

State/Territory: DELAWARE
(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))

Thomas R. Carper, Governor June 30, 1998
(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: Theodore Mermigos Position/Title: Acting Director
Name: Lisa Zimmerman Position/Title: Deputy Director
Name: Unkyong Goldie Position/Title: Chief of Administration

*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.

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

Original Plan

Effective Date: **October 1, 1998**

Implementation Date: **February 1, 1999**

Subsequent Plan Amendments

State Plan Amendment	Effective Date	Implementation Date
SPA #1	July 1, 1999	
SPA #2	October 1, 2001	August 1, 2001
SPA #3	June 12, 2003	Withdrawn – June 12, 2003
SPA #4	January 1, 2007	October 1, 2009
SPA #5	April 1, 2009	April 1, 2009
SPA #6	July 1, 2010	July 1, 2010
SPA #7	July 1, 2014	July 1, 2014
SPA # DE-CHIP-16-001	January 1, 2017	January 1, 2017
SPA # DE-CHIP-17-003	October 2, 2017	October 2, 2017
SPA # DE-CHIP-18-003	October 12, 2018	October 12, 2018
SPA # DE-CHIP-19-004	July 1, 2018	July 1, 2018
SPA # DE-CHIP-20-0003	March 1, 2020	March 1, 2020
SPA # DE-CHIP-20-0007	October 1, 2020	October 1, 2020
SPA # DE-CHIP-22-005	March 11, 2021	March 11, 2021
SPA # DE-CHIP-22-0012	July 1, 2022	July 1, 2022
SPA # DE-CHIP-22-0014	July 1, 2023	July 1, 2023

Summary of Approved CHIP MAGI SPAs:

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
DE-13-0012 Effective/ Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 CS15	Eligibility – Targeted Low Income Children MAGI-Based Income Methodologies	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3 Incorporate within a separate subsection under section 4.3
DE-13-0013 Effective/ Implementation Date:	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion	Supersedes the current Medicaid expansion section

January 1, 2014			Program	4.0	
DE-13-0016 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	
DE-13-0015 Effective/ Implementation Date: January 1, 2014	Non- Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5	
		CS18	Non-Financial Eligibility – Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR	
		CS19	Non-Financial Eligibility – Social Security Number	Supersedes the current section 4.1.9.1	
		CS20	Non-Financial Eligibility – Substitution of Coverage	Supersedes the current section 4.4.4	
		CS21			
		CS27	Non-Payment of Premiums Continuous Eligibility	Supersedes the current section 8.7 Supersedes the current section 4.1.8	
DE-13-0014 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4	
DE-22-0012 Effective/Implementation Date: July 1, 2022	Non- Financial Eligibility	CS27	Continuous Eligibility	Supersedes the current CS27 SPA MMDL template under SPA #DE-13- 0015	

SPA #: DE-CHIP-22-0012

Purpose of SPA: The purpose of this SPA is to implement postpartum continuous eligibility.

Proposed effective date: July 1, 2022

Proposed implementation date: July 1, 2022

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.

Delaware does not have any federally recognized Indian tribes. Any Delaware resident, including those who are American Indians or Alaska Natives, may participate in the review of amendments to state law or regulation and may offer comments on all program policies, including those relating to provision of child health assistance to American Indian or Alaskan Native children.

TN No: Approval Date Effective Date

- 1.4** Provide the effective and implementation 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.

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SPA # DE-CHIP-22-005	March 11, 2021	March 11, 2021

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		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
DE-13-0013 Effective/ Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
DE-13-0016 Effective/	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a	Incorporate within a separate subsection under section 4.1

Approval Date: November 15, 2022

Effective Date: March 11, 2021

Implementation Date: January 1, 2014			Result of the Elimination of Income Disregards	
DE-13-0015 Effective/ Implementation Date: January 1, 2014	Non- Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5
		CS18	Non-Financial Eligibility – Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1- LR
		CS19	Non-Financial Eligibility – Social Security Number	Supersedes the current section 4.1.9.1
		CS20	Non-Financial Eligibility – Substitution of Coverage	Supersedes the current section 4.4.4
		CS21	Non-Payment of Premiums	
		CS27	Continuous Eligibility	Supersedes the current section 8.7 Supersedes the current section 4.1.8
DE-13-0014 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4

SPA number: [DE-22-0005](#)

Purpose of SPA: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

Proposed effective date: [March 11, 2021](#)

Proposed implementation date: [March 11, 2021](#)

Approval Date: November 15, 2022

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Delaware does not have any federally recognized Indian tribes. Any Delaware resident, including those who are American Indians or Alaska Natives, may participate in the review of amendments to state law or regulation and may offer comments on all program policies, including those relating to provision of child health assistance to American Indian or Alaskan Native children.

TN No: Approval Date Effective Date

Approval Date: November 15, 2022

Effective Date: March 11, 2021

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

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

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

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

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

The population of Delaware was estimated to be 724,773 in 1996. There were 183,895 children in the 0 - 18 age group or 25% of the State population. Based on the Center for Applied Demography and Survey Research, University of Delaware, approximately 23,432 children (or 13% of the children in Delaware) are uninsured. Of the 23,432 uninsured children in the 0 - 18 age group, 14,581 (or 2.0% of the State's population) are \leq 200% FPL; 8,851 (4.8% of the State's population) are $>$ 200% FPL. It is assumed that approximately 4,068 uninsured children age 0 - 18 \leq 100% FPL are eligible for Medicaid/Title XIX. Therefore, DHCP will target approximately 10,513 children between 100% - 200% FPL.

Of the 183,895 children 0 - 18 in Delaware at the time the DHCP was created, 89.5% have some form of health insurance: 112,135 (or 61.0%) have private insurance; 48,328 (or 26.3%) currently have health care coverage through Title XIX Medicaid; 4,068 (or 2.2%) are eligible for, but not receiving Medicaid. In essence, Title XXI will increase the number of insured children in the 0 - 18 group by 10,513 (or 5.7%), thereby bringing the total of insured children in Delaware to 95.2%. The remaining 8,851 (or 4.8%) of the 0 - 18 population comprises uninsured children above 200% FPL.

According to a published report by the Center for Applied Demography and Survey Research, University of Delaware (U of D), Blacks are twice as likely to be without health insurance compared to Caucasians. Hispanics have a higher risk, almost 5% higher, than Blacks of being without insurance. 51% of the uninsured are male, 69% are White, 8% are Hispanic.

The major reason cited by the U of D report for lack of insurance among 0 -18 year olds are: poverty, lack of education, lack of work experience, and no family responsibility (i.e., unmarried and without children). Parents of these children are

likely to be single-parent households with low-income jobs.

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

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

Pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act, Delaware will use administrative funds to offer health services initiatives under this plan with the goal of improving the health of children, defined as “individual(s) under the age of 19 including the period from conception to birth,” per 42 CFR 457.10. Delaware assures that it will use no more than 10% of the total expenditures under this Plan, as specified in 42 CFR 457.618, to fund the State’s health service initiatives.

Vision Services – School-Based Initiative

Access to vision exams and glasses is critical for students’ educational achievements and health outcomes, as 80% of all learning during a child’s first 12 years is vital. It comes as no surprise that students with vision problems tend to have lower academic performance, as measured by test scores and grades, and that students’ performance in school impacts future employment earnings, health behaviors, and life expectancy. As such, Delaware seeks to use the health services initiative option to improve the health of low-income children by increasing their access to needed vision services and glasses through a targeted, school-based initiative. Delaware intends to contract with a Medicaid participating provider to offer these services on-site at certain Delaware schools.

