

(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: **Mari Cantwell** Position/Title: **Chief Deputy Director, Department of Health Care Services**
Name: Position/Title:
Name: Position/Title:

*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 0938-0707. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, 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.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

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

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

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

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

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

The template includes the following sections:

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

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

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

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

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

  Medicaid Expansion- CHIP SPA Requirements
  In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:
    - 1 (General Description)
    - 2 (General Background)

  They will also be required to complete the appropriate program sections, including:
    - 4 (Eligibility Standards and Methodology)
    - 5 (Outreach)
    - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
    - 10 (Annual Reports and Evaluations).

  Medicaid Expansion- Medicaid SPA Requirements
  States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
    - 3 (Methods of Delivery and Utilization Controls)
    - 4 (Eligibility Standards and Methodology)
    - 6 (Coverage Requirements for Children's Health Insurance)
    - 7 (Quality and Appropriateness of Care)
    - 8 (Cost Sharing and Payment)
    - 11 (Program Integrity)
    - 12 (Applicant and Enrollee Protections)

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

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

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

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

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

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

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

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

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

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

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

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

CA RESPONSE:

CHIP Program History and 2013/2014 Transition of Healthy Families Children

Shortly after enactment of the federal Children's Health Insurance Program (CHIP), Governor Wilson developed a program for implementing this initiative in California. He submitted his legislative package to the legislature in August of 1997, and the Legislature worked with the Governor to enact the Healthy Families Program (HFP) in the last weeks of the 1997-98 legislative sessions. The Managed Risk Medical Insurance Board (MRMIB) created the HFP, and the County Children's Health Initiative Program (CCHIP) under a separate CHIP program. The HFP provided coverage to infants up through the age of two born to mothers enrolled in the Access for Infants and Mothers (AIM) Program. On March 28, 2006, under CHIP SPA #12, the state also received approval to expand coverage to unborn children (pregnant women) under the state's separate CHIP plan.

Effective July 1, 2014, SB 857 (Chapter 31, Statutes of 2014) eliminated the MRMIB and transferred its responsibilities to the Department of Health Care Services (DHCS). This bill required the elimination of the HFP under California's separate program and the transition of the majority of children in the HFP to a title XXI funded Medicaid expansion program. The bill also prohibited DHCS from approving additional local entities for participation in CCHIP. In addition, SB 857 required local entities that were participating in CCHIP on March 23, 2010, to continue to participate in the program, maintaining eligibility standards, methodologies, and procedures at least as favorable as those in effect on March 23, 2010, through September 30, 2019 (September 30, 2019 the federal Maintenance of Effort (MOE) date). If a county participating in the program as of March 23, 2010, elects to cease funding the non-federal share of program expenditures during the MOE timeframe, the bill requires DHCS to provide funding from the General Fund in amounts equal to the total non-federal share of incurred expenditures.

On December 31, 2012, California received approval from CMS to amend California's section 1115 demonstration, the "California Bridge to Reform Demonstration (11-W-00193/9)." The authority provided California with time limited authority to transition a population of approximately 751,293 children from HFP into a Medicaid (Medi-Cal) expansion demonstration population in several phases. Approval of this demonstration amendment was effective through December 31, 2013. The state also received approval on April 29, 2015 to expand coverage to optional targeted low-income children with family incomes up to and including 250 percent of the FPL under the Medicaid state plan (SPA CA-13-0021).

As specified above, the programs covered under CHIP transitioned from the authority of MRMIB to the DHCS. As part of this transition, the majority of children covered under HFP were transitioned to a new Medicaid expansion program, referred to in California as the Optional Targeted Low-Income Children's Program (OTLICP). However, the state continues to cover four populations, described in detail below, in its separate CHIP.

- **CCHIP children in three counties (Santa Clara, San Francisco, and San Mateo):** This program retains its name and program operations.
- **Unborn children (pregnant women):** Lower income
    - Benefits and cost sharing for the *lower income* children are based on the Medi-Cal program. This program is referred to as the "unborn option."
- **Unborn children (pregnant women):** Upper income
    - Benefits and cost sharing for the *upper income* children are based on state employee benchmark coverage. This program is referred to as the Medi-Cal Access Program (MCAP), and was formerly referred to as AIM.
- **Infants.** This program was originally referred to as MCAP infant program, and is now referred to as the Medi-Cal Access Infant Program (MCAIP).

Overview of Current Structure of Coverage in California and CHIP Combination Program

Coverage in California
Covered California (http://www.coveredca.com) is the health insurance marketplace in California. The exchange enables individuals and small businesses to purchase health insurance at federally subsidized rates. It is administered by an independent agency of the government of California. Individuals, including families with children potentially eligible for Medicaid or CHIP, can also apply online at the Covered California website. California determines whether children are eligible for Medicaid (no-cost Medi-Cal) or other CHIP programs via the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). CalHEERS is a computer system that contains California's Single Streamlined Application, which is consistent with ACA requirements.

Individuals can also apply in person or by mail at a local county human services agency or by phone or mail at Covered California. If individuals need assistance applying or have questions, the state provides a link to find a certified enroller in the area.

Children's Coverage through Separate CHIP
Under the Title XXI plan, children will receive health coverage, as well as comprehensive vision and dental coverage. California covers children in its separate CHIPs under the following programs:

- Population 1: COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAMS (*CCHIP*)
- Population 2: UNBORN OPTION (low income population receiving MEDI-CAL like benefit)
- Population 3: MEDI-CAL ACCESS PROGRAM (MCAP/higher income population receiving state employee benchmark coverage)
- Population 4: MEDI-CAL ACCESS INFANT PROGRAM (MCAIP/infants born to Population 3 only)

In addition to the separate CHIP, certain title XXI funded children receive coverage through a Medicaid expansion that also includes dental and vision coverage. Children with certain complicated medical conditions will receive treatment of those conditions through the state's highly regarded California Children's Services (CCS) program. Similarly, children with serious emotional disturbances may receive treatment of their condition from county mental health departments. This comprehensive child focused benefits package provides children with preventive, full scope, quality health care which is designed to help promote healthier children and, as a result, healthier families for the state of California.

POPULATION 1/COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAMS (CCHIP)

CCHIP is available in Santa Clara, San Francisco, and San Mateo counties. These children receive coverage that is benchmarked to California's state employees under the California Public Employees Retirement System (CalPERS).

In Santa Clara, San Francisco, and San Mateo counties, CCHIP enrolled children receive health coverage from a Medicaid health plan that participates in CCHIP, and has a contract with the counties to provide the services. Specialized services are carved out for CCS, as is also carved out for Medicaid and MCAIP children. Under the CCHIP model, children diagnosed with an eligible CCS condition will be referred to the CCS program for a full eligibility determination, including financial eligibility. In the CHIP Program, enrolled children with an eligible CCS condition are "deemed" to meet the financial eligibility requirements. In CCHIP, children that do not meet all the CCS eligibility criteria have all their medical needs met by the health plan as occurs today under the CalPERS. Children enrolled in the CCHIP also receive comprehensive dental and vision coverage also designed after the CalPERS.

CCHIP is administered by the counties on behalf of DHCS. Application screening to assure children are not eligible for no-cost Medi-Cal is done via CalHEERS. CCHIP covers children with income above 261 percent of the Federal Poverty Level (FPL) up to and including 317 percent of the FPL. This is consistent with the CS7 in Attachment 1.

DHCS is responsible for review and ongoing monitoring of each of the CCHIP expansions to assure compliance with federal Title XXI regulations and California's approved state plan.

POPULATION 2/UNBORN OPTION (LOW INCOME POPULATION RECEIVING MEDI-CAL BENEFIT)

The Unborn Option offers prenatal care, prescriptions, labor and delivery, dental care, and services for other conditions that may complicate the pregnancy to pregnant women whose income is from 0 to 208 percent of the FPL. This is consistent with the CS9 template in Attachment 1. Postpartum coverage is also included and lasts until the end of the month of the 60th day following the end of the pregnancy. Infants are eligible for Medi-Cal at birth with no family income limit for the first year of life.

POPULATIONS 3 MEDI-CAL ACCESS PROGRAM (MCAP)/ POPULATION 4 MEDI-CAL ACCESS INFANT PROGRAM (MCAIP)

MCAP provides comprehensive health benefits for targeted low income unborn children with household incomes above 208 percent up to and including 317 percent of the FPL. This is consistent with the CS9 template in Attachment 1. Pregnant women are not eligible for MCAP if they are on Medi-Cal or have employer-sponsored coverage

(unless the coverage has such high deductibles that DHCS views the coverage as being tantamount to being uninsured). As approved in California's SPA, FFP is claimed for infants through the age of one born to MCAP mothers with household incomes above 208 percent of the FPL up to and including 317 percent FPL. This is consistent with the CS9 in Attachment 1. MCAIP provides health benefits for infants up to age two born to MCAP mothers with incomes above 261 percent of the FPL up to and including 317 percent of the FPL.

California CHIP State Plan Attachments

Attachment #	Name of Attachment	Relevant CHIP State Plan Section	Purpose of Attachment
1	CA approved ACA Eligibility Templates	Section 4/Eligibility	To reflect approved eligibility pages referenced in the table in section 1.4, subsections of 4.0, and 8.7 specifically.
2	State Employee Benchmark Benefit for MCAP and CCHIP	Section 6.1.1.2/Benefits	To describe benefits for Population 1 (CCHIP) and 3 (MCAP)
3	Medicaid benefits for the Unborn Option and MCAIP	Section 6.1.4.1/Benefits	To describe Medicaid benefits for Population 2 (Unborn Option) and 4 (MCAIP)
4	Medicaid benefit limitations for the Unborn Option and MCAIP	Section 6.1.4.1/Benefits	To describe applicable limitations under Medicaid for Populations 2 and 4
5	Summary table of benefits for all pops	Section 6.2/Benefits	To provide a summary of benefits across all separate CHIP populations
6 & 7	Dental coverage for MCAP and CCHIP	Section 6.2.2.2/Benefits	This attachment includes CDT codes for Delta Dental (Attachment 6) and Liberty Dental (Attachment 7). Also, there is a general description in Attachment 2 on page 11.
8	Dental coverage for the Unborn Option and MCAIP	Section 6.2.1/Benefits	Attachment 3, Page 4, Paragraph 10 and Attachment 4, Page 53, Section 10.

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

(Section 2110(b)(5))

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

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

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

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

CA RESPONSE:

Date Original Plan Submitted: November 19, 1997
Date Plan Approved: March 24, 1998
Date Plan Effective/Implemented: July 1, 1998

Date Amendment#1 Purpose: Changed its income eligibility for the Healthy Families Program to be in compliance with the State enabling legislation. This amendment lowered income eligibility from 200 percent of the FPL net income to 200 percent of the FPL gross income. This amendment was initiated at the start of the program's implementation on July 1, 1998.
Date Amendment #1 Submitted: April 14, 1998
Date Amendment #1 Approved: June 29, 1998
Date Amendment #1 Effective/Implemented: July 1, 1998

Date Amendment#2 Purpose: Increased the enrollment broker fees from $25 to $50 per successful applicant.