The following describes how the CHIP HSI will be operationalized:

- The qualified provider will target Delaware’s low-income children by identifying Community Eligibility (CEP) Schools. A school is eligible for CEP if at least 40% of its students are “directly certified” through the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) and the school provides free breakfast and lunch to all of its students.
- These schools will provide the qualified provider with a list of children who have failed the school-supplied vision screening.
- The qualified provider will send a parental/guardian consent form home with these children informing the parent/guardian that their child has the opportunity to receive vision services and, if necessary, corrective lenses and frames following the procedure set forth in this policy. The parent/guardian has the opportunity to return the form and accept or refuse these services. If no form is returned, no services will be provided to the child.
- For children who return with parental/guardian consent the qualified provider will vision services on-site in a mobile eye clinic.
- If the vision service results determine that corrective lenses and frames are needed, the qualified provider will send a notice home to the child’s parent/guardian informing them of the results and requesting insurance information.

- • The qualified provider is then scheduled to return to the school to fit the child for glasses.
- • The qualified provider will collect the following information, at a minimum, from all children it serves, and submit it to the Delaware Division of Medicaid and Medical Assistance (DMMA):
 - o Child's first and last name;
 - o Child's date of birth;
 - o Name of the parent or guardian;
 - o Name of the school the services were provided at and CEP status;
 - o Indication that the insurance information form was or was not returned; and if it was returned;
 - o The insurance information that was provided.
- • DMMA will identify children on this list who are enrolled in Medicaid or CHIP and their managed care organization (MCO) and return this information to the qualified provider, who will then submit bills for Medicaid and CHIP enrollees directly to the MCOs. The MCOs will pay based on negotiated, standard fees.
- • The qualified provider will use this data and submit a second report to DMMA to include only those children that are under the age of 19, returned the insurance information form, did not indicate a private insurance carrier, and were not identified by DMMA as enrolled in Medicaid or CHIP on the previous submission.
- • DMMA will remit payment for these services through CHIP HSI funding.
- • DMMA will perform outreach by supplying the provider with brochures and information about the CHIP and Medicaid Programs to provide to children that are not currently enrolled in Medicaid or CHIP.

Delaware provides the following assurances regarding this Health Service Initiative (HSI), Vision Services – School–Based Initiative:

- • This HSI will only target children under the age of 19;
- • This HSI will not supplant or match CHIP Federal funds with other Federal funds nor allow other Federal funds to supplant or match CHIP Federal funds; and
- • HSI funds will not be used for children with private coverage and will only be used to cover services provided to uninsured children.

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 (IHCA). 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.

Delaware does not have any state or federally recognized Indian tribes. Any Delaware resident, including those who are American Indians or Alaska Natives, may participate in the review of amendments to state law or regulation and may offer comments on all program policies, including those relating to provision of child health assistance to American Indian or Alaskan Native children.

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

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

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

3.1. **Delivery Standards** (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.

The Delaware Healthy Children Program (DHCP) is targeted to children under age 19 with income at or below 212% of the Federal Poverty Level (FPL). There are no variances in service delivery or benefits based upon geography or population. The majority of services are provided by the same fully capitated managed care organizations (MCOs) serving Delaware's Medicaid population. Children are eligible under Title XXI (DHCP) only after enrollment with a MCO. In addition, there are some benefits provided fee-for-service (FFS).

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

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

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

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

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

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

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

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

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

- No
 Yes

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

Carved out services are:

Similarly to the Medicaid population, children in DHCP receive all medically necessary mental health and substance abuse treatment services (for any treatment modality). Services which exceed the basic MCO benefit of thirty (30) outpatient visits for mental health and substance abuse treatment are provided through the State's Department of Services for Children, Youth, and Families (DSCYF) or the Division of Developmental Disability Services (DDDS). DDDS provides FFS coverage for Applied Behavioral Analysis visits, beyond the initial thirty (30) outpatient visits and DSCYF provides FFS

coverage for all other mental health and substance abuse treatment visits, beyond the initial thirty (30) outpatient visits. Additionally, all inpatient mental health and substance abuse treatment for children is provided FFS by DSCYF.

Also equally to the Medicaid population, children in DHCP receive all medically necessary dental benefits through a FFS delivery mechanism managed by Delaware's Division of Medicaid and Medical Assistance (DMMA).

DMMA also uses administrative funds to, through an approved Health Services Initiative, to improve the health of low-income children by increasing their access to needed vision services and glasses through a targeted, school-based initiative. DMMA administers this through a FFS structure directly with providers.

Delaware assures that it will spend no more than 10% of actual or estimated Federal expenditures for outreach and administrative costs in accordance with Section 2105(a)(2)).

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: [The entire DHCP population.](#)
- Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
 - Capitation payment
 - Other (please explain)
Describe population served:

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

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

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

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

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

3.1.3 Nonemergency Medical Transportation PAHPs

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

- The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):
- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
 - The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
 - The provision against provider discrimination in 42 CFR 457.1208.
 - The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
 - The provisions on enrollee rights and protections in 42 CFR 457.1220,

457.1222, 457.1224, and 457.1226.

- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

3.2.1 The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))

3.2.2 The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))

3.2.3 The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

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

www.dhss.delaware.gov/DHSS/DMMA/FILES/MCO_MSA2018.PDF

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

- Based on public or private payment rates for comparable services for comparable populations; and
- Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

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

If the State is unable to meet the requirements under 42 CFR 457.1203(a), the State attests that it must establish higher rates because such rates are necessary to ensure sufficient provider participation or provider access or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. (42 CFR 457.1203(b))

3.3.2 The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))

3.3.3 The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))

3.3.4 The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))

3.3.5 Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))

No, the State does not require any MCO, PIHP, or PAHP to pay remittances.

Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.

Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

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

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

The State assures that if a remittance is owed by an MCO, PIHP, or PAHP to the State, the State:

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

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

3.4 Enrollment

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

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

3.4.1 Enrollment Process

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

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

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

- Yes
 No

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

- The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))
- The State maximizes continuation of existing provider-beneficiary relationships under 42 CFR 457.1210(a)(1)(ii) or if that is not possible, distributes the beneficiaries equitably and does not arbitrarily exclude any MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

- 3.4.2.1 The State assures that the State will notify enrollees of their right to disenroll consistent with the requirements of 42 CFR 438.56 at least annually. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2))
- 3.4.2.2 The State assures that the effective date of an approved disenrollment, regardless of the procedure followed to request the disenrollment, will be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCO, PIHP, PAHP, PCCM or PCCM entity refers the request to the State. (42 CFR 457.1212, cross-referencing to 438.56(e)(1))
- 3.4.2.3 If a beneficiary disenrolls from an MCO, PIHP, PAHP, PCCM, or PCCM entity, the State assures that the beneficiary is provided the option to enroll in another plan or receive benefits from an alternative delivery system. (Section 2103(f)(3) of the Social Security Act, incorporating section 1932(a)(4); 42 CFR 457.1212, cross referencing to 42 CFR 438.56; State Health Official Letter #09-008)
- 3.4.2.4 **MCO, PIHP, PAHP, PCCM and PCCM Entity Requests for Disenrollment.**
- The State assures that contracts with MCOs, PIHPs, PAHPs, PCCMs and PCCM entities describe the reasons for which an MCO, PIHP, PAHP, PCCM and PCCM entity may request disenrollment of an enrollee, if any. (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(b))

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

3.4.2.5 **Enrollee Requests for Disenrollment.**

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

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

- Yes
 No

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

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

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

3.5 Information Requirements for Enrollees and Potential Enrollees

- 3.5.1** The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.
- 3.5.2** The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))
- 3.5.3** The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.
- 3.5.4** The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:
 - Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
 - Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))

3.5.5

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

- The format is readily accessible;
- The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
- The information is provided in an electronic form which can be electronically retained and printed;
- The information is consistent with the content and language requirements in 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.

3.5.6

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

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

3.5.7

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

- Information about the potential enrollee's right to disenroll consistent with the requirements of 42 CFR 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;

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

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

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

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

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

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
 - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;

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

3.5.11 ☒

The State assures that each MCO, PIHP, PAHP and PCCM entity will give each enrollee notice of any change that the State defines as significant in the

information specified in the enrollee handbook at least 30 days before the intended effective date of the change. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)(4))

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

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

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

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

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

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

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

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

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

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

3.5.18 ☒ The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR

438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

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

- 3.6.1 The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)
- Delaware does not have any state or federally recognized Indian tribes.
- 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 contact 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 sub-regulatory 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))

[State \[Delaware\] is working to be compliant with these assurances by January 1, 2020](#)

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))

State [Delaware] is working to be compliant with these assurances by January 1, 2020

- 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))

State [Delaware] is working to be compliant with these assurances by January 1, 2020

- 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.

Section 4. Eligibility Standards and Methodology

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If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. Medicaid Expansion

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

Infants are covered up to 1. The household income must not exceed 212% of the FPL.

Child Medicaid covers children starting at age 1 through age 5. The household income must not exceed 142% of the FPL.

Youth Medicaid covers youths starting at age 6 through age 18. The household income must not exceed 133% of the FPL.

4.1. Separate Program Check all standards that will apply to the State plan.

(42CFR 457.305(a) and 457.320(a)) [Refer to attached MAGI page CS14.](#)

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

Delaware has opted to use the SSA Electronic Data Source as a verification option. Based on Regulations at 42 CFR 435.945(j) and 457.380(j), Delaware is required to develop, and update as modified, a Medicaid/CHIP verification plan describing the verification policies and procedures adopted by the agency in accordance with §435.940-435.965, and §457.380.

[Refer to attached MAGI page CS18.](#)

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

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

[Refer to attached MAGI page CS7.](#)

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

2002)

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

Refer to attached MAGI page CS7.

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

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

4.1.5 Residency (so long as residency requirement is not based on length of time in state): Refer to attached MAGI page CS17.

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

4.1.7 Access to or coverage under other health coverage:

Refer to MAGI page CS20.

4.1.8 Duration of eligibility, not to exceed 12 months:

Refer to attached MAGI page CS27.

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: Other standards include: (1) must be ineligible for enrollment in any public group health plan; and

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.

(2) A social security number is required for an applicant child, 1 year of age and older, effective August 24, 2001.

Refer to attached MAGI page CS19.

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

4.1.9.2 Continuous eligibility.

The initial month of the continuous period of eligibility is the first month of eligibility. A new period of continuous eligibility will be established beginning with the month following the last month of the previous period of continuous eligibility, when a scheduled renewal is completed and the child is determined to be eligible. A new 12-month period of continuous eligibility will also begin after any break in DHCP eligibility.

Refer to attached MAGI page CS27

4.1-PW **Pregnant Women Option** (section 2112) - The State includes eligibility for

one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this

section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

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

4.1- LR

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

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

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

- (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
 - (vi) Aliens currently in deferred action status; or
 - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
 - (6) An alien who has been granted withholding of removal under the Convention Against Torture;
 - (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
 - (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
 - (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

Elected for pregnant women.

Elected for children under age.

[Refer to attached MAGI page CS18.](#)

4.1.1-LR

The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

[Refer to attached MAGI page CS18.](#)

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)

[Refer to attached MAGI page CS15 and CS24.](#)

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

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

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

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

4.3.2. Check if the State elects to provide presumptive eligibility for children that

meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

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

4.3.3-EL Express Lane Eligibility

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

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

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

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

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

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

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

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal,

State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs

States must describe how they will assure that:

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

[Refer to attached MAGI page CS24.](#)

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

[Refer to attached MAGI page CS24.](#)

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

[Refer to attached MAGI page CS24.](#)

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

[Refer to attached MAGI page CS20.](#)

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

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

[American Indian and Alaska Native children are eligible for the Delaware Healthy Children Program on the same basis as any other children in Delaware.](#)

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):

The State of Delaware expanded coverage for children to age 18 and to 100% of the Federal poverty level in 1992, in tandem with plans to develop an 1115 waiver. This waiver was in conjunction with the duPont Hospital for Children a.k.a. the Nemours Foundation. Nearly 7,000 newly eligible children were added in the first year of increased eligibility which constituted a 31.3% increase in the number of children served by Medicaid. When the State received approval for the 1115 waiver that authorized the Diamond State Health Plan, this population of children was rolled into the Diamond State Health Plan and duPont became a provider with all MCOs.

Effective October 1, 2001, all children under the age of 1 enrolled in the Delaware Healthy Children Program were transferred to a Medicaid expansion with no interruption in coverage.

Pursuant to an initiative by the State, the Nemours Foundation also provides free primary health care services in physician clinics to uninsured children up to 175% of poverty and charges a fee on a sliding scale basis to those above 175% of poverty. Since its inception in 1993, the Nemours initiative has resulted in the creation of ten (10) new primary care facilities providing physician services to over 6,200 non-Medicaid children annually.

The Division of Social Services, Medical Assistance Program, the Division of Public Health and the Department of Education work closely together to identify uninsured children and route them to Medicaid for eligibility determination. We have developed an early identification program with the largest hospitals in the State to notify us immediately of the birth of a child to a Medicaid eligible mother. The State's Enrollment Broker (Health Benefits Manager) provides multiple outreach programs to bring the Diamond State Health Plan and Medicaid to the attention of possibly eligible persons. The State will amend the HBM contract to include these same services for the Title XXI population.

The enrollment process through the Health Benefits Manager worked very well and prevented direct marketing and adverse selection by managed care plans.

The WIC program also participates with the State and the MCOs to identify children in the WIC program who may also be eligible for Medicaid.

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:

The State's relationship with its managed care companies and the Health Benefits Manager (Enrollment Broker) are public-private partnerships. The outreach and education programs are provided in a public-private environment with the State working with each of these entities to identify and enroll eligible persons into the Medicaid program.

In addition, the Nemours Clinics provide services for the Medicaid Children, primarily through contracts with the Managed Care Organizations. They also provide services to uninsured children up to approximately 175% for no charge. These primary care clinics are supported primarily by the Nemours Foundation, a private philanthropical organization, whose trust requires investments in the health of Delaware's children

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

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

The public and private entities, which provide health care to children in the State, are already in partnership with Delaware's Department of Health and Social Services, which will be administering this program. The State is entering discussions with the Nemours Foundation, which provides primary care services to low-income and underinsured children who are not eligible for Medicaid to obtain their agreement to alter their income cap to cover children above 200% of FPL on a more generous basis since the State will assume coverage for uninsured children below 200% of the FPL who meet eligibility criteria.