Date Amendment #2 Submitted: January 8, 1999
Date Amendment #2 Approved: December 21, 1999
Date Amendment #2 Effective/Implemented: October 1, 1998

Date Amendment#3 Purpose: Expanded income eligibility for the Healthy Families Program by disregarding income between 200 to 250 percent of the FPL. Income eligibility for the Healthy Families Program is further expanded by applying Medi-Cal income deductions when determining eligibility for the Healthy Families Program. The Child Health and Disability Prevention (CHDP) provider-claiming period for services received prior to enrollment is also lengthened from 30 to 90 days.
Date Amendment #3 Submitted: August 3, 1999
Date Amendment #3 Approved: November 23, 1999
Date Amendment #3 Effective/Implemented: July 22, 1999

Date Amendment#4 Purpose: Allowed a Family Contribution Sponsor to pay a specific child's HFP) premiums for the first year of enrollment.
Date Amendment #4 Submitted: December 9, 1999
Date Amendment #4 Approved: March 6, 2000
Date Amendment #4 Effective/Implemented: March 1, 2000

Date Amendment#5 Purpose: Exempted cost sharing for American Indians (AI) and Alaskan Native (AN) children who meet the eligibility criteria for the Healthy Families Program (HFP) and provide acceptable documentation of their status as AI or AN children.
Date Amendment #5 Submitted: April 17, 2000
Date Amendment #5 Approved: July 7, 2000
Date Amendment #5 Effective Date: October 6, 1999

Date Amendment#6 Purpose: Indicated the State's partial compliance with the final SCHIP regulations.
Date Amendment #6 Submitted: July 2, 2002
Date Amendment #6 Approved: September 19, 2002
Date Amendment #6 Effective Date: August 24, 2001
Date Amendment#7 Purpose: Expanded coverage levels to 300 percent of the FPL for children residing in selected counties (Alameda, San Francisco, San Mateo and Santa Clara) through the CCHIP). This amendment also expands coverage to children up to age 2 born to mothers enrolled in the AIM program with family incomes up to 300 percent of the FPL.
Date Amendment #7 Submitted: April 1, 2003
Date Amendment #7 Approved: June 10, 2004
Date Amendment #7 Effective: January 1, 2003 – CCHIP Expanded Coverage levels; and July 1, 2004 – AIM Program

Date Amendment #8 Purpose: Implemented oral health services initiative, including case management, oral health education, preventative services, and mobile dental vans.
Date Amendment #8 Submitted: July 24, 2003
Date Amendment #8 Approved: January 16, 2004
Date Amendment #8 Effective: January 1, 2004

Date Amendment #9 Purpose: Allowed the State to provide presumptive eligibility to children with family incomes from 100 to 200 percent of the FPL through the CHDP program.
Date Amendment #9 Submitted: September 9, 2003
Date Amendment #9 Approved: December 8, 2003
Date Amendment #9 Effective: July 1, 2003

Date Amendment #10 Purpose: Allowed the State to claim for the State's rural health demonstration projects as a health services initiative under the SCHIP 10 percent administrative cap. The rural health demonstration projects, which were previously approved under the California SCHIP State plan, aim to improve access to health care services for low-income medically underserved and uninsured populations in rural areas and special populations who have rural occupations. By claiming for the rural health demonstrations under the 10 percent cap, the State has the flexibility to provide services for all low-income children, thereby benefiting all low-income children, not just SCHIP enrollees. The amendment also allows the State to use tobacco taxes as a new source of State funding.
Date Amendment #10 Submitted: December 15, 2003
Date Amendment #10 Approved: March 11, 2004
Date Amendment #10 Effective: February 1, 2004

Date Amendment #11 Purpose: Increased premiums for children with family incomes from above 200 percent of the FPL up to and including 250 percent of the FPL. The amendment also provides for school-based outreach for the Healthy Families Program through a partnership between the State and the David and Lucile Packard Foundation.
Date Amendment #11 Submitted: March 23, 2005
Date Amendment #11 Approved: March 15, 2007
Date Amendment #11 Effective: March 22, 2005 (School-based Outreach) July 1, 2005 (Premium Increase)

Date Amendment #12 Purpose: Extend health care coverage to unborn children with family income up to 300 percent of the Federal poverty level (FPL).
Date Amendment #12 Submitted: June 30, 2005
Date Amendment #12 Approved: March 28, 2006

Date Amendment #12 Effective: July 1, 2004

Date Amendment #13 Purpose: Added a fifth county (Santa Cruz) to their County Program allowing children to be enrolled from 250 percent to 300 percent of the FPL. However, it was subsequently withdrawn by the State on 11/6/08.
Date Amendment #13 Submitted: July 12, 2007
Date Amendment #13 Approved: Withdrawn (November 6, 2008)

Date Amendment #14 Purpose: Responded to program changes enacted by the Legislature to increase premiums, place a cap on dental benefits, limit 5 certain vision benefits, apply a wait list, and remove the 6-month residency requirement for pregnant women in the Access for Infants and Mothers program.
Date Amendment #14 Submitted: April 2, 2009
Date Amendment #14 Approved: January 14, 2010
Date Amendment #14 Effective: January 31, 2009 Wait List /Disenrollment Infrastructure January 6, 2009 AIM 6-Month Residency Requirement Elimination February 1, 2009 HFP Family Contribution Increase, & Vision Benefit Modification July 1, 2009 Dental Benefit Cap

Date Amendment #15 Purpose: CHIPRA Shifting of Presumptive Eligibility Cost to Title XIX Funds; CHIPRA Option of Lawfully Residing Children; CHIPRA Shifting of Accelerated Enrollment Cost to Title XIX Funds; Presumptive Eligibility at Initial Application under Title XXI Funds.
Date Amendment #15 Submitted: June 30, 2009
Date Amendment #15 Approved: December 29, 2009
Date Amendment #15 Effective: April 1, 2009

Date Amendment #16 Purpose: Implemented a health services initiative to support the California Poison Control System (CPSC).
Date Amendment #16 Submitted: October 16, 2009
Date Amendment #16 Approved: December 3, 2009
Date Amendment #16 Effective: July 1, 2009

Date Amendment #17 Purpose: Increased premiums and co-payments for children with a family income above 150 percent up to and including 250 percent of the FPL. The amendment also proposes to limit dental plan choices for new subscribers. These changes are based on changes in State law.
Date Amendment #17 Submitted: December 24, 2009
Date Amendment #17 Approved: July 29, 2010
Date Amendment #17 Effective: November 1, 2009

Date Amendment #18 Purpose: Premium Increases

Date Amendment #18 Submitted: June 1, 2011
Date Amendment #18 Approved: Withdrawn July 3, 2012
Date Amendment #18 Effective: Not applicable.

Date Amendment #19 Purpose: Expanded eligibility in CCHIP from 300 percent of the FPL to 400 percent of the FPL in San Mateo County; Eliminated the dental benefit cap; Implemented an electronic data match with the Social Security Administration for citizen verification; Required CHIP payments to FQHCs and RHCs comply with Medicaid payment requirements.
Date Amendment #19 Submitted: June 29, 2012
Date Amendment #19 Approved: September 7, 2012
Date Amendment #19 Effective:
October 1, 2011: Dental Benefit Cap Elimination
January 1, 2012: County Children's Health Initiative Program (CCHIP)
October 1, 2009: Prospective Payment System for FQHC's and RHC's
January 1, 2010: Citizenship Verification Requirement

SPA # 20. Purpose of SPA: To eliminate the "Healthy Families" program, and transition the majority of children from a separate program to a Medicaid expansion under the Medi-Cal program in California. This SPA reflects changes previously effectuated through section 1115 demonstration authority.
Proposed effective date: December 31, 2013
Proposed implementation date: January 1, 2013 through December 31, 2014

SPA #17-0043. Purpose of SPA: To implement provisions for temporary adjustments to enrollment, eligibility determination and redetermination policies, and premium and cost-sharing requirements for children in families living and/or working in Governor or FEMA declared disaster areas. In the event of a declared disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment, eligibility determination and/or redetermination policies, and premium and/or cost-sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or FEMA declared disaster areas.

Some or all of the temporary adjustments would apply to the following populations:
Population 1 (County Children's Health Initiative Program - CCHIP)
Population 2 (Unborn Option)
Population 3 (Medi-Cal Access Program - MCAP)
Population 4 (Medi-Cal Access Infant Program - MCAIP)
Proposed effective date: October 1, 2017
Proposed implementation date: October 1, 2017

SPA #18-0028. Purpose of SPA: To implement the transition of MCAP (Population 3) services provided by public-private-partnership to services provided by

California's Medi-Cal Managed Care delivery system.
Proposed effective date: July 1, 2017
Proposed implementation date: July 1, 2017

SPA # 19-0036 Purpose of SPA: To demonstrate compliance with 42 CFR section 457 et al., the Managed Care Final Rule FR 81 27497.
Proposed effective date: July 1, 2018
Proposed implementation date: July 1, 2018

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
CA-14-0001 Approval Date: 8/11/2016 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS15	Eligibility – Targeted Low Income Children MAGI-Based Income Methodologies	Supersedes the current sections 4.1.1, 4.1.2 and 4.1.3 Incorporate within a separate subsection under section 4.3
CA-14-0002 Approval Date: 9/08/2015 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
CA-14-0003 Approval Date: 7/22/2014 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
CA-14-0004 Approval Date: 3/18/2019 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	
CA-14-0005	Non-	CS17	Non-Financial	Supersedes the current section 4.1.5

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Approval Date: 4/9/2015 Effective/Implementation Date: January 1, 2014	Financial Eligibility	CS18	Eligibility – Residency	Supersedes the current sections 4.1.0; 4.1-LR; 4.1.1-LR
		CS19	Non-Financial Eligibility – Citizenship	Supersedes the current section 4.1.9.1
		CS20	Non-Financial Eligibility – Social Security Number	Supersedes the current section 4.4.4
		CS21		Supersedes the current section 8.7
		CS27	Non-Financial Eligibility – Substitution of Coverage	Supersedes the current section 4.1.8
		CS28	Non-Financial Eligibility – Non-Payment of Premiums	Supersedes the current section 4.3.2
			General Eligibility – Continuous Eligibility	

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.

CA RESPONSE:

In July 2014, CMS determined that tribal consultation was not necessary for the Medicaid companion SPA (Medicaid SPA CA-13-0021), expanding Medicaid eligibility related to the end of the HFP and the transition of children from a separate to a Medicaid expansion. This CHIP SPA is administrative in nature and does restrict eligibility, reduce payment rates or make updates to payment methodologies to Indian health programs, reduce or restrict access to covered services, increase services reimbursed to Indian health programs or update the tribal consultation policy in any way.

TN No: Approval Date Effective Date: NA

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

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

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

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

CA RESPONSE:

The uninsurance rate for children 0-18 in California is 4 percent. Type of coverage breaks out in the following manner for children in the state:

- Employer coverage is 45 percent,
- Non-group coverage is 7 percent,
- Medicaid coverage is 42 percent, and
- Other public coverage is 2 percent.

The data source for this information is the Kaiser Family Foundation's (KFF) analysis of the Census Bureau's March 2014-2016 Current Population Survey (CPS: Annual Social and Economic Supplements). Estimates are based on the average taken from March 2014-2016 data.

Population 1/CCHIP: CCHIP is a health insurance program in Santa Clara, San Francisco and San Mateo counties. CCHIP provides medical, dental and vision to children from age 0 up to age 19 with family income above 261 percent of the FPL and up to and including 317 percent FPL. This is consistent with the CS7 in Attachment 1.

- Only available in Santa Clara, San Francisco, and San Mateo counties.
- There are approximately -6,300 individuals enrolled in the three counties that offer CCHIP.
- Race demographics not tracked

Source: CalHEERS daily extract file on enrollment.

Population 2/Unborn Option: The Unborn Option offers prenatal care, prescriptions, and labor and delivery, dental care, and services for other conditions that may complicate the pregnancy. Unborn Children (pregnant women) with income from 0 up to 208 percent of the FPL and who are not eligible for Medi-Cal. This is consistent with the CS9 in Attachment 1. Postpartum coverage is also included and lasts until the end of the month of the 60th day following the end of the pregnancy. An infant is eligible for Medi-Cal at birth with no family income limit for the first year of life.

- There are approximately 18,000 individuals enrolled in California's Unborn Option.
- 75 percent of the population identify as Hispanic, Other races rank at 6 percent or under.
- >65 years of age
- California's Unborn Option is available throughout the state.

Source: DHCS enrollment data.

Population 3/MCAP: Provides low cost health insurance coverage to uninsured, unborn children (pregnant women) with income from 208 up to 317 percent FPL. This is consistent with the CS9 in Attachment 1. MCAP provides comprehensive healthcare from the effective date of coverage in MCAP until the last day of the month in which the 60th day following the end of the pregnancy occurs. Pregnant women receive their care from participating health plans. Infants born to women enrolled in MCAP are eligible for enrollment in MCAIP (see Population 4 below) or the Medi-Cal program.

- There are approximately 3,100 enrolled in MCAP.
- 74 percent of the population identify as "Other" in regards to Race/Ethnicity; 8 percent White; 6 Hispanic; <1 percent other ethnicities
- >18 pregnant woman; <18 if emancipated minor
- MCAP is available throughout the state

Source: MCAP enrollment data provided by DHCS' administrative vendor.

Population 4/MCAIP: MCAP linked infants and children (MCAIP) ages 0 up to 2 years with income above 261 percent of the FPL up to and including 317 percent of the FPL. This is consistent with the CS7 in Attachment 1. Provides health care services (medical, dental and vision) through Medi-Cal Managed Care Plans. There are approximately 986 individuals enrolled in MCAIP

- 64 percent of the population identify as "Other" in regards to Race/Ethnicity; 8 percent Hispanic; 6 percent White; <1 percent other ethnicities
- Ages 0-2
- MCAIP is available throughout the state

Source: DHCS enrollment data provided by MIS/DSS data warehouse.

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))

CA REPSONSE:

Public Health Care Programs for Children. A significant number are served through public programs. The public programs under which children may get coverage include the following:

Medi-Cal. California's largest public health insurance program serving children is Medicaid (known in California as Medi-Cal).

- Children served under the categorically needy categories (SSI/SSP and Federal Poverty Level coverage groups).
- The Medically Needy program under Title XIX, Section 1902(a)(10)(C) provides benefits to children under age 21 who meet the applicable eligibility requirements.