Additionally, in the State's Division of Public Health, Maternal and Child Health program activities are funded under the Maternal and Child Health Block Grant program, Title V of the Social Security Act. This funding is intended to improve the health of all mothers and children and must be equally divided on prevention and primary care services for children, pregnant women, mothers and infants, and children with special health care needs. Referral processes are in place with the DPH and FQHCs, which aid in the identification and referral of uninsured children in the appropriate program. Applicants who do not qualify for Medicaid or the DHCP are referred to FQHCs.

All applicants will be screened by staff employed by the State of Delaware Division of Social Services to assure that they are potentially eligible targeted low income children. The screening document will determine:

1. If the child(ren) has Medicaid coverage or is potentially eligible. If the child has Medicaid, the Social Services staff will cease screening for The Delaware

Healthy Children Program. If potentially eligible because family income appears to be less than the Medicaid limit, a Medicaid application will be processed.

2. If the child is not Medicaid eligible, the social worker will screen for family income, credible coverage within last six months, residency, citizenship, Social Security Numbers, and age.
3. If child appears to qualify based on passing those screens, an application will be mailed or handed to the family.
4. Other State and private agencies serving potentially eligible targeted low-income children will be encouraged to refer such children for screening.

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)

The State plans a multi-pronged approach to finding, notifying and assisting eligible children to enroll in DHCP such as:

- The State plans to replicate the simplified application process in place for Medicaid and continue to outstation staff to complete Medicaid and DHCP applications. Staff will coordinate the application so families can be screened and apply for both programs with a single application by mail without a face to face interview.
- During the Public Hearing process we will elicit partners who can help outreach to children in their communities, service area, client base etc. We will ask for their suggestions for outreach strategies. Delaware will supplement this process by considering the schools as an outreach point, because the Title XXI program targets children.
- Non-traditional outreach strategies, which have been used successfully in other States, such as adding a check off box to the reduced/free lunch application in schools, will be considered. The sentence will ask parents if they would like their child's name referred to Medicaid for an application for benefits. Other non-traditional strategies may include fliers on pizza boxes and fast food trays, temporary agency employees paycheck inserts, article in the American Association of Retire Persons newsletter to reach grandparents raising their grandchildren.

- Delaware plans to search out other states' initiatives that have been successful and replicate those in Delaware if feasible.
- The State will use all media types, which are cost effective, such as traditional mailings, newspaper, buses, and Public Service Announcements on radio and television for different ethnic/racial/demographic/age markets.
- The State will target children within the State programs who are known to be potentially eligible like children receiving food stamps, WIC, subsidized child care, etc. for a special "invitation" to join with a simplified application process since income/technical requirements are stored in common shared computer eligibility file.
- The State will periodically reevaluate and revise outreach strategies so enrollment is successful.

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

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

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

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

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

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

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

6.1.4.4. Coverage that includes benchmark coverage plus additional coverage

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

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

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

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

6.1.4.7. Other (Describe)

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

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

6.2. The State elects to provide the following forms of coverage to children: (Check all

that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

Coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations, is applied in the same manner as coverage under Delaware's Title XIX Medicaid State Plan.

- 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. 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))
- 6.2.11. 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.

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

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

- 6.2.13. Nursing care services (Section 2110(a)(15))
- 6.2.14. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.15. Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
- 6.2.16. Vision screenings and services (Section 2110(a)(24))
- 6.2.17. Hearing screenings and services (Section 2110(a)(24))
- 6.2.18. Case management services (Section 2110(a)(20))
- 6.2.19. Care coordination services (Section 2110(a)(21))
- 6.2.20. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.21. Hospice care (Section 2110(a)(23))

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

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

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

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

furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

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

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

6.2.25. Medical transportation (Section 2110(a)(26))

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

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

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

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

STATE: Delaware	CHIP Health Service Initiative	Cost Projection of Approved CHIP Plan	Total
Federal Fiscal Year	FFY 2023	FFY 2023	FFY 2023
State's enhanced FMAP rate	75.28%	75.28%	75.28%
Benefit Cost			
Insurance Payments			
Managed care		\$25,323,201	\$25,323,201
per member/per month rate		\$299	
# of enrollees		5,200	5,200
Fee for Service		\$5,307,360	\$5,307,360
Total Benefit Costs		\$30,630,561	\$30,630,561
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs		\$30,630,561	\$30,630,561
Cost of Proposed SPA Changes - Benefit		\$177,355	\$177,355
Administrative Costs			
Personnel		\$115,719	\$115,719
General Administration		\$1,040,000	\$1,040,000
Contractors/Brokers		\$272,658	\$272,658
Claims Processing		\$117,996	\$117,996

Outreach/marketing costs			
Health Services Initiatives	\$48,000		\$48,000
Other			
Total Administrative Costs		\$1,546,373	\$1,594,373
10% Administrative Cap		\$3,403,396	\$3,403,396
Cost of Proposed SPA Changes			
Federal Share		\$24,356,309	\$24,356,309
State Share		\$7,997,980	\$7,997,980
Total Program Costs		\$32,354,289	\$32,354,289

Budget Assumptions

- Client growth will decrease throughout FFY 2023 until redeterminations start
- Capitation rates paid to commercial managed care organizations will increase an average of 2.5% based on new contracts;
- Enhanced Federal FMAP will start at 75.28% and “step down” during the PHE unwinding.
- The primary cost driver of adding coverage of EPSDT benefits is our NEMT benefit.

CHIP Budget

STATE: Delaware	CHIP Health Service Initiative	Cost Projection of Approved CHIP Plan	Total
Federal Fiscal Year	FFY 2024	FFY 2024	FFY 2024
State's enhanced FMAP rate	71.80%	71.80%	71.80%
Benefit Cost			
Insurance Payments			
Managed care		\$30,709,270	\$30,709,270
per member/per month rate		\$325	
# of enrollees		7,450	7,450
Fee for Service		\$5,418,943	\$5,418,943
Total Benefit Costs		\$36,128,213	\$36,128,213
(Offsetting beneficiary cost sharing		(\$75,000)	(\$75,000)

payments)			
Net Benefit Costs		\$36,053,213	\$36,053,213
Cost of Proposed SPA Changes - Benefit		\$945,977	\$945,977
Administrative Costs			
Personnel		\$116,877	\$116,877
General Administration		\$1,060,000	\$1,060,000
Contractors/Brokers		\$275,385	\$275,385
Claims Processing		\$119,176	\$119,176
Outreach/marketing costs			
Health Services Initiatives	\$48,000		\$48,000
Other			
Total Administrative Costs		\$1,571,438	\$1,619,438
10% Administrative Cap		\$4,005,913	\$4,005,913
Cost of Proposed SPA Changes			
Federal Share		\$27,693,711	\$27,693,711
State Share		\$10,876,917	\$10,876,917
Total Program Costs		\$38,570,628	\$38,570,628

Budget Assumptions

- Client growth will increase 10% during FFFY 24 due to Medicaid changes
- Capitation rates paid to commercial managed care organizations will increase an average of 2.5% based on new contracts;
- Enhanced Federal FMAP will start “step down” during the PHE unwinding and remain at 71.80%.
- The primary cost driver of adding coverage of EPSDT benefits is our NEMT benefit.