California Health Care for Indigents Program. This program provides funding to large counties for uncompensated hospital, physician, and other health service costs.

To be eligible for California Health Care for Indigents funds, counties must meet their Maintenance of Effort (MOE) requirement, and provide or arrange for follow-up medical treatment for children with health problems and/or medical disorders detected through the CHDP program.

Rural Health Services (RHS). RHS provides funding to small rural counties for uncompensated hospital, physician, and other health services costs. This is not the same as the Rural Health Demonstration Project.

To be eligible, counties must participate in the County Medical Services Program, meet their MOE requirement, and provide or arrange for follow-up medical treatment for children with health problems and/or medical disorders detected through the CHDP program.

Counties may contract with the DHCS for the rural counties' obligation to provide follow-up treatment for the conditions identified in CHDP screens.

Seasonal Agricultural and Migratory Workers Health Program. This program provides financial and technical assistance to primary care clinics serving the needs of seasonal, agricultural, and migratory workers and their families. Individuals pay on a sliding scale.

California Children's Services (CCS). CCS provides funding for medical care for eligible low-income families with children with serious medical problems, such as critical acute illnesses, chronic illnesses, genetic diseases, physical handicaps, major injuries due to violence and accidents, congenital defects, and neonatal and pediatric intensive care unit level conditions. It provides physician, hospital, laboratory, X-ray, rehabilitation services, medications, and medical case management.

To be eligible, individuals must be under 21years of age, have a medical condition covered by CCS, be a resident of the county, have an adjusted gross family income below $40,000 or a projected out-of-pocket medical cost greater than twenty percent of the family income.

Direct health services are frequently provided through community health centers, school based health centers and voluntary practitioner programs.

Type of coverage breaks out in the following manner for children in California:

- Employer coverage is 45 percent,
- Non-group coverage is 7 percent,
- Medicaid coverage is 42 percent, and
- Other public coverage is 2 percent.

The data source for this information is the Kaiser Family Foundation's (KFF) analysis of the Census Bureau's March 2014-2016 Current Population Survey (CPS: Annual Social and Economic Supplements). Estimates are based on the average taken from March 2014-2016 data.

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

2.2. **Health Services Initiatives (HSI) -** 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)

CA RESPONSE:

Poison Treatment Advice and Prevention. California uses CHIP funds, within the 10 percent federal administrative expenditures cap allowed for states, to support the California Poison Control System (CPCS). CPCS provides daily, 24-hour emergency telephone treatment advice, referral assistance, and information to manage exposure to poisonous and hazardous substances. The CPCS answers poisoning emergency calls from the general public 24 hours a day, 365 days each year at no charge. At all times, a Specialist in Poison Information (SPI) is available to manage cases and Certified Specialists in Poison Information (CSPI) manage cases and direct Poison Information Providers. The service is provided to all communities, including underserved and indigent populations, in over 150 languages and via telecommunications devices for the deaf and hearing impaired (TDD).

The call center receives approximately 220,000 calls per year involving someone ingesting poison and other hazardous substances. Nearly 40 percent of all calls relate to children age 0-18 with annual household incomes of $55,000 or less (250 percent FPL for a family of 4). Another 10 percent of calls are for children 0-18 with incomes up to $65,000 (250 percent FPL for a family of 5). Children under the age of five account for the majority of poison exposures. In addition to calls regarding exposure, another 90,000 calls are for information and are considered preventive. Of these calls, 64 percent are for children age 0- 18 in families with incomes at $55,000 or less, and another 12 percent for families with incomes up to $65,000. Only children below the age of 19 are served through this HSI.

Poison center public education programs direct attention and resources to "identified at-risk populations". In California, the targeted at-risk populations are Latinos, African Americans, and children born to low income parents. Of California's 2.5 million children under the age of five (2016 U.S. Census), approximately 525,000 live in poverty. African-Americans and Latinos are California's largest at-risk groups.

A line of consumer-based educational materials has been developed in Spanish using research findings with target audiences. Materials are culturally relevant, take into consideration health literacy levels and clearly illustrate and describe poison center services. Chinese, Korean, Vietnamese, Tagalog, Hmong, Russian and Armenian brochures have also been developed. Materials are customized and culturally relevant to each group.

A Community Health Worker Initiative directs efforts to the "hardest to reach" and "at highest risk" populations. Community health workers deliver the CPCS message through group education sessions, community health fairs, and local events, as well as informally, though one-on-one outreach in their neighborhoods, churches, and community gatherings

CPCS advertises the national public toll free number and its own TTY toll free number in both the white pages and the "customer guide" (usually appearing on page 2) of all

California telephone directories. Listings placed with the major local phone companies (SBC, Verizon) are applied to each directory they publish in California. CPCS also places these listings in the smaller rural phone company, as well as independent community directories.

The State assures that the HSI programs will not supplant or match CHIP federal funds with other federal funds, or allow other federal funds to supplant or match CHIP federal funds.

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.

CA REPSONSE:

California's Title XXI program follows the same tribal consultation process as the California Medicaid Program. This process is identified in the Medicaid approved State Plan Amendment (SPA) 10-018, effective October 1, 2010, which was approved by CMS on March 16, 2011, and further amended in the Medicaid approved SPA 12-002, effective January 1, 2012, and approved on June 15, 2012.

DHCS participates in the Tribal Consultation activities, as the administering state agency for California's Medicaid Program.

Section 3. <u>Methods of Delivery and Utilization Controls</u>

☐ 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.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to the CMS Regional Office servicing them for review and approval.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding.
If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

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.

CA Response:

MANAGED CARE DELIVERY SYSTEM

These populations use a managed care plan delivery system for health care:

- Population 1 (CCHIP)
- Population 3 (MCAP)
- Population 4 (MCAIP)

FEE-FOR SERVICE

This population is included in a fee-for-service (FFS) system for health care:

- Population 2 (Unborn Option)

OTHER SERVICES

Dental

Dental Services are provided in a FFS system; however, Dental Managed Care (DMC) operates in Los Angeles and Sacramento Counties. In Sacramento County DMC enrollment is mandatory, and in Los Angeles County beneficiaries have the option to enroll in a DMC plan or access dental benefits through the Dental FFS delivery system

This applies to all four CHIP populations.

Mental Health/Substance Use Disorder (SUD)

County Mental Health Plans (MHP) are PIHPs that provide specialty mental health services and are reimbursed through a claims-based FFS payment structure rather than on a capitated basis.

SUD services are provided through Drug Medi-Cal (DMC) providers on a FFS basis, with the exception of counties that operate a Drug Medi-Cal Organized Delivery System (DMC-ODS). The DMC-ODS is a delivery system for SUD services in counties that choose to opt-in and implement the pilot. By opting into DMC-ODS, a county agrees to provide or arrange for the provision of DMC-ODS services through PIHPs, as well as FFS.

This applies to all four CHIP populations.

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.

DENTAL

Dental Services are provided in a FFS system; however, Dental Managed Care (DMC) operates in Los Angeles and Sacramento Counties. In Sacramento County DMC enrollment is mandatory, and in Los Angeles County beneficiaries have the option to enroll in a DMC plan or access dental benefits through the Dental FFS delivery system

This applies to all four CHIP populations.

MENTAL HEALTH/SUBSTANCE ABUSE DISORDER (SUD)

County Mental Health Plans (MHP) are PIHPs that provide specialty

mental health services and are reimbursed through a claims-based FFS payment structure rather than on a capitated basis.

SUD services are provided through Drug Medi-Cal (DMC) providers on a FFS basis, with the exception of counties that operate a Drug Medi-Cal Organized Delivery System (DMC-ODS). The DMC-ODS is a delivery system for SUD services in counties that choose to opt-in and implement the pilot. By opting into DMC-ODS, a county agrees to provide or arrange for the provision of DMC-ODS services through PIHPs, as well as FFS.

This applies to all four CHIP populations.

CALIFORNIA CHILDREN'S SERVICES (CCS)

CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. In certain designated counties, SB 586 established a Whole Child Model program authorizing these CCS services to be incorporated into a Managed Care Plan. The remaining counties provide CCS services on a FFS basis.

This applies to Population 1 (CCHIP).
San Mateo – Whole Child Model
San Francisco and Santa Clara - FFS

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:

California utilizes MCOs for its Medi-Cal Managed Care Plans and Dental Managed Care Plans; however, Dental Managed Care Plans only operate in Sacramento and Los Angeles counties. Outside of these two counties, dental services are provided through the Medi-Cal dental FFS system.

POPULATION 1 (CCHIP)

CCHIP only operates in San Francisco, San Mateo, and Santa Clara counties, and only has its dental services provided on an FFS basis.

☒ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
- ☐ Capitation payment
- ☒ Other (please explain)

  Describe population served:

California utilizes PIHPs for its County Mental Health Plans (MHP) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS) Plans.

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)

Individuals enrolled in a County Organized Health System (COHS) plan do not have the option of accessing services through a different plan or traditional Medi-Cal FFS. This is part of the freedom of choice waiver in the Medi-Cal 2020 Demonstration. This waiver authorizes the state to mandatorily enroll beneficiaries in managed care and lock them in after 90 days. .

However, if moving to that COHS managed care plan would cause disruption in the continuity of care or access to care for the subscriber, they can request Continuity of Care from the COHS plan. Through this, the individual can continue care with their current doctor and continue with medications already prescribed.

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

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

CA RESPONSE: Please see Attachment 1 for all of the references to the approved templates, including details regarding eligibility levels, in Section 4 below.

4.0. ☒ **Medicaid Expansion**

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

CA REPSONSE:

OPTIONAL TARGETED LOW INCOME CHILDREN PROGRAM (OTLICP):
Please see approved CS3 template for age and income standards.

ASSET WAIVER CHILDREN/CS3 PROXY:
Please see approved CS3 template.

Please also see approved CS3 template for age and income levels for OTLICP, as well as the state's narrative to the CS3 related to the proxy methodology for asset waiver children.

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

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

Please see approved CS18 template for citizenship verification requirements.

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

Please see approved CS7 and CS9 templates for geographic area requirements.

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

CA RESPONSE:
Please see Section 2 above for overview of relevant separate CHIP populations (Populations 1, 2, 3 and 4 above), and also see CS7 template for approved income levels for Populations 1. Also please see CS23 template for approved income levels for Population 4.

4.1.2.1-PC ☒ Age: From confirmed pregnancy to birth (SHO #02-004, issued November 12, 2002)

CA RESPONSE:

Please see Section 2 above for overview of relevant separate CHIP populations (Populations 2 and 3) and also see approved CS9 template for approved income levels for the unborn population.

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

CA RESPONSE: Please see information above for each group.

4.1.3.1-PC ☒ 0% of the FPL (and not eligible for Medicaid) through 317% of the FPL (SHO #02-004, issued November 12, 2002).

CA RESPONSE: Please see information above for Populations 2 and 3.

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):

CA REPSONSE: Please see approved CS17 template for residency requirements.

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:

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

CA RESPONSE: Please see approved CS27 template related to continuous eligibility requirements.

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:

CA RESPONSE: Please see approved CS23 template for other eligibility standards related to Population 4.

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

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

CA RESPONSE: Please see approved CS19 for SSN requirements.

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

4.1.9.2 ☒ Continuous eligibility

CA RESPONSE: DHCS has continuous eligibility programs for children and

unborn children (pregnant women). Please see the approved CS27 template for continuous eligibility requirements. Continuous eligibility is applicable to Populations 1 and 2.

Continuous Eligibility for Children (CEC) provides children with 12 months of continuous coverage through Medicaid and CHIP, even if the family experiences a change in income during the year. CEC is applicable for Population 1.

Continuous eligibility for Unborn ("Pregnant Women"): Provides continuous eligibility throughout the pregnancy and until the end of the post-partum period, regardless of changes in income or household composition. The post-partum period begins on the date the pregnancy ends and lasts until the end of the month in which the 60th day after the end of the pregnancy occurs. This is applicable for Population 2.

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

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

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

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

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
(4) An alien who belongs to one of the following classes:
   (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
   (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
   (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
   (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
   (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
   (vi) Aliens currently in deferred action status; or
   (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;
(6) An alien who has been granted withholding of removal under the Convention Against Torture;
(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☒ Elected for children under age 19

Please see approved CS18 template.

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.

Please see approved CS18 template.

4.1-DS ☐ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. **Assurances** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS ☐ These standards do not discriminate on the basis of diagnosis.

4.2.2-DS ☐ Within a defined group of covered targeted low-income children, these

standards do not cover children of higher income families without covering children with a lower family income.

4.2.3-DS ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

CA RESPONSE:

The state's eligibility and enrollment processes operate in a manner consistent with the requirements of 42 CFR 457, subpart C. These processes are applied at the time of initial application and at redetermination, and ensure that eligible targeted low-income children are identified and appropriately enrolled in the California separate CHIP programs. California determines whether children are eligible for Medicaid (no-cost Medi-Cal) or other CHIP programs via the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). CalHEERS is a computer system that contains California's Single Streamlined Application, which can be used for both CHIP and the OTLICP, as well as other Medicaid populations. California's Single Streamlined Application is consistent with ACA requirements.