- 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))

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- 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)

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

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

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- 6.1.4.1. Coverage of all benefits that are provided to children under the the same as Medicaid State plan, including Early Periodic Screening Diagnosis and Treatment (EPSDT)
- 6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver
- 6.1.4.3. Coverage that the State has extended to the entire Medicaid population

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

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

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

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

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

- 6.1.4.7. Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children

under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a) (42CFR, 457.490)

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

- 6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a) (42CFR 457.490))
- 6.2.1. Inpatient services (Section 2110(a)(1))
- 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)) - included as a “wrap-around” service with the same limitations as the Title XIX program.
- 6.2.7. Over-the-counter medications (Section 2110(a)(7)) - included as a “wrap-around” and limited to drug categories where the over-the-counter product may be less toxic, have fewer side effects, and be less costly than an equivalent legend product.
- 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)) - inpatient mental health and/or substance abuse treatment services will be provided as “wrap-around” services by the DSCYF. Inpatient services will be provided with limits based on medical necessity. Children who need inpatient services beyond this will convert to Medicaid Long-Term Care.
- 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)) - 30 days of outpatient care included in the basic MCO benefit. Additional days of

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outpatient mental health and/or substance abuse treatment services, with limitations based on medical necessity, will be provided by the DSCYF. See note in 6.2.10.

- 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))

Limited to medically necessary home health services provided by the MCOs as part of the basic benefit. Does NOT include personal care, chore services, day care, respite care, or home modifications. Home health aide services are covered as medically necessary according to the State's published definition.

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)) - there is a limit of 28 hours of Private Duty Nursing Services per week in the basic benefit; no additional hours available.

- 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) – included as “wrap-around” services with the same limitations as the EPSDT dental program. The SCHIP dental benefit is comprehensive in nature and consists of the following services: Diagnostic, Preventive, Restorative, Endodontics, Periodontics, Prosthodontics, Oral Surgery, and adjunctive services (such as, anesthesia, behavior management, occlusal guard, and treatment of dental pain). Orthodontic services are covered for diagnosed conditions considered to be handicapping malocclusions.

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

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

- 6.2.20. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18)) – see note in 6.2.10.

- 6.2.21. Outpatient substance abuse treatment services (Section 2110(a)(19)) – see note in 6.2.11.
- 6.2.22. Case management services (Section 2110(a)(20))
- 6.2.23. Care coordination services (Section 2110(a)(21))
- 6.2.24. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.25. Hospice care (Section 2110(a)(23))

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

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

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

- 6.2.27. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(28))

Effective March 11, 2021, and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan:

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration, in accordance with the requirements of section 2103(c)(11)(A) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act.
- The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.
- The state assures that coverage includes all types of FDA authorized COVID-19 tests.

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COVID-19 Treatment:

- The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
 - The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
 - The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and
 - The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without amount, duration, or scope limitations, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

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

6.2.29. Medical transportation (Section 2110(a)(26)) - **Emergency transportation only as provided in the basic benefit package.**

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

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

CHIP Disaster Relief:

At the State's discretion, it may temporarily provide nonemergency transportation to CHIP enrollees who reside and/or work in a State or Federally declared disaster area.

6.2.31 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

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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 (CDT¹) codes are included in the dental benefits:

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

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

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

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

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² 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

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checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

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

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

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

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

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

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

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International Classification of Disease (ICD)

For the purpose of the MHPAEA analysis, Delaware defined mental health and substance use disorder (MH/SUD) benefits as benefits for the conditions listed in ICD-10-CM, Chapter 5 “Mental, Behavioral, and Neurodevelopmental Disorders” with the exception of:

- The conditions listed in subchapter 1, “Mental disorders due to known physiological conditions” (F01 to F09);
- The conditions listed in subchapter 8, “Intellectual disabilities” (F70 to F79); and
- The conditions listed in subchapter 9, “Pervasive and specific developmental disorders” (F80 to F89).

Delaware defined medical/surgical (M/S) benefits as benefits for the conditions listed in ICD-10-CM Chapters 1-4, subchapters 1, 8 and 9 of Chapter 5, and Chapters 6-20.

Diagnostic and Statistical Manual of Mental Disorders (DSM)

State guidelines (Describe: _____)

Other (Describe: _____)

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

Yes

No

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

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

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

Yes

No

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

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

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

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

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

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

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

- All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))
- All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))
- All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))
- Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

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- Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))
- EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))
- The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))
- All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

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

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

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

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

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

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

Inpatient: All covered services or items (including medications) provided to a member while in a setting (other than a home and community-based setting as defined in 42 CFR Part 441) that requires an overnight stay.

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Outpatient: All covered services or items (including medications) provided to a member that do not otherwise meet the definition of inpatient, emergency care, or prescription drugs.

Emergency Care: All covered services or items (including medications) delivered in an emergency department (ED) setting or free standing emergency room.

Prescription Drugs: Covered medications, drugs and associated supplies and services that require a prescription to be dispensed. These products are claimed using the National Council for Prescription Drug Programs (NCPDP) format.

6.2.3.1.1 MHPAEA The State assures that:

- The State has classified all benefits covered under the State plan into one of the four classifications.
- The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

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

- Yes
- No

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

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

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

6.2.3.2 MHPAEA The State assures that:

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

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

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Annual and Aggregate Lifetime Dollar Limits

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

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

- Aggregate lifetime dollar limit is applied
- Aggregate annual dollar limit is applied
- No dollar limit is applied

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

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

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

- Yes (Type(s) of limit:)
- No

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

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

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

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

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

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

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

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

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

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

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

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

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

the State child health plan.

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

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

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

Quantitative Treatment Limitations

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

Yes (Specify:)

No

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

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

Yes

No

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

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan

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year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

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

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

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

Yes

No

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

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

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

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

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

Non-Quantitative Treatment Limitations

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

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

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

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

See Attachment 1 for a list of NQTLs and MH/SUD benefits by classification and benefit package for each for Highmark Health Options and Attachment 2 for UnitedHealthCare Community Plan. Attachment 3 provides the NQTL analysis by classification and benefit package for each for UnitedHealthCare Community Plan and Attachment 4 for Highmark Health Options. Note that this same information was submitted to CMS as documentation of parity compliance for MCO enrollees (42 CFR Part 438).

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

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

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Yes No **However, Attachment 1 through 4 include information on Standards for Out-of-Network Coverage since information on that NQTL was provided to CMS as part of the Part 438 documentation for MCO enrollees.**

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

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

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

Availability of Plan Information

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

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

- State
- Managed Care entities
- Both
- Other

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

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

- State
- Managed Care entities
- Both

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Other

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

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;*

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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.

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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.)

Quality Assurance Structure

The MCO's utilization management and quality assurance program will consist of internal monitoring by the MCOs, oversight by DSS and the federal government, and evaluation by an independent, external review organization (EQRO). These programs are in place for the MCOs currently contracting for Title XIX clients and the same programs will be used for Title XXI. Future RFPs for Managed Care Organizations will include the need to provide services for both the Title XIX and the Title XXI programs. All MCOs must have a quality assurance structure composed of:

- (a) an internal system of monitoring services;
- (b) designated staff with expertise in quality improvement and quality assurance; and
- (c) written policies and procedures for quality assurance and utilization management.

Quality Assurance System

As with Title XIX, MCOs are required to establish, implement, and adhere to the Quality Assurance and Utilization Management review systems approved by the Department and based on the current HCFA guidelines (A Health Care Quality Improvement System for Medicaid Managed Care issued July 6, 1993) or subsequent revisions thereof (9/2017), and shall:

- (a) ensure that health care is provided as medically necessary in an effective and efficient manner;
- (b) assess the appropriateness and timeliness of care provided;
- (c) evaluate and improve, as necessary, access to care and quality of care with a focus on improving patient outcomes;
- (d) focus on the clinical quality of medical care rendered to enrollees; and
- (e) incorporate all the "Minimum Quality Assurance and Utilization Management Requirements."