DHCS and the county programs are responsible for reviewing eligibility determinations and establishing continued enrollment.

Please also reference the approved CS15 template.

In the event of a FEMA or Governor declared disaster, the State will notify CMS of its intent to provide temporary adjustments to its enrollment, eligibility determination and/or redetermination policies, and premium and/or cost-sharing requirements, the effective dates of such adjustments, and the counties/areas impacted by the disaster.

CA RESPONSE:

In the event of a FEMA or Governor declared disaster and at the State's discretion, the State may waive premium balances and/or cost-sharing for applicants and/or beneficiaries living in, working in, and/or displaced from FEMA or Governor declared disaster areas at the time of a disaster event in accordance with Sections 8.2.1 and 8.2.2. These temporary waivers would apply to:

Population 1 (CCHIP)

Population 3 (MCAP)
Population 4 (MCAIP)

In the event of a FEMA or Governor declared disaster and at the State's discretion, applicants and/or enrollees may be granted eligibility and receive services beyond their certification period and may be provided additional time to submit a renewal or verification. These temporary waivers would apply to:

Population 1 (CCHIP)
Population 4 (MCAIP)

In the event of a FEMA or Governor declared disaster and at the State's discretion, eligibility verification requirements may be waived at application and/or renewal. The State may allow self-attestation to complete the eligibility determination, in accordance with 42 CFR 457.380. These temporary waivers would apply to:

Population 1 (CCHIP)
Population 2 (Unborn Option)
Population 3 (MCAP)
Population 4 (MCAIP)

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

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

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

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

If DHCS determines that sufficient funds are not available to cover the estimated cost of program expenditures and it is necessary to limit enrollment, DHCS will place children on a waiting list until adequate funding becomes available to resume enrollment. This determination will be made in a public meeting, pursuant to State law. DHCS will notify the Center for Medicare and Medicaid Services prior to implementation of a waiting list in writing (by email, fax, letter or other appropriate means).

In addition, the DHCS website is updated to reflect any program changes and newsletter articles are updated for our community partners. Each new applicant family affected by the waiting list will receive notification in writing.

a. **When a waiting list is implemented,** the program will continue to receive new applications; however, no eligibility determinations will be made until adequate funding is available. Placement on the waiting list is only for new applications. New applications will be screened through CalHEERS' Single Streamlined Application for Medi-Cal, California's Title XIX Medicaid program and these applications will be forwarded to the applicant's local county welfare department for a Medi-Cal eligibility determination. Siblings and newborns of current enrollees and children formerly eligible for No-Cost Medi-Cal who apply are considered new applicants and are subject to the waiting list. Each new applicant family whose child is placed on the waiting list will be notified by letter. In addition, the notification letter will contain information about where the family may apply for other potential coverage (e.g., Medi-Cal).

b. **If the State is using a waiting list,** children will be placed on the waiting list in the order in which their applications were received based on the date the application was received. If DHCS determines that sufficient funds are available to cover some or all children on the waiting list, the applications will be reviewed for children on the waiting list in the order their application was received.

c. **When children are removed from the waiting list,** each family will receive a notification letter, informing them that sufficient funding is now available for the enrollment of their child and requesting that the family complete a pre-printed application, updating any changes and information to determine eligibility for enrollment. When the application and other updated documentation is received, DHCS will screen the application based upon income eligibility to either the CHIP Program or the state's Medi-Cal program. If the family does not reply within seventeen (17) calendar days, as noted on the application, the application will be denied for being incomplete.

If the family submits the information after the requested due date the child may be placed back onto the waiting list, in the order in which the new application is received. In addition, the DHCS website is updated to reflect any program changes and newsletter articles are updated for our community partners. Each family affected by disenrollments will receive notification in writing thirty (30) days prior to disenrollment. These subscribers will also be placed on the waiting list until sufficient funding is available to cover program expenditures. The subscriber child's effective date on the waiting list will be the date of his or her disenrollment. However, children with chronic conditions through California Children's Services (CCS) who are CCS eligible solely by virtue of their eligibility are exempt from disenrollment and will continue their enrollment.

If DHCS later determines sufficient funds are available to cover some or all eligible subscriber children, the Program will stop disenrolling children during the renewal process and begin enrolling subscriber children back into the program. When all children who were disenrolled have been removed from the

waiting list, eligibility will then be assessed for the additional waitlisted children, in the order of their effective dates on the waiting list.

If only a waiting list is implemented, children who have current enrollment in the Program will remain enrolled, so long as they continue to meet all eligibility criteria and remain current with premium payments.

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)

CA REPSONSE:
Please see approved CS28 template for presumptive eligibility requirements.

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

4.3.3-EL Express Lane Eligibility ☐ Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

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

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

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

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

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment

requirements before a child may be enrolled under title XXI.

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

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

4.4. Eligibility screening and coordination with other health coverage programs

States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

CA RESPONSE: California ("Covered California") is a State Based Marketplace (SBM) and is responsible for performing all Marketplace functions, such as application processing, eligibility and enrollment activities. All individuals, including individuals seeking coverage through CHIP, apply for and enroll in coverage through Marketplace websites established and maintained by California. California is currently using a Single Streamlined Application, which can be used for both CHIP and the OTLICP, and other type of coverage. California ensures that applicants who appear to be eligible for Medicaid are enrolled in Medicaid, and that eligible targeted low-income children are appropriately enrolled in separate CHIP coverage. These screening processes are used

both at the time of initial eligibility determinations and at redetermination.

4.4.2. ☒ children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))

CA RESPONSE: California ensures that applicants who appear to be eligible for Medicaid are enrolled in Medicaid, and that eligible targeted low-income children are appropriately enrolled in separate CHIP coverage. These screening processes are used both at the time of initial eligibility determinations and at redetermination. As noted above, California is currently using a Single Streamlined Application, which can be used for both CHIP and Medi-Cal children.

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

4.4.4. ☒ the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)

Please see approved CS20 template for CA's substitution strategies.

4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

4.4.5. ☒ Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

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

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

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a)

and 42 CFR 457.80(c). Describe this process.

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

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

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

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

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

CA REPSONSE:

California currently identifies and enrolls uncovered children who are potentially eligible to participate in public programs in several ways:

- CCS and Women, Infants, and Children (WIC) providers identify children who may be potentially eligible for Medi-Cal and refer the family to the appropriate office to apply. State statute requires CCS applicants who may be eligible to apply for Medi-Cal .
- CHDP providers identify children who are uninsured and appear to be eligible for no cost Medi-Cal or the CHIP programs, grant presumptive eligibility in one of

the two programs, and encourage families to apply for continuing coverage.

- To facilitate the application process, Medi-Cal outstations eligibility workers in locations that serve large numbers of potentially eligible children, such as disproportionate share hospitals, prenatal clinics and federally qualified health centers.
- DHCS utilizes a Single Streamlined Application, which can be used for both CHIP and the Medi-Cal program.

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

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

CA REPSONSE:

Historical

POPULATION 1/CCHIP

Historically, since CCHIP projects were sponsored and funded from local funds, there were financial incentives built in for local counties to assure coordination with Medi-Cal and HFP. More children could be covered at the county level using local dollars if they were not financially sponsoring children who could otherwise be covered by state and federal dollars. In 2014, California transferred the funding source from local entities to the state.

Other standards that were put in place to identify and enroll all children were:

- CCHIP used the same income standards and deductions as the Medi-Cal and HFP to assure consistency among the programs.
- CCHIP used a resource disregard when determining eligibility, again to assure consistency with the Medi-Cal and HFP.
- At the time of initial application, a Medi-Cal and Healthy Families screening occurred. Applications with children screened to Medi-Cal or Healthy Families were submitted to the State's Single Point of Entry for processing.
- As with the initial eligibility determination, annual reviews occurred to assure continued eligibility for CCHIP, including the Medi-Cal and Healthy Families

screening.

- The State also modified its annual review process to include forwarding applications to counties known to have a CCHIP when a child was determined to have income above Healthy Families guidelines.

POPULATIONS 2, 3 & 4/UNBORN OPTION, MCAP, and MCAIP

Historically, DHCS utilized it's Baby-Cal program which provided extensive outreach to pregnant women about the importance of obtaining prenatal care, and informed them that, if they had modest incomes, state programs were available to help them. The program targeted pregnant women who may have been eligible for participation in the MCAP program. MCAP also worked with three community-based outreach contractors in various regions of the state to distribute informational materials via mail and at public events. MCAP's contractors previously conducted other innovative activities such as educating insurance agents about the program, conducting a telemarketing campaign, and producing public service announcements. MCAP also conducted outreach through an application assistance fee paid to individuals and entities that assisted families in filling out the MCAP application.

Current Practice

Currently the State utilizes a number of ways to identify and ensure uninsured eligible children are enrolled, such as:

- Use of a Single Streamlined Application
- Coordinated Open Enrollment Outreach
- County grants
- UCLA Center data
- Stakeholder Engagement
- State-Only Expansion
- Healthcare Options for all children

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

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

be coordinated with and improve upon existing State efforts.

CA RESPONSE:
A central component in the design of the CHIP programs is an extensive outreach campaign. The outreach for the programs is designed to be performed by CHDP providers, community-based organizations, county health agencies, and other entities that are geared to assist targeted low-income families in obtaining needed health and related services. CHDP providers will provide early medical screenings and immunizations (following Early Periodic, Screening, Diagnostic, and Treatment (EPSDT) guidelines), grant presumptive eligibility for uninsured children in appropriate CHIP program and Medi-Cal programs, and encourage families to apply for continuing coverage for either Medi-Cal, CHIP, or Covered California.

Note that California provides EPSDT only Population 4 (MCAIP) and Population 2 (Unborn) if the beneficiary is under the age of 19 in the separate CHIP.

POPULATION 1/COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM (CCHIP)

Outreach Efforts Include

- Covered California Quick Guide for Certified Enrollment Counselors for CCHIP
- Certified Enrollment Counselors from Covered California assist in the enrollment process
- County funds for outreach
- County Eligibility Workers to assist in enrollment

POPULATION 2/UNBORN OPTION

Outreach Efforts Include:

- DHCS Stakeholder Communication Update
- DHCS Pregnancy Stakeholder Workgroup
- Various Stakeholders and Advocates have outreach efforts relating to DHCS programs
- County funds for outreach efforts
- County Eligibility Workers assist in the enrollment process

POPULATION 3 & 4/MEDI-CAL ACCESS PROGRAM (MCAP) & MEDI-CAL ACCESS INFANT PROGRAM (MCAIP)

Outreach Efforts Include:

- DHCS Stakeholder Communication Update
- DHCS Pregnancy Stakeholder Workgroup

- Various Stakeholders and Advocates have outreach efforts relating to DHCS programs
- MCAP Welcome Packet
- Single Streamlined Application process simplifies the entire process by determining eligibility for all Insurance Affordability Programs (IAPs)
- Covered California's website mentions MCAP and its benefits
- Enrollment information is shared with insurance brokers
- Certified Enrollment Counselors from Covered California assist in the enrollment process
- County funds for outreach efforts
- County Eligibility Workers assist in the enrollment process

Coordination with Medicaid (Medi-Cal):

OPTIONAL TARGETED LOW INCOME CHILDRENS PROGRAM (OTLICP)

OTLICP, a CHIP Medicaid Expansion, serves children whose family income falls above the applicable Medi-Cal FPL income standard and who are not eligible for no-cost Medi-Cal. OTLICP has been designed to have a smooth interface with Title XIX Medi-Cal and includes a number of provisions to ensure that the program enrolls only targeted low-income children. DHCS compares its participant list against Medi-Cal's enrollment files to ensure that children do not already have creditable coverage through Medi-Cal.

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

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

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

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

CA RESPONSE:

1. DHCS continues to improve the state's Single Streamlined Application to allow enrollment in all programs, including subsidized and unsubsidized coverage in the marketplace.
    - Having a simplified application in an environment where all eligibility is determined provides ease of access. It also shows the availability of all programs the applicant may be eligible for.

2. Enrollment information packets.
    - Managed care plans provide mailed out information to provide options and education to what benefits are offered.

Section 6. **<u>Coverage Requirements for Children's Health Insurance</u>**

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

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

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

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

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

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

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered

and generally available to State employees in the state. (Section 2103(b)(2))

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

CA RESPONSE: This type of coverage applies to Populations 1 (CCHIP) and 3 (MCAP). Please see Attachment 2.

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

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

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

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

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

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

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

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

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania.

Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide

an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

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

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

6.1.4.1. ☒ Coverage the same as Medicaid State plan

CA RESPONSE: This coverage applies to Population 2 (Unborn Option) and Population 4 (MCAIP). Please see Attachment 3.

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

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

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

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

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

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

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

6.1.4.7. ☐ Other (Describe)

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

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

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

CA RESPONSE: Unless otherwise specified, these services are provided to all four separate CHIP populations. Please see Attachment 5.

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

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

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

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

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

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

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

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

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

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))

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)

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))

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

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

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

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

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

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)

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)

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

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

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

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))

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

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

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

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

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

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

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services) (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))

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

CA RESPONSE: This coverage is applicable to Population 2 (Unborn Option) and Population 4 (MCAIP). Please see Attachments 3 and 4.

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)

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[1] Current Dental Terminology, © 2010 American Dental Association. All rights reserved.
[2] Current Dental Terminology, © 2010 American Dental Association. All rights reserved.

CA RESPONSE: This coverage is applicable to Population 1 (CCHIP) and 3 (MCAP). Please see Attachments 2, 6, and 7, which includes covered CPT codes for the two dental plans.

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

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

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

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

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

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

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

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

6.4. **Additional Purchase Options-** If the State wishes to provide services under the plan

through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

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

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

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

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

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in

Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

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

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

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

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

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

6.4.2.3. The State assures that the coverage for the family otherwise meets title

XXI requirements. (42CFR 457.1010(c))

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

☐ Yes
☐ No

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

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

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

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

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

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

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described

in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

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

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

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

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

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

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

☐ Yes
☐ No

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

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

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

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

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

Section 7. Quality and Appropriateness of Care

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

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

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

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

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

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

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

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

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

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

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

CA RESPONSE:

The state views the use of quality standards, performance measurement information strategies, and quality improvement strategies as critical components to transforming access to health plan coverage from the provision of access to the creation of a medical home. Below is a description of how California uses a number of tools and strategies in CHIP to ensure health care coverage translates to meaningful access to necessary services.

With the transition of MRMIB programs to DHCS, quality improvement strategies, quality standards, and performance measurement information strategies are conducted in the same manner as Medi-Cal. Medi-Cal is addressed in California's Title XIX plan.

Measuring Clinical Quality: The model health plan contract requires contractors to provide the state with audited clinical measures consisting of the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS) 3.0 Performance Measures as well as any age relevant HEDIS measures which are included in versions of HEDIS numbered higher than 3.0. Plans must also report the number of subscribers who received a health assessment visit within 120 days or four consecutive months after their effective date of coverage. These data must be measured or audited by an independent third party and reported annually. DHCS may use the data to provide information to subscribers in its annual open enrollment or program application materials.

Standards Designed to Improve to Quality of Care: Health plans are required to assure that its providers will use the most recent recommendations of the American Academy of Pediatrics (AAP) with regard to recommendations for preventive pediatric health care. Annually, the plan must inform the caretakers of its enrollees of the AAP's recommended schedule of preventive care visits. The notice must be in English, Spanish and any other language which is spoken in more than 5 percent of the plan's enrollee's households.

Quality Management Processes: The contractor must assure the State that its Quality Management processes have been reviewed and found to be satisfactory by either the National Committee on Quality Assurance, the Joint Commission on the Accreditation of Healthcare Organizations, or the State of California's Medi-Cal Managed Care Program. The contractor must also maintain a system of accountability for quality improvement activities which includes the participation of the contractor's governing body, the designation of a Quality Improvement Committee, supervision of the activities of the Medical Director, and the inclusion of contracted physicians and other providers in the process of quality improvement development and performance.

Quality Assurance Measures

Virtually all of the plans are regulated by California's Department of Managed Health Care (DMHC) under the Knox-Keene Act - established specifically for managed care plans licensing. The Knox-Keene Act prescribes rules for the organization of HMOs and other managed care entities. It specifies plan standards, marketing rules, and consumer disclosure requirements. It also establishes fiscal solvency requirements and quality assurance standards.

California's separate CHIP populations rely on the quality assurance requirements of the Knox-Keene Act which regulates health plans. Quality assurance requirements specifically require that plans have quality assurance programs, and that providers

establish a program to review the quality of care being provided and identify, evaluate and remedy problems related to access, continuity of care, utilization and monitoring of plan providers.
POPULATION 1/CCHIP
POPULATION 2/UNBORN OPTION
POPULATION 3/MCAP
POPULATION 4/MCAIP

7.1.1. ☒ Quality standards

CA RESPONSE:

POPULATION 2/UNBORN OPTION
POPULATION 3/ MCAP
POPULATION 4/MCAIP

DHCS monitors quality standards through:

- Analysis and trending of reports from health, dental and vision plans. DHCS staff will collect and analyze a variety of reports generated by participating plans, regulatory entities, and external quality review organizations to monitor the quality of care received and to focus plan efforts on areas needing improvement. These reports include:

    1. Benefit Grievances: Benefit grievances filed by CHIP Program subscribers with participating plans. Participating plans will be contractually required to report benefit grievances once a year. These reports will be shared with subscribers who request the information. In addition, DHCS will track any publicly available information on the number and type of benefit grievances filed by all subscribers enrolled in a participating plan (Department of Managed Health Care (DMHC) reports all benefit grievances filed with plans annually). Grievance information will be used by DHCS to identify plan performance needing improvement and to form the basis of future performance standards.

    2. Regulatory Entity Reports: DHCS will work with the state's two health insurance industry regulatory entities (the Departments of Insurance and Managed Health Care) to assure that all publicly available data on health plan performance is known to DHCS.

    3. Enrollment and Disenrollment Reports: These reports will be generated by the program's administrative contractor

POPULATION 1/CCHIP

DHCS monitors quality standards in the CCHIP projects through:

- Analysis and trending of reports from health, dental and vision plans. DHCS staff will collect and analyze a variety of reports generated by participating plans, regulatory entities, and external review organizations to monitor the quality of care received and to focus plan efforts on areas needing improvement. These reports include:

    1. Benefit Grievances: Benefit grievances filed by CCHIP Program subscribers with participating plans. Participating plans will be contractually required to report benefit grievances once a year. These reports will be shared with subscribers who request the information. In addition, DHCS will track any publicly available information on the number and type of benefit grievances filed by all subscribers enrolled in a participating plan (DMHC reports all benefit grievances filed with plans annually). Grievance information will be used by DHCS to identify plan performance needing improvement and to form the basis of future performance standards.

    2. Regulatory Entity Reports: DHCS will work with the state's two health insurance industry regulatory entities (the Departments of Insurance and Corporations) to assure that all publicly available data on health plan performance is known to DHCS.

- Monitoring the accreditation status of participating plans by entities such as the National Committee for Quality Assurance (NCQA).

- The specific indicators to be tracked will focus on child or adolescent specific outcome measures, such as:

    a. Ambulatory Care – Emergency Department Visits (AMB-ED)
    b. Children and Adolescent Access to Primary Care Practitioners (CAP-CH)
    c. Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34-CH)
    d. Child Immunization Status (CIS-3)
    e. Immunizations for Adolescents (IMA-2)

To the extent feasible, DHCS intends to utilize the audited HEDIS measures generated by the California Cooperative Healthcare Reporting Initiative (CCHRI). CCHRI is a collaborative effort of purchasers, providers and plans who are committed to produce audited performance data on health plans that can be compared across plans and tracked over time. The health plans participating in CCHRI represent

95 percent of the commercially enrolled California health maintenance organization population. At present, the only audited child-specific HEDIS measure being collected by CCHRI is the immunization status of two year olds. Until audited measures are available, DHCS will collect unaudited health plan reported information on other HEDIS child and adolescent based measures.

7.1.2. ☒ Performance measurement

POPULATION 2/UNBORN OPTION
POPULATION 3/ MCAP
POPULATION 4/MCAIP

DHCS evaluates and selects a means to enforce plan performance related to the performance standards. Enforcement can take one of several approaches. These include using either a fiscal (or enrollment) penalty based system in which plans are penalized when DHCS identifies a deficiency, or a performance target based system in which plans agree to put a percentage of their premium at risk if they do not achieve the predetermined performance levels.

POPULATION 1/CCHIP

The volume of children in CCHIP, coupled with the short-term duration of the funding makes it infeasible to set up separate performance measures.

However, the CCHIP projects are modeled consistent with the CHIP Program and the health plans delivering the CCHIP services are the same health plans, and also participate in Medicaid. Thus, the information produced for the CHIP and Medicaid program plans will be reflective of the performance for CCHIP.

7.1.2 (a) ☐ CHIPRA Quality Core Set

7.1.2 (b) ☒ Other
DHCS External Accountability Set

7.1.3. ☒ Information strategies

POPULATION 2/UNBORN OPTION
POPULATION 3/ MCAP
POPULATION 4/MCAIP
DHCS will use information strategies in line with the Medi-Cal program.

POPULATION 1/ CCHIP
The county LI and COHS will provide to its enrolled members a detailed description of covered benefits, exclusions, and grievance procedures in their Evidence of Coverage (EOC) booklet.

7.1.4. ☒ Quality improvement strategies

All of the approaches described under quality standards, performance measurement, and information strategies are used by DHCS to encourage quality improvement by participating plans. This is done through five strategic approaches. These are:

- Keeping up to date on developments in quality improvement, including any indicators that may be developed regarding the high quality medical home;
- Feeding back information to plans to help them understand their own performance over time and how they compare to other plans providing services to subscribers;
- Enforcing of contractual provisions which link quality based measures to plan performance;
- Increasing plan performance targets over time; and
- Providing quality based information to families. This final approach empowers the consumer to punish or reward plans with enrollment based on the value each family places on the quality standards.

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

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

DHCS will also take a number of steps to monitor access to covered services. Some of these are:

- DHCS will monitor the ongoing status of health plans with their regulators to assure quality services are available to subscribers.
- DHCS will use plan enrollment and disenrollment reports as an early warning signal of access problems with a health plan.

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

The State utilizes three steps to assure and monitor access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations.

1. Through contracts, all plans are required to provide preventive services in accordance with recommendations from the American Academy of Pediatrics and immunizations in accordance with the American Committee for Immunization Practices (ACIP). Health plans are also required on an annual basis to inform enrollees of the schedule for receiving preventive and immunization services and on the availability of these services (which include well baby, child and adolescent care, and childhood and adolescent immunizations).

2. The State issues an annual member guide to CHIP enrollees. This member guide includes a schedule for well-visits and immunizations for babies, young children and adolescents.

3. The State monitors access to preventive services using HEDIS. Each year health plans report the number of children receiving well visits and immunizations. The State compares plan reports to national guidelines and benchmarks to determine deficiencies. Plans with deficient performance compared to all plans in the program are asked to submit a corrective action plan. The State is currently exploring minimum performance thresholds which will be implemented with the July 1, 2004 contracts.

The State assures that the monitoring efforts used for CHIP and Medicaid will be used for CCHIP.

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

California state law contains specific requirements for access to services, including emergency services. These requirements can be found in Health and Safety Code, Section 1367 and California Code of Regulations, Sections, 1300.67.2 and 1300.67.2.1. All plans operating in California are subject to these requirements. The State regulator of managed care organizations, DMHC, enforces this law.

In addition to State law, the State uses several methods to monitor access to services. The State collects information on the number of specific CHIP enrollee grievances each plan has received, and the number of enrollee complaints the State had directly received. The plan grievances and enrollee complaints are categorized and patterns of complaints among the plans are reviewed periodically.

The State requires plans to submit annual performance measures, using HEDIS, which provides information on the delivery of well care and immunizations. This information is

provided on DHCS website, including Managed Care – Quality Improvement & Performance Measurement Reports and the Managed Care Performance Dashboard.

Through the county contracts with the State, counties will be required to submit utilization data on preventive and emergency services and grievances from CCHIP enrollees.

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

To meet the special needs of children, CHIP ensures the provision of necessary specialized services beyond those offered through the comprehensive insurance package in a coordinated manner. The CCS program addresses the significant needs of the minority of children whose needs may not be fully met under an insurance benefit package. The CCS program provides case management and treatment for chronic, serious, and complex physically handicapping conditions. Coverage is and will be limited to coverage of the specific condition. The program establishes standards for the approval of inpatient hospital facilities and pediatric specialty and subspecialty providers delivering care to eligible children. The program also has an extensive system of special care centers located at tertiary medical center at which multispecialty, multidisciplinary teams deliver coordinated inpatient and outpatient care to children with chronic medical conditions. The centers include cardiac, chronic pulmonary disease, hematology and oncology, myelomeningocele, hemophilia, sickle cell, renal, infectious disease/immunology, hearing and speech metabolic disorders, inherited neurologic disease, limb defect, gastroenterology, craniofacial anomalies and endocrinology. The program also approves neonatal intensive care, pediatric intensive care, and pediatric rehabilitation units.