MCOs will be held accountable for monitoring, evaluating, and taking action as necessary to improve the health of its members under contract with DSS. MCOs will also be held accountable for the quality of care delivered by sub-contractors, which must comply with all quality management procedures and requirements of this RFP.

Quality Assurance Policy and Procedures

NOTE: These policies and procedures are already in place for Title XIX. MCOs must distinguish between Title XIX and Title XXI for reporting.

Internal policies and procedures must:

- (a) assure that the utilization management and quality assurance committee has established parameters for operating and meets on a regular schedule which is at least quarterly, committee members must be clearly identified and representative of the MCO's providers, accountable to the medical director and governing body, and must maintain appropriate documentation of the committee's activities, findings, recommendations, and actions;
- (b) provide for regular utilization management and quality assurance reporting to the MCO management and MCO providers, including profiling of provider utilization patterns;

- (c) be developed and implemented by professionals with adequate and appropriate experience in quality assurance;
- (d) provide for systematic data collection and analysis of performance and patient results;
- (e) provide for interpretation of this data to practitioners;
- (f) provide for making appropriate changes when problems in quality of care are found; and
- (g) clearly define the roles, functions, and responsibilities of the quality assurance committee and medical director.

Internal Quality Assurance Program

The MCO must have an internal written quality assurance plan (QAP) that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas. Emphasis must be placed on, but need not be limited to, clinical areas relating to well baby care, well child care, pediatric and adolescent development, as well as on key access or other priority issues for Title XXI members such as teen age pregnancy and immunizations.

All MCOs are to structure their internal QAPs in a manner consistent with the standards as outlined in the Federal Government's "Quality Assurance Reform Initiative Guide for States" (QARI) or subsequent revisions thereof, for internal and external quality assurance reviews.

Provider Profiling

The MCO must have written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State and qualified to perform their services according to CMS's "A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for the States", or subsequent revisions thereof. The MCO also must have written policies and procedures for monitoring its providers and for disciplining providers who are found to be out-of-compliance with the MCO's medical management standards.

Quality Assurance Report

As with the existing Title XIX program, plans will also be required to submit periodically to DSS reports regarding results of their internal monitoring. This will include the reporting of The Healthcare Effectiveness Data and Information Set (HEDIS), Volume 3.0 or subsequent revisions, and other targeted health indicators that shall be monitored by DSS as well as other specific quality data periodically requested by the federal government. The MCO must agree to submit a quality assurance report six (6) months after the contract effective date and semi-annually thereafter. These reports will distinguish clearly between the Title XIX and the Title XXI programs.

Outcomes Objectives

The State, in conjunction with the MCOs, will develop a system of incentives for reaching outcomes objectives in certain key areas to be defined by the State and MCOs. These outcomes objectives will include, at a minimum, childhood immunizations, well baby and well child care, pediatric asthma, and behavioral health care. MCOs will be required to submit on a periodic basis objective numerical data and/or

narrative reports describing clinical and related information on health services and outcomes of health care for the Title XXI and Title XIX populations. Each program will be handled as separate populations for reporting

Internal Staff

The State's enrolled populations for the Title XIX and the Title XXI programs are too small to require separate internal programs for the MCOs. Therefore, internal staff and internal committees may serve both populations. A clear definition will be made during reporting.

The MCO must designate a quality assurance and utilization management coordinator, who is either the MCO's medical director or a person who reports directly to the medical director. This individual is responsible for the development and implementation of the quality assurance program. The coordinator must have adequate and appropriate experience in successful utilization management and quality assurance programs and be given sufficient time and support staff to carry out the MCO's utilization management and quality assurance functions. This person, or group will also be responsible for assuring the interface and support of the EQRO and State quality assurance functions as necessary.

Quality Assurance Committee

MCOs must have a quality assurance committee that assists the coordinator in carrying out all quality assurance functions. This committee must satisfy the DSS's requirements and, at a minimum:

- (a) demonstrate that the Committee will have oversight responsibility and input on all quality assurance and utilization management activities;
- (b) demonstrate that the committee has accountability to the MCOs governing board;
- (c) ensure membership on the committee and active participation by individuals representative of the MCOs provider community;
- (d) and demonstrate that the contractor will secure adequate insurance for members of the committee and subcommittees.

Quality Assurance and Utilization Management Coordinator

The coordinator and the quality assurance committee must be accountable to the MCO's governing body.

The qualifications and responsibilities must include but need not be limited to what follows below. Specifically, the coordinator must:

- (a) the head of the governing body must be licensed to practice medicine in the United States and be board-certified or board-eligible in his or her field of specialty;
- (b) oversee the development of the MCO's annual written quality assurance description including areas and objectives, scope, specific activities, and methodologies for continuous tracking, provide review and focus on health outcomes;
- (c) oversee the MCO's utilization management and quality assurance committee, direct the development and implementation of the MCO's internal quality assurance plan and utilization management activities, and monitor the quality of care that MCO members receive;
- (d) oversee the development of clinical care standards and practice guidelines and

- protocols for the MCO;
- (e) review all potential quality of care problems and oversee development and implementation of continuous assessment and improvement of the quality of care provided to members;
 - (f) assure that adequate staff and resources are available for the provision of proper medical care and health education to members;
 - (g) specify clinical or health service areas to be monitored;
 - (h) specify the use of quality indicators that are objective, measurable, and based on current knowledge and clinical experience for priority areas selected by DSS as well as for areas the MCO selects; current Health Plan Employer Data and Information Set standards must be used;
 - (i) oversee the MCO's referral process for specialty and out-of-plan services; all denied services must be reviewed by a physician, physician assistant, or advanced nurse practitioner; the reason for the denial must be documented and logged; all denials must identify appeal rights of the member;
 - (j) be involved in the MCO's recruiting and credentialing activities;
 - (k) be involved in the MCO's process for prior authorization and denying services;
 - (l) be involved in the MCO's process for ensuring the confidentiality of medical records and member information;
 - (m) be involved in the MCO's process for ensuring the confidentiality of the appointments, treatments, and required State reporting of adolescent sexually transmitted diseases;
 - (n) work with the special programs coordinator to assure that reports of disease and conditions are made to DSS in accordance with all applicable State statutes, rules, guidelines, and policies and with all metropolitan ordinances and policies;
 - (o) assure that control measures for tuberculosis, sexually transmitted diseases, and communicable disease are carried out in accordance with applicable laws and guidelines and contained in each provider manual;
 - (p) serve as a liaison between the MCO and its providers and communicate regularly with the MCO's providers, including oversight of provider education, in-service training, and orientation;
 - (q) be available to the MCO's medical staff for consultation on referrals, denials, complaints, and problems;
 - (r) attend State medical director's meetings;
 - (s) maintain current medical information pertaining to clinical practice and guidelines;
 - (t) and attend grievance committee meetings when necessary.

External Quality Assurance Reviews

DSS will contract with independent, external evaluators to examine the quality of care provided by MCOs. The State will amend the existing contract with its EQRO for the Title XIX program. The amendment will clearly define the need to keep the populations and associated reporting separate.

The MCO will be required to cooperate with any external quality, independent assessment of its performance, which has been duly authorized by DSS. Independent assessments shall include, but not be limited to, the federally required reviews of (1) access to care, quality of care, cost effectiveness, and the effect of case management; (2) the contractor's quality assurance procedures, implementation of the procedures, and the quality of care provided; and (3) consumer satisfaction surveys.