The program staff determines the appropriate source of health care for eligible children, assist families in accessing care, and identify other needs of the child and family that could impact the care of the eligible condition.

The services to treat the CCS eligible medical condition of a child enrolled in CHIP will not be the responsibility of the contracting health plan in which the child is enrolled. The CCS program will continue to authorize the medically necessary services to treat the conditions using the program's regulations, policies, procedures, and guidelines in determining the appropriateness of providers, and the necessity for services. CCS will expand the systems of communication that have been instituted to work with Medi-Cal managed care plans that have CCS services "carved out" from their capitation rate. Local CCS programs carefully coordinate the authorization and delivery of specialty and

subspecialty services with the primary care provider to which the child is assigned. This program will reimburse providers for these specialized services. Children receiving such services will continue to have their primary health needs serviced through the insurance program. Allowing those specialized services to be provided as a complement to, but outside of, the managed care setting is consistent with recent actions in the Federal Budget Reconciliation Act (BBA 1997) which prohibit mandatory enrollment of children with special medical needs in managed care.

On an annual basis the State will review the number of active CHIP cases in the CCS program. The State will also require participating plans to report the number of referrals they have made to the CCS program each quarter. The State will also use the HEDIS CAHPS survey to monitor access and quality of these services. This survey has a special module to address the satisfaction and experiences of families which children who have chronic conditions.

The state will include in its CCHIP contracts a requirement to report the number of active CCHIP/CCS cases and the number of children referred to the CCS program. Of those children enrolled in CCHIP, some will qualify for CCS services based on CCS eligibility requirements whereby services for the qualifying CCS eligible condition will be provided by CCS. In those cases where a family does not qualify based on CCS eligibility requirements, the medically necessary services will be provided by the CCHIP health plan.

California's State Department of Managed Healthcare licensure requirements includes adequacy of network including specialists covered services not available in network must be covered out of network.

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

California state law contains specific requirements for health plan utilization review, including prospective, retrospective, and concurrent review. State law also requires independent medical review of health plans decisions concerning medical necessity. These requirements, found at Health and Safety Code Section 1367.01 and 1374.30 et seq., are designed to ensure that the prior authorization process does not present an undue barrier for continuity and access to care.

The State assures that this method is implemented under the CCHIP program.

Section 8. Cost-Sharing and Payment

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

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

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

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

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

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

8.2.1. ☒ Premiums:

CA RESPONSE:

Population 1 (CCHIP): $21 per child per month with a maximum of $63 per family per month

- Families who prepay 3 months of premiums do not have to pay the fourth month
- Families who pay their premiums with Electronic Funds Transfer receive a 25 percent discount

Population 2 (Unborn) Not applicable
Population 3 (MCAP): 1.5 percent of the enrollee's annual Modified Adjusted Gross Income (MAGI)
Population 4 (MCAIP): $13 per child per month with a maximum of $36 per family per month

In the event of a FEMA or Governor declared disaster, the State has the discretion to waive premiums for CHIP applicants and/or beneficiaries who meet income and other eligibility requirements and who reside and/or work in Governor or FEMA declared disaster areas, for a specified period of time.

CA RESPONSE:

These temporary waivers would apply to:
Population 1 (CCHIP)
Population 3 (MCAP)
Population 4 (MCAIP)

8.2.2. ☐ Deductibles:

8.2.3. ☒ Coinsurance or copayments:

CA RESPONSE:

<u>POPULATION 1 (CCHIP)</u>
Depending on the family income, the copayment may be $5, $10, or$15 a visit. The maximum out-of-pocket amount for services in one benefit year is $250/household.

No Copay: Preventative Care Services
Maternity Care
Medical Transportation
X-Ray and Laboratory Services
Inpatient Hospital Services
Durable Medical Equipment
Family Planning Services
Inpatient Mental Health
Serious Emotional Disturbance (SED)
Inpatient Alcohol and Substance Abuse Treatment
Inpatient Physical, Occupational, and Speech Therapy
Skilled Nursing Care
Dental: Preventative
Dental: Fillings
Dental: Sealants

Dental: Diagnostic X-Rays
Dental: Orthodontia

$10 Copay: Physician Services
Generic Prescription Drugs
Emergency Care Services
Outpatient Mental Health
Outpatient Alcohol and Substance Abuse Treatment
Outpatient Physical, Occupational, and Speech Therapy
Acupuncture (optional)
Chiropractic (optional)
Biofeedback (optional)
Vision: Examination
Vision: Prescription Glasses
Dental: Major Services (Root canal, oral surgery, crowns, bridges, dentures)

$15 Copay: Name Brand Prescription Drugs
Outpatient Hospital Services (unless hospitalized)

POPULATION 2 (Unborn)/POPULATION 3 (MCAP)/POPULATION 4 (MCAIP)
Not applicable

8.2.4. ☐ Other:

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

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost

sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))

CA RESPONSE:
The public has been notified of cost-sharing requirements in the application, and enrollment materials and program regulations. If there is a change in the enrollee's contribution, the program plan will provide notification in writing. Enrollee copays are also listed in plan disclosure documents, such as Evidence of Coverage (EOC) documents provided to each family. Income Guidelines and cost sharing is also available on DHCS' website. Agencies and individuals who help families with their application will also be familiar with the program's cost-sharing requirements and be able to communicate them to families when discussing the program.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

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

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)
8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)
8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

CA RESPONSE: Chapter 3 of California Statute 2011 (AB 97) assures that cost-sharing is consistent with Section 2103 of the Social Security Act.

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

CA RESPONSE:

POPULATION 1 (CCHIP)

Copayments

DHCS sets health benefit copayments from $5 to $15 for CCHIP. Copayments are not applicable in CCHIP for preventive services. In addition, DHCS has set a $250 annual maximum out-of-pocket so that no family is required to pay copayments after it has contributed $250 during a given year. Enrollees are encouraged to retain all of their copayment receipts and notify the health plan when $250 maximum has been reached. The CCHIP health plans also electronically track the number of enrollees who meet the annual maximum to ensure that no family's copay goes over the annual maximum out-of-pocket contribution. However, the $250 limit does not apply to dental or vision coverage. California does not have copays for most dental services that children receive (preventive exams, cleanings, restorations, sealants, and fluoride treatments), and has lowered all other copays to a maximum of $5. Children who meet CCS conditions receive their services (orthodontics) from CCS without a copay. Therefore, California has determined that including dental services in the $250 maximum is not needed. Very few families will have to pay a copay at all for dental services and those that do will be for a specific condition (root canal) which should have limited utilization.

California rules are consistent with title XXI, which require that cost sharing not exceed an amount that is "nominal" under Medicaid law, with appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable.

Premiums

CCHIP premiums are based on $21 per child per month, with a maximum of $63 per family per month, equaling annual premiums of $252 for one child, $504 for two children, and $756 for three children or more. Cost sharing requirements do not exceed those allowable under title XXI. Using 261 percent FPL as the baseline income, Table 1 below provides an analysis of the 5 percent cost sharing limit compared to the highest premium that is charged. Therefore, California provides assurances that the cost sharing requirements continue to be within the allowable limits established under title XXI and is highly unlikely the family will ever get close to the 5 percent limit.

Table 1: Aggregate Cost Sharing for Families Above 261 percent FPL up to and including 317 percent FPL under CCHIP

Family Size	Annual Income of a Single Parent Family @ 261% FPL +$1*	5% Ceiling	Annual Premium Contribution **	Annual Premium + $250 Family Cap on Health Copays	Number of Dental and Vision Visits for Non-Preventive Services Needed to Exceed

1 child	$42,387	$2,119	$252	$502	101
2 children	$53,297	$2,665	$504	$754	151
3 children	$64,207	$3,210	$756	$1,006	202

*Dollar amounts are based on March, 1 2017 Federal Poverty Level
**Does not include premium discounts for pre-payment. If included, it would reduce the premium amounts by 25 percent.

POPULATION 2 (UNBORN)

Co-payments and premiums are not applicable to this population.

POPULATION 3 (MCAP)

Premiums

The premium charged to pregnant women (unborn) enrolled on or after July 1, 2004, is limited to 1.5 percent of family income. Copayments and deductibles are not applicable to this population.

California ensures that the annual aggregate cost-sharing for a family does not exceed 5 percent of a family's income as is required by Section 2103(3)(B) of title XXI. The table below demonstrates that the maximum cost sharing falls well within the 5 percent annual cap.

Table 2: Aggregate Premiums for Pregnant Women/Families Above 208 percent of FPL up to and including 317 percent of FPL:

Family Size	Annual Income of a Single Parent Family @ 208% FPL + $1*	5% Ceiling	Percentage of Annual Income	Annual Premium Contribution
1 child	$33,781	$1,689	1.5%	$507
2 children	$42,475	$2,124	1.5%	$637
3+children	$51,169	$2,558	1.5%	$767

*Dollar amounts are based on March 1, 2017 FPL.

POPULATION 4 (MCAIP)

Premiums

California ensures that the annual aggregate cost-sharing for a family does not exceed 5 percent of a family's income as is required by Section 2103(3)(B) of title XXI. Copayments and deductibles are not applicable to this population. The table below demonstrates that the maximum cost sharing falls well within the 5 percent annual cap.

Table 3: Aggregate Cost Sharing for Families Above 261 percent FPL up to and including 317 percent FPL for MCAIP

Family Size	Annual Income of a Single Parent Family @ 261% FPL +$1*	5% Ceiling	Annual Premium Contribution**
1 child	$42,387	$2,119	$156
2 children	$53,297	$2,665	$312
3 children	$64,207	$3,210	$468

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

CA RESPONSE:

Indian means any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual:

(i) Is a member of a Federally recognized Indian tribe;

(ii) Resides in an urban center and meets one or more of the four criteria:

(A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(D) Is determined to be an Indian under regulations issued by the Secretary;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as Start Printed Page 27868a California Indian, Eskimo, Aleut, or other Alaska Native.

The provision of child health assistance to low income children who are American Indians/Alaskan Natives will be assured through the following procedures:

- Technical assistance by the state American Indian Health Program, Federal Indian Health Services, and tribes in tracking of services to American Indians.
- Inclusion of American Indian ethnicity using the federal definition on the application form for tracking purposes.
- Training to local American Indian clinic staff for outreach and referral to the program.
- Use of the 30 American Indian primary care clinics (which are CHDP providers) to screen low-income youth, provide initial treatment and referral either to Medi-Cal or the appropriate CHIP program.
- Implementation of a provision to exempt American Indian and
- Alaska Native (AI/AN) families that meet the cost sharing waiver requirements, from monthly premiums and benefit copayments. This exemption is implemented the same in CCHIP as it is in the other CHIP populations. The exemption from premiums will be made at the time of application submission when a family declares AI/AN status consistent with the documentation requirements listed below. The family will have two months to submit the required documentation to continue the premium waiver. If documentation is not submitted within two months from enrollment, premiums will be charged prospectively. When acceptable documentation is submitted, the copayment waiver will also be applied. Acceptable documentation for the applicant or the child includes:

    1. An American Indian or Alaskan Native enrollment document from a federally recognized tribe; or
    2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs; or
    3. A Certificate of Indian Heritage from an Indian Health Service facility operating in the State of California.

- Education to Certified Application Assistants about the cost sharing

exemption for AI/AN families that meet the cost sharing waiver requirements.
- CCHIPs will provide the same cost sharing waivers as the other CHIP programs.
- CCHIP will include this cost sharing exemption notice in their member handbooks.

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

CA RESPONSE:

Exception to Disenrollment for Failure to Pay Premiums—At State discretion, premiums may be waived for CHIP applicants and/or beneficiaries who meet income and other eligibility requirements and who reside and/or work in Governor or FEMA declared disaster areas, for a specified period of time. The premium balance will be waived if the family is determined to have been living or working in FEMA or Governor declared disaster areas based on self-declared application information or other documentation provided by the family.

POPULATION 1/COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (CCHIP)

Premium payments are invoiced the first week of the month and due on the 20th day of the coverage month. If a family fails to make a payment for a child/children, the next month's invoice the family receives includes a 30 day past due warning, the amount due for the previous month and the current month, the date by which payment must be remitted, and the date the coverage will end if payment is not made. If the premium remains unpaid, the following month's invoice includes a 60 day past due warning. If the premium has not been received on the 20th day of that month, a courtesy call is placed to the family, and the same day, a warning letter is sent to the family, which includes information on payment options, the disenrollment date, and instructions on how to complete the request form for continued enrollment. On the call, the family is reminded that a premium payment is due and that a child/children will be disenrolled as of the end of the month. The family is also questioned regarding whether the notification was received. A last billing statement is also mailed to the family on the 20th day of the month coverage is set to end, and if the payment has still not been received by the last day of that month, a disenrollment with appeal information letter is sent to the applicant. After disenrollment, if the full past-due premium is paid within 30-days, the child will be reinstated with no break in coverage.

POPULATION 2/MEDI-CAL UNBORN OPTION

There is no cost sharing for this population.

POPULATION 3/MEDI-CAL ACCESS PROGRAM (MCAP)

Once a pregnant woman is enrolled into MCAP, she cannot be disenrolled for non-payment.

POPULATION 4/MEDI-CAL ACCESS INFANT PROGRAM (MCAIP)

If a program participant fails to make a payment, the next month's invoice he receives includes a 30 day past due warning. The second month's invoice includes the amount due for the previous month and the current month, the date by which payment must be remitted, and the date the coverage will end if payment is not made. If the premium is 45 days past due, a warning letter is sent to the applicant, which includes information on payment options, the disenrollment date, and an instructions on how to complete the request form for continued enrollment. If the premium has not been received on the 20th of the second month, a courtesy call is placed to the applicant. The applicant is reminded that a premium payment is due and that his or her child will be disenrolled as of the end of the month. He or she is also questioned regarding whether he or she received the notification. A last billing statement is also mailed to the applicant on the 20th day of the month, and if the payment has still not been received by the last day of the second month, a disenrollment with appeal information letter is sent to the applicant.

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

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

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

8.7.1.2. ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

8.7.1.3. ☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as

appropriate. (42CFR 457.570(b))

8.7.1.4 ☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

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

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

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

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

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

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

CA RESPONSE:

California has developed strategic objectives for increasing the extent of creditable health coverage for targeted low-income children and other low-income children. These objectives are all focused toward the state’s overarching concern that increasing the extent of creditable health coverage will significantly improve the health status of

California's children. The strategic objectives are to:

1. Increase the awareness of low income uninsured families about the availability of comprehensive low or no cost health coverage for children as well as the importance of timely and ongoing care for children. Motivate such families to obtain coverage for their children.

2. Continue to provide an application and enrollment process that is easy for targeted low-income families to understand and use, and measure monitoring efforts to ensure compliance with ACA requirements.

3. Assure that health services purchased by the program are accessible to enrolled children.

4. Assure the participation of community-based organizations in outreach and education activities.

5. Encourage the inclusion of traditional and safety net providers in health plan networks.

6. Assure that enrolled children with significant health needs receive access to appropriate care.

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

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

CA RESPONSE:

Objective 1: Increase the awareness of low-income families about the availability of comprehensive low or no cost health coverage for children as well as the importance of timely and ongoing care for children. Motivate such families to obtain coverage for their children.

Performance goals:
1.1 Using Current Population Survey (CPS) longitudinal data, increase the percentage of Medi-Cal and CHIP eligible children who are enrolled in the programs.

1.2 Reduce the percentage of uninsured children in target income families that have family incomes above no cost Medi-Cal levels.

1.3 Based on DHCS' External Accountability Set Measures for Emergency Department visits (AMB-ED), reduce the percentage of children using the emergency room as their usual source of primary care.

Proposed measures:
California will use Current Population Survey (CPS) longitudinal data to identify children who eligible but not enrolled in the programs, as well as Medi-Cal and emergency room data as obtained by the AMB-ED DHCS External Accountability Set measures for Emergency Department visits.

<u>Objective 2:</u> Continue to provide an application and enrollment process that is easy for targeted low-income families to understand and use, and measure monitoring efforts to ensure compliance with ACA requirements.

Performance goals:
2.1 Assure that Medi-Cal and CHIP program services provide written and telephone services in the languages spoken by the target population.

2.2 Continue to improve an application process that can be completed without an in-person meeting.

Proposed measures:
California uses a Single Streamlined Application that is available in English and Spanish in the electronic version, with all threshold languages being available for the paper application.

<u>Objective 3:</u> Assure that health services purchased by the program are accessible to enrolled children by using DHCS Accountability Measures.

Performance goals:
3.1 Based on DHCS' External Accountability Set Measures for Children and Adolescents Access to Primary Care Physicians (CAP-CH), achieve year-to-year improvements in the percentage of targeted low-income children that have had a visit with a primary care provider during the year.

3.2 Based on DHCS' External Accountability Set Measures for well-child visits for the third through sixth year of life (W34-CH), achieve year-to-year improvements in the percentage of targeted low-income children that have had well-child examinations at the appropriate intervals for their age.

3.3 Based on DHCS' External Accountability Set Measures for Childhood Immunization Status (CIS-3) and Immunizations for Adolescents (IMA-CH), achieve

year-to-year improvements in the percentage of targeted low-income children who receive required immunizations by age 2 and by age 13.

3.4 Based on the 2017 Child Core Set for Attention Deficit/Hyperactivity Disorder (ADHD); DHCS will utilize the ADD-CH measure to monitor dose adjustment, follow-up visits, support services, ongoing treatment, and potential risks with ongoing treatment.

Proposed measures:
California will use DHCS' External Accountability Set Measures relevant to children's service accessibility for all health plans participating in the insurance program, and participating health plans will be contractually obligated to participate in annual reporting. California will also use Behavioral health measures – Clinical Depression and Follow-up Plan (CDF) from the 2017 Child Core Set measure to track usage and follow-up care for children with ADHD.

<u>Objective 4:</u> Assure the participation of community-based organizations in outreach and education activities.

Performance goals:
4.1 Ensure that varieties of entities experienced in working with targeted low-income populations are eligible to assist families with enrollment.
4.2 Ensure that a variety of entities experienced in working with targeted low-income populations conduct outreach/education and have input in the development of culturally and linguistically appropriate outreach and enrollment materials.

Proposed measures:
DHCS requires the outreach/education contractor to allocate a percentage of resources to fund the participation of community-based organizations in the state's outreach efforts, and requires the contractor to document their participation.

<u>Objective 5:</u> Encourage the inclusion of traditional and safety net providers in health plan networks.

Performance goals:
5.1 Achieve increases in the number of children enrolled in health coverage who have access to a provider located within their zip code.

5.2 Achieve increases in the number of children who have access to traditional and safety net providers as defined by Health Resources and Services Administration's Federally Qualified Health Center Look-Alike Program.

Proposed measures:

DHCS requires participating plans to report annually on the number of subscribers selecting traditional and safety net providers.

<u>Objective 6:</u> Assure that enrolled children with significant health needs receive access to appropriate care.

Performance goals:

6.1 Based on DHCS' External Accountability Set Measures for Children and Adolescents Access to Primary Care Physicians (CAP-CH), achieve year-to-year maintenance and/or improvements in the percentage of children with special health care needs with a source of coverage for primary care and specialty care. California will also use Behavioral health measures – Clinical Depression and Follow-up Plan (CDF) from the 2017 Child Core Set measure to track usage and follow-up care for children with ADHD.

6.2 Ensure that children with special health care needs experience no break in coverage/services as they access specialized services.

6.3 Based on the 2017 Child Core Set for ADHD (ADD-CH), ensure that there is follow-up care for children prescribed ADHD medications to help address quality of care for children with significant health needs.

Proposed measures:

DHCS tracks the number of children with special health care needs who participate in the program. DMHC will also monitor subscriber complaints and health plans' compliance with referral requirements. These complaints and grievances can be submitted to DMHC, and provide an Independent Medical Review (IMR) if needed.

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM (CCHIP)

The volume of children in CCHIP makes it infeasible to set up separate performance goals and measures. However, the CCHIP projects are modeled consistent with the Medi-Cal and CHIP programs and the health plans delivering the CCHIP services are the same health plans. Thus, the information produced for the Medi-Cal and CHIP programs plans will be reflective of the performance for CCHIP.

<u>Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.</u>

<u>It is acceptable for the State to include performance measures for population subgroups</u>

chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

CA RESPONSE:
Measures are outlined in Section 9.2 above.

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☐ The increase in the percentage of children with a usual source of care.
9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- **9.3.7.1.** ☐ Immunizations
- **9.3.7.2.** ☐ Well childcare
- **9.3.7.3.** ☐ Adolescent well visits
- **9.3.7.4.** ☐ Satisfaction with care
- **9.3.7.5.** ☐ Mental health
- **9.3.7.6.** ☐ Dental care

9.3.7.7. ☐ Other, list:

9.3.8. ☒ Performance measures for special targeted populations.

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

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

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

The state will perform the annual assessments and evaluations required in Section 2108(a) to assess its progress in meeting the performance goals and measures identified in Section 9. Data necessary to prepare these reports will be drawn from administrative files maintained by the CHIP and Medi-Cal programs, the Current Population Survey, disenrollment surveys of CHIP Program participants, and HEDIS reports.

9.6. ☒ The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

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

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

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

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

CA RESPONSE:
From the beginning, California has sought to gather public input in the design of the program. In anticipation of developing a Title XXI children's health program, in late July and early August of 1997, the Secretary of the Health and Welfare Agency and the Director of DHCS held round table discussions with interested parties and solicited written feedback from constituency groups. Governor Wilson introduced his children's health proposal on August 27, 1997. After introduction of the plan, the Secretary of the Health and Welfare Agency held meetings with numerous stakeholder groups to obtain their feedback on the proposal. Using the Governor's proposal as a framework, the state legislative package (AB 1126, SB 903, AB 217, and AB 1572) was developed through a joint "Health Access" conference committee. The conference committee held several open committee meetings, during which time the public was invited to offer feedback on the proposal.

Since the passage of the enabling legislation, the state staff has met with numerous interested parties to solicit feedback on the design and implementation of the state plan. Some examples of such interested parties are: the Association of California Life and Health Insurance Companies, the California Association of Public Hospitals, the California Medical Association, the California Primary Care Association, the Local Health Plans of California, the DHS Multicultural Task Force, representatives of the Private Essential Access Community Hospitals, the California HealthCare Foundation, the Los Angeles County Medi-Cal Managed Care Oversight Council, the Children's Hospital Association, the Child Health Policy Advisory Committee, and the Statewide Parent-Teacher Association.

Furthermore, California held two public forums to receive input from the community to implement its children's health program. The forums, held in Oakland, were hosted by the state. Over 400 people attended and roughly 60 gave public testimony regarding Healthy Families implementation.

DHCS has also solicited input specifically relating to the development of the Healthy Families outreach campaign through a series of eight meetings with representatives of

counties, program agencies, community based organizations, advocacy groups, health plans and providers.

The public had the opportunity to offer input as to the implementation of the Program on an ongoing basis, through opportunities to provide input directly to the state or through the Advisory Board established in statute. The state maintains an extensive mailing list for individuals and entities who want to receive information. Mailing list subscribers receive agendas and minutes of Board meetings and draft regulations. California holds open meetings twice monthly, where it solicits public input on draft regulations prior to adopting them. In addition to receiving oral feedback from the public during public meetings, state staff distribute copies of all correspondence regarding the implementation to all.

The enabling legislation also established a 14 member Advisory Panel. The Advisory Panel includes representatives from the subscriber population, primary care clinics, disproportionate share hospitals, mental health providers, substance abuse providers, county public health providers, health plans, the education community, and the business community; physicians who are board certified in pediatrics and family practice medicine; and a representative of a family of children with special needs.

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

CA RESPONSE:
Throughout the years, California has solicited and received input from various Indian Tribes, tribal affiliated organizations and boards on matters related to enrollment in the Medi-Cal and CHIP Programs. Several activities include:

- Participation in American Indian sponsored conferences, meetings and workgroups.
- Coordinated distribution of targeted outreach materials to the American Indian population via conferences, clinics, and meetings.
- Meetings with various tribal affiliated organizations and boards to identify acceptable documentation to demonstrate tribal affiliation for families to qualify for the Healthy Families cost sharing waiver.

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).

CA RESPONSE:

Initially, the public was informed of the premium and benefit change through budget hearings, legislative approval and enactment of the Chapter 157, Statutes of 2009 (Assembly Bill 1422) affecting premiums, and was again informed of those changes through promulgation of regulations in accordance with State law. Promulgation of regulations also entailed public meetings of the state.

The family contribution amounts increased for the highest income families pursuant to the Chapter 157, Statutes of 2009 (Assembly Bill 1422), which took effect on November 1, 2009. The family contribution increased for families with income greater than 150 percent and up to 250 percent FPL. In addition, benefit changes enacted by regulations increased co-payments for families with incomes greater than 150 percent and up to 250 percent FPL. Lastly, pursuant to regulations new families with children enrolled on or after November 1, 2009, will have limited dental plan choice effective November 1, 2009.

The dental benefit change aligns the CHIP rules with state employees dental benefit rules.

In order to provide adequate prior public notice of the family contribution increase, co-payment benefit increase and changes to the applicant's choice of participating dental plans, the Program took a multi-layered approach. Each existing family received advanced notification through an initial 30-day notification letter of the upcoming program change.