The MCO agrees to assist in the identification and collection of any data or medical records to be reviewed by the independent assessors and/or DSS. The contractor shall ensure that the data, medical records, and workspace are available to the independent assessors or DSS at the contractor's work site.

DSS will monitor each MCO's adherence to Quality Assurance Reform Initiative (QARI) standards through one or more of the following mechanisms:

- (a) Review of each MCO's written QAP prior to contract execution:
- (b) periodic review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes of health care for the enrolled population;
- (c) on-site monitoring by DSS of QAP implementation to ensure compliance with all standards; such monitoring will take place at least once every six (6) months;
- (d) independent, external review of the quality of services furnished by each MCO, conducted by an entity under contract to DSS; such reviews will be conducted at least once each year; the MCO must agree to make available to DSS's external evaluator medical and other records (subject to confidentiality constraints) for review as requested;
- (e) on-site visits and inspections of facilities;
- (f) staff and enrollee interviews;
- (g) review of appointment scheduling logs, emergency room logs, denial of services, and other areas that will indicate quality of care delivered to enrollees;
- (h) medical records reviews;
- (i) all quality assurance procedures, reports, committee activities and recommendations, and corrective actions;
- (j) review of staff and provider qualifications;
- (k) review of grievance procedures and resolutions;
- (l) and review of requests for transfers between primary care providers within each MCO.

The MCO shall submit a corrective action plan (CAP) to resolve any performance or quality of care deficiencies identified by the independent assessors and DSS as determined necessary by DSS.

Fraud and Abuse Protections

The MCO may not knowingly:

- have a person who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order 12549 or under guidelines implementing such order, as a

Director, officer, partner, or person with beneficial ownership of more than 5% of the entity's equity;

- or have an employment, consulting, or other agreement with a person described above for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

The MCO may not distribute directly or indirectly or through any agent or independent contractor marketing materials within the state:

- without prior approval of the State, or
- that contains false or materially misleading information.

The MCO shall develop marketing materials especially for the Title XXI program. These materials will be provided to the State's Health Benefit Manager (HBM). The HBM will include these materials in all mailings to the eligible population.

The MCO shall distribute marketing materials to entire service areas covered under this contract.

The MCO or its subcontractors may not seek to influence an individual's enrollment with the MCO in conjunction with the sale of any other insurance.

The MCO shall comply with such procedures and conditions as the State prescribes in order to ensure that before a member is enrolled with the MCO, the individual is provided accurate oral and written information sufficient to make an informed decision.

The MCO shall not directly or indirectly, conduct door-to-door, telephonic or other "cold-call" marketing of enrollment.

The MCO shall require each professional providing services to members, eligible for the program, to have a unique provider identifier, the method of which will be approved by the State.

The MCO shall report any fraudulent or abusive practices by subcontractors or providers to DSS for investigation or referral to other appropriate authorities and must cooperate with any subsequent investigation. The MCO and its providers are subject to review or investigation by DSS and other State agencies for quality of care, fraud or abuse, and must cooperate fully in the provision of requested information to offices, including, but not limited to, DHSS, the Department of Justice, the State Auditor, the Insurance Department, and the appropriate licensing agencies within the Department of Administrative Services.

Member Satisfaction Report

MCOs must survey their members on at least an annual basis to determine satisfaction with MCO's services.

The MCO must agree to collect and assist DSS in collecting annual member satisfaction data through application of a uniform instrument to a randomly selected sample of its members. The State will design a questionnaire to measure satisfaction and include measures of out-of-plan use, to include use of emergency rooms; average waiting time for appointments, including physician office visits; average time and distance to reach providers; access to specialty providers; and the number and causes of disenrollment; and coordination with other health programs. This member satisfaction survey will be based on the CAHPS survey. To ensure comparability of results, all members will receive the same survey. DSS will consider suggestions

from the MCO for questions to be included in this survey. DSS will tally the results of these surveys, which will be published.

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
 - 7.1.2 (a) CHIPRA Quality Core Set
 - 7.1.2 (b) Other
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

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)

NOTE: These policies and procedures are already in place for Title XIX. MCOs must distinguish between Title XIX and Title XXI for reporting.

- 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))

MCO's must have an internal written QAP that monitors, assures, and approves the quality of care delivered over a wide range of clinical and health service delivery areas to include, but are not limited to:

- Well baby care;
- Well child care;
- Pediatric and adolescent development; and
- Immunizations.

Plans are also required to report semi-annual results of their internal monitoring. This will include the reporting of the above-referenced HEDIS indicators.

- 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))

Delaware will expect its contracting Medicaid MCOs to use existing provider panels to provide services to the DHCP. The State requires a 1:2500 patient to primary care provider ratio for DSHP and expects the MCOs to maintain that ratio for the DHCP. The DMES provides weekly reports on MCO capacity. These reports are monitored by DSHP staff. The MCOs are notified of access issues and the need to add providers. Delaware Medicaid's contracting MCOs have contracts with all of the State's hospitals for outpatient and emergency care. A majority of Delaware's physician providers also contract with the Medicaid MCOs. The State's contracting MCOs report percentage of primary providers with open panels on a quarterly basis to DSHP.

The state requires the "prudent layperson" language for emergency services as defined by the BBA of 1997. This regulation also restricts the use of prior authorizations for emergency care and the denial of emergency care provided by non-network providers.

The State will perform consumer satisfaction surveys and will require the MCOs to perform consumer satisfaction surveys. Issues related to access are an integral part of these surveys. The State uses a modified CAHPs survey for the DSHP and will use the same methodology for the DHCP. The State also uses grievance and complaint records for DSHP to identify MCO panels that may be reaching capacity. These methods have worked well for DSHP and we would expect the same results for the DHCP.

- 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))

Benefit procedures exist for members with chronic, complex, or serious conditions. All of the managed care organizations must comply with regulations regarding access to and adequacy of specialists.

During enrollment, the Health Benefits Manager screens enrollees with chronic, complex, or serious medical conditions and refers this information to the MCOs. The MCOs utilize case managers to assure appropriate access to care for children with serious health care needs.

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

The state complies with SCHIP requirement of decisions related to the prior authorization of health services within 14 days after receipt of request.

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:

- \$10 PFFM for families with children ages one (1) through five (5) with family incomes ranging from 143% FPL through 159% of FPL,
- \$10 PFFM for families with children ages six (6) through eighteen (18) with family incomes ranging from 134% FPL through 159% of FPL,
- \$15 PFFM for families with children ages one (1) through eighteen (18) with family incomes ranging from 143% to 160 % through 176% of the FPL, and
- \$25 PFFM for families with children ages one (1) through eighteen (18) with family incomes ranging from 177% to 212% of the FPL.

(refer to CHIP MAGI State Plan Page CS21 for information on the effect of non-payment of premiums).

Incentives for pre-payment of premiums include the following: Pay three (3) months get one (1) premium free month; pay six (6) months get two (2) premium free months; pay nine (9) months get three (3) premium free months.

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other:

8.2-DS **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family

income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

- 8.2.1-DS Premiums:
- 8.2.2-DS Deductibles:
- 8.2.3-DS Coinsurance or copayments:
- 8.2.4-DS Other:

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

The public will be notified of cost sharing requirements and any other aspects of the DHCP through the State's Administrative Procedures Act which requires publishing everything that has an impact on State citizens and provides an opportunity for public comment. Information is published in the Delaware Register of Regulations monthly as changes or new initiatives occur (www.state.de.us/research/dor/register.htm). Information will also be initially provided at public meetings and through outreach and educational efforts. Delaware will also use the Health Benefits Manager to educate and continue to do outreach similar to the DSHP.