The Program included this 30-day notification letter with the September monthly billing invoice regarding the program changes. This notice was sent to all existing subscribers. If any family experienced a change in circumstances and would be impacted by the premium and co-payment increase, they were allowed to request a premium re-evaluation. Premium Re-Evaluation Forms were also posted on the program website or families could call the toll free line to receive a pre-filled out form. In addition, the website was updated to reflect all program changes and newsletter articles were provided to community partners and stakeholders.

The program also took additional steps to ensure adequate public notice of the increase in family contributions and co-payments for higher income families and changes in new applicants' choice of participating dental plans. For example, enrollment Entities and Certified Application Assistants in the local communities were notified through the monthly newsletter and users of the electronic application were also notified through an electronic online message when logging onto the system.

Public Service Announcements were provided on the dedicated toll-free line.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and

organizations in the State regarding implementation of the Express Lane eligibility option.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

CHIP Budget Projections

STATE: CA	**FFY Budget**	**FFY Budget**
Federal Fiscal Year	**2013**	**2014**
State's enhanced FMAP rate	**65.00%**	**65.00%**
Benefit Costs		
Insurance payments	-	-

STATE: CA	FFY Budget	FFY Budget
Managed care	$1,309,760,269	$1,161,016,067
per member/per month rate	$119.15	$119.07
Fee for Service	$547,879,132	$483,378,754
Total Benefit Costs	**$1,857,639,520**	**$1,644,394,940**
(Offsetting beneficiary cost sharing payments)	(92,585,780)	(68,784,114)
Net Benefit Costs	**$1,765,053,739**	**$1,575,610,826**
Cost of Proposed SPA Changes – Benefit	**-**	**-**
Administration Costs		
Personnel	-	-
General administration	$94,422,201	$43,414,158
Contractors/Brokers	-	-
Claims Processing	-	-
Outreach/marketing costs	-	-
Health Services Initiatives	-	-
Other	-	-
Total Administration Costs	**$94,422,201**	**$43,414,158**
10% Administrative Cap	$196,117,069	$175,067,856
Cost of Proposed SPA Changes	-	-
Federal Share	$1,208,659,284	$1,052,366,163
State Share	$650,816,537	$566,658,703
Total Costs of Approved CHIP Plan	**$1,859,475,940**	**$1,619,024,985**

NOTE: California does not have projections from FY 2012 for baseline prior to transition of children from Healthy Families under separate to Medicaid expansion. Actual costs are described below.

The Source of State Share Funds: State General Fund

CMS tracks state expenditures through the automated Medicaid Budget and Expenditure System/State Children's Health Insurance Budget and Expenditure System (MBES/CBES). The system allows states to report budgeted and actual expenditures for Medicaid and CHIP, by electronically submitting their forms to the CMS Data Center and the Medicaid data base. The information provided below is based on *actuals* from the CMS21 forms for California's separate population and from the CMS 64.21 Medicaid

expansion program for the quarters before and after the former Healthy Families transition from a separate program to a Medicaid expansion. As illustrated below, the total state and Federal expenditures after the transition decreased by approximately $219 million.

Type of Title XXI Funded Program	**FFY Quarter 1 of 2013 (Prior to Transition of Separate to Medicaid Expansion)**	**FFY Quarter 2 of 2013 (After Transition from Separate to Medicaid Expansion)**	**Cost difference after transition of former Healthy Families children from a separate to a Medicaid expansion.**
Separate	Federal: $247,155,406 State: $107,779,971 Total: $354,935,377	Federal: $99,762,091 State: $34,057,914 Total: $133,820,005	**Federal:** Decrease of $147,393,315 **State:** Decrease of $73,722,057 **Total:** Decrease of $221,115,372
Medicaid Expansion	Federal: $18,762,043 State: $10,102,635 Total: $28,864,678	Federal: $17,175,695 State: $9,248,450 Total: $26,424,145	**Federal:** Decrease of $1,586,348 **State:** Decrease of $854,185 **Total:** Decrease of $2,440,533
Total for Separate and Medicaid Expansion	Federal: $265,917,449 State: $117,882,606 Total: $383,800,055	Federal: $116,937,786 State: $43,306,364 Total: $160,244,150	**Federal:** Decrease of $148,979,663 **State:** Decrease of $74,576,242 **Total: Decrease of $223,555,905**

In the event of a FEMA or Governor declared disaster, the State will provide an updated budget outlining significant budgetary impacts, if there are any.

CA RESPONSE:
There is no budgetary impact for the changes related to SPA#17-0043.

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to

implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

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

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

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

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

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

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

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

11.1. ☒ The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. <u>Applicant and Enrollee Protections (Sections 2101(a))</u>

☐ 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.

CA RESPONSE:

Described below is a description of California's review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. These processes reflect those in the CHIP Program and CCHIP.

a. As required in 42 CFR 457.1130(a), California provides applicants and enrollees the opportunity to review eligibility and enrollment issues such as denial of eligibility; failure to make a timely determination of eligibility; and suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. These eligibility and enrollment issues are specifically included in the CHIP program regulations, and notification letters to applicants and enrollees. All decisions are provided in writing and all decisions which have a negative impact on an applicant or enrollee include instructions on how to appeal the decision if the applicant or enrollee believes the decision is incorrect.

b. For purposes of implementing 42 CFR 457.1170 California has determined that the first level appeal review conducted by the Title XXI Unit within DHCS meets the core requirements as defined in 42 CFR 457.1150(a) as an impartial review. This unit operates separately from the administrative vendor or health plan and the functions involving an eligibility determination. During an appeal, the information is received from the enrollee regarding the eligibility appeal, and the Title XXI unit evaluates the appeal based on specific criteria.

An applicant may file an appeal if s/he is dissatisfied with any action or failure to act, which has occurred in connection with a participating health plan's coverage the applicant's remedy shall be to file an appeal with DHCS, with the Title XXI unit evaluating the appeal. An applicant may also file an appeal if s/he believes eligibility effective date of coverage, enrollment decision, disenrollment decision, or plan transfer request decision was made in violation of the program rules. An applicant may designate an authorized representative to file the appeal and inquire about the status of the appeal.

The applicant must file a written appeal within 60 calendar days from the date of the written notice of the decision. The appeal is forwarded to DHCS within five (5) business days of receipt and will send the applicant a letter with this information.

Special handling cases i.e. cases that require the State's attention, will be forwarded to DHCS (including copies of all documentation and correspondence) within five (5) business days.

If an appeal is incomplete or does not concern at least one of the three issues listed above or is received beyond the specified timeframe (i.e., 60 days), the applicant is not entitled to a full appeal, and the administrative vendor will review the request and process as correspondence.

First level appeals are written appeals received by the health plan, administrative vendor, or DHCS for the first time. A first level appeal must be filed within 60 days of the date on the decision notification by vendor or state. The administrative vendor or health plan will forward first level appeals within five (5) business days of receipt to DHCS. The appeal must explain why the applicant thinks the decision was incorrect and how they want the program to resolve the issue.

Exceptions:

The administrative vendor or health plan will forward any first level appeal to DHCS if:

- The appeal includes outstanding medical bills incurred due to a disputed effective date of coverage.
- The appeal is of a sensitive nature and the referral has been approved (i.e., request from legislative member).

All appeals requiring DHCS' review will be forwarded to DHCS within 5 business days of receipt. MCAP will provide a timeline/chronology of critical events (application received, determination made or not made, letters sent to or by the applicant, earliest effective date, etc.) and identify any mistakes.

If a first level appeal is denied, the applicant will be notified of his or her right to request an administrative hearing.

c. As required in 42 CFR 457.1170, California provides enrollees the opportunity for continuation of enrollment pending the completion of review of a termination of enrollment, including a decision to disenroll for failure to pay cost sharing. Prior to disenrollment, enrollees are notified of the impending termination, the reason for such termination, and a pre-printed form in which to request continued enrollment and to provide the necessary information or explanation as to why termination should not occur. This provision of the Program was implemented in February 2003.

d. As required by 42 CFR 457.1180, California provides timely written notification to applicants and enrollees on all decisions made. In addition, as explained in Paragraphs a., and c. above, all decisions which have a negative impact on an applicant or enrollee include the reason for the determination, instructions on how to appeal the decision and request continued enrollment if the applicant or enrollee believes the decision is incorrect, and the standard and expedited timeframes for review.

e. As required by 42 CFR 457.1140(c), California provides all review decisions in writing.

f. As required by 42 CFR 457.1140(b) and 457.1160(a), California completes reviews in a reasonable amount of time. When determining what a reasonable amount of time is, California considers an expedited review in situations where there is an immediate need for health services. Appeals are forwarded to DHCS within 5 business days of receipt, and are filed within 60 days of the date on the decision notification by vendor or state.

g. California affirms that each applicant or enrollee has the right to represent him or herself or choose a representative, the right to review his or her file and other relevant information and the right to participate fully in the review process. In reviewing the specific requirements of 42 CFR 457.1140(d)(1)-(3) California modified its current appeal language to include an affirmative statement regarding an applicant's or enrollee's right to representation and opportunity to review his or her records. California complies with the requirement to allow an applicant or enrollee to participate fully in the review process. Any notification of an appeal able determination includes full notification of appeal rights and instructs the applicant or enrollee that he or she can submit additional information for review.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. **Health Services Matters-** Describe the review process for health services matters that

complies with 42 CFR 457.1120.

CA REPSONSE:

a. Participating plans are required by state law to establish and maintain a grievance system approved by the Department of Managed Health Care (DMHC). The DMHC is responsible for licensing and regulating pre-paid plans (health, dental, and vision) in California.

The plan's grievance process must provide reasonable procedures in accordance with DMHC regulations to ensure adequate consideration of grievances and provide for recertification when appropriate. Subscribers who are not satisfied with the plan's final determination or who have not received a response to their grievance with 30 calendar days, have the option of appealing to the DMHC.

DHCS complies with 42 CFR 457.1120(a)(2) using the statewide review system which is required of all health care service plans operating in California, including DHCS and CCHIP participating plans. This system is enforced by the California Department of Managed Care (DMHC). The statewide review system provides an impartial review of any health care service eligible for coverage and payment under a health plan contract. The issues that are handled through this process include:

- Accessibility
- Coverage/Benefits Disputes
- Appeals of Denials, delays, reductions, suspensions, terminations of Care
- Appeals of failure to approve, furnish, provide Payment
- Quality of Care
- Billing and Financial
- Attitude and Service

These issues handled through the statewide review system are consistent with the issues that would otherwise be addressed by 42 CFR 457.1130(b).

DMHC reviews the appeals as a standard review or as an Independent Medical Review (IMR). (The IMR allows subscribers to obtain an impartial review of any health care service eligible for coverage and payment under a health plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the services are not medically necessary). The standard review and IMR process include a final resolution by DMHC staff or DMHC contractor that is binding on the health plan.

As required by 42 CFR 457.1160(b), California has established a time frame for completing external reviews, through both the standard review process and IMR, that

accounts for the medical need of patients. To this end, within standard conditions, the review is completed within 90 calendar days of the date that a request for review was made. California also provides review within 72 hours for situations if operating under the standard timeframe could jeopardize the life or health of the enrollee.

The patient protection provision in state law that was established for managed care enrollees in California also apply to the Program subscribers since they are enrolled in licensed managed care plans. Thus, members are instructed to use their health plan's grievance process-including the DMHC's IMR process, if the subscriber has a grievance. When subscribers call DHCS directly, staff serves as an ombudsman assisting subscribers with the grievance process.

b. As required by 42 CFR 457.1180, California provides or requires the managed care plans to provide timely written notice of any decision that is subject to review under 457.1130(b) (described above). This notice includes the reason for the determination, the standard and expedited timeframes (described above), the way in which review can be requested, and the circumstances in which the enrollee may continue pending review.

c. As required by 42 CFR 457.1140(d), all applicants and enrollees have the opportunity to represent themselves, or have a representative they choose in the review process. All applicants and enrollees can review their files, or other information that is relevant to their review decision in a timely manner. And, all applicants and enrollees have the opportunity to fully participate in the review process, whether that process is in person or in writing.

d. As required by 42 CFR 457.1140(c), all review decisions are in writing.

e. DHCS requires all participating plans to report benefits-related grievances once a year. In addition, DHCS tracks all complaints directly received from subscribers, and any publicly available information on the number and type of benefit grievances filed by subscribers enrolled in a participating plan. Grievance information is used by DHCS to identify problem areas and to take appropriate steps towards improvements.

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

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

1. IN GENERAL- Subject to paragraph (2), the term 'targeted low-income child' means a child--
    a. who has been determined eligible by the State for child health assistance under the State plan;
    b. (i) who is a low-income child, or
       (ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
    c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. CHILDREN EXCLUDED- Such term does not include--
    a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
    b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. MEDICAID APPLICABLE INCOME LEVEL- The term 'Medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical

assistance under Section 1902(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.