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

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

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

8.4.1- MHPAEA There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

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

- Yes (Specify:)
 No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below. Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

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

- Yes
 No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

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

- The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: **Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.**

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

- Yes
 No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

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

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

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

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

Since cost sharing is per family per month (PFPM), rather than per member per month, each family will pay the same amount no matter the number of children in the household. The premium rates are significantly less than those allowed by the Balance Budget Act of 1997 for premiums (see chart below). Delaware believes these levels of cost sharing are affordable but, at the same time, provide an incentive for clients to responsibly use health care services.

Premiums as a Percentage of Income									
Premium Amount Per Month	Age	Family Size	134% FPL lower limit	143% FPL lower limit	159% FPL upper limit	160% FPL lower limit	176%FPL upper limit	177% FPL lower limit	212% FPL upper limit
\$10 Monthly Premium	1 through 5	1		0.69%	0.62%				
	1 through 5	2		0.51%	0.46%				
	1 through 5	3		0.40%	0.36%				
	6 through 18	1	0.74%		0.62%				
	6 through 18	2	0.54%		0.46%				
	6 through 18	3	0.43%		0.36%				
\$15 Monthly Premium	1 through 18	1				0.93%	0.84%		
	1 through 18	2				0.68%	0.62%		
	1 through 18	3				0.54%	0.49%		
\$25 Monthly Premium	1 through 18	1						1.40%	1.17%
	1 through 18	2						1.03%	0.86%
	1 through 18	3						0.82%	0.68%

*Based on the 2018 Poverty Limit of \$12,140 for 1 person, \$16,460 for 2, and \$20,780 for 3.

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)

Delaware's application form asks for race group including American Indian/Alaskan Native and we accept self-declaration. This information is included in the automated record, which enables us to exclude these families from premium requirements. We will add a statement to the approval notices indicating that American Indian/Alaskan Native families are exempt from premium requirements. The approval notices include a toll free contact number. To exclude American Indian/Alaska Native enrollees from any copayments on non-emergent use of emergency room services, the premium and approval notices will include a statement advising families the AI/AN families are exempt. The notices will advise AI/AN families to call the Health Benefits Manager (HBM) at a toll-free number to identify themselves and request an exemption. MMIS has an exemption code that must be manually entered by the HBM.

- 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))

Coverage will be cancelled when the family is in arrears for two premium payments. The coverage will end the last day of the month when the second payment is due. A notice of cancellation will be sent to the family advising the family to report any change in circumstances, such as a decrease in income that may result in eligibility for Medicaid. If one premium payment is received by the last day of the cancellation month, coverage will be reinstated. Refer to attached MAGI page CS21.

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

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

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

- 8.7.1.1. State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- 8.7.1.2. The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
- 8.7.1.3. In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- 8.7.1.4. The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

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

- 8.8.1. No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2. No cost-sharing (including premiums, deductibles, copayments, coinsurance

and all other types) will be used toward State matching requirements.
(Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

- 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))
- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)
- 8.8.6. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

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

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))
- 1) to decrease the number of uninsured children and thereby improve their health and chances for life success;
 - 2) to mainstream uninsured children in the health care industry so they receive the same quality of care as insured children; and
 - 3) to go from a clinical based system (fee-for-service/sick care) to a community-based system (managed care/preventive care) which provides genuine access to high quality 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))
- 1) show-rate of uninsured children;
 - 2) percentage increase in wellness visits; and
 - 3) percentage decline in unnecessary emergency room visits.

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

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

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

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

The State will use the first year of the DHCP to develop base line information to monitor future years of the program. In addition, the State will expect the same utilization reporting for the DHCP that we currently receive for the DSHP. We will also monitor the experience

of the DHCP against the experience for the same age cohorts under the DSHP to look for possible outliers.

The State will require encounter data submission for the DHCP. The State can also identify specific reporting categories and require the MCOs to report that information from their database. The State will be able to report all of the CMS required information identified in section 9.3.

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: [ER Visits](#)
- 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)
- 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) - State general funds for mental health services covered under the SCHIP State Plan are appropriated annually to the Delaware Department of Services for Children, Youth and Their Families (DSCYF). Claims for covered behavioral health services are submitted to DMMA by DSCYF during the year as services are provided, and as the claims are processed and paid by DMMA. The State draws down the appropriate federal share and provides it to DSCYF.
- 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))
- A Legislative hearing was held on 3/18/98 related to Senate Bill 246, which would authorize the DHCP for Delaware. There were thirty (30) advocates present with testimony from eleven (11) and written testimony from three (3).
- The Delaware Health Care Commission (DHCC) hosted public hearings to obtain input on the Title XXI Plan in Kent County (Milford Library) on 3/31/98 and New Castle County (Stanton Middle School) on April 1, 1998.
- The major issues raised at all hearings were the imposition of premiums, the six-month waiting period after loss of other insurance, the proposed \$25 copay on ER services, and the exclusion of dental benefits for these children. In addition, advocates expressed concern that the State was not pursuing presumptive eligibility.
- The DHCC, after deliberating the testimony, supported the Plan as written with modifications/exceptions to the six-month waiting period and the \$25 copay on ER services. The recommended changes are reflected in this submission.
- Delaware will publish, concurrent with this Plan submission, notice in the State's Register of Regulations under the requirements of the Administrative Procedures Act (APA). Any changes proposed after the Plan is implemented will be published in accordance with the APA with appropriate periods for comment and review/consideration of comments.
- 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))

Delaware has no federally or State-recognized Indian tribes. Any Delaware resident, including those who are American Indians or Alaska natives, may participate in the review of amendments to State law or regulation and may offer comments on all Program policies, including those relating to provision of child health assistance to American Indian or Alaska native children. The process for review and comment is outlined in 9.9.2 below.

- 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).

Delaware will publish, concurrent with Plan submission, notice in the State's Register of Regulations under the requirements of the Administrative Procedures Act (APA). Any changes proposed after the Plan is implemented will be published in accordance with the APA with appropriate periods for comment and review/consideration of comments.

- 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

STATE: Delaware	CHIP Health Service Initiative	Cost Projection of Approved CHIP Plan	Total
Federal Fiscal Year	FFY 2019	FFY 2019	FFY 2019
State's enhanced FMAP rate	93.29%	93.29%	93.29%
Benefit Cost			
Insurance Payments			
Managed care		\$29,781,503	\$29,781,503
per member/per month rate		8,732 / \$284.22	
Fee for Service		\$6,763,666	\$6,763,666
Total Benefit Costs		\$36,545,169	\$36,545,169
(Offsetting beneficiary cost sharing payments)		(\$900,000)	(\$900,000)
Net Benefit Costs		\$35,645,169	\$35,645,169
Cost of Proposed SPA Changes - Benefit	\$49,500	\$49,500	\$49,500
Administrative Costs			
Personnel		\$100,000	\$100,000
General Administration		\$369,298	\$369,298
Contractors/Brokers		\$267,115	\$267,115
Claims Processing		\$756,508	\$756,508
Outreach/marketing costs			
Health Services Initiatives		\$98,880	\$98,880
Other			
Total Administrative Costs		\$1,591,801	\$1,591,801
10% Administrative Cap		\$3,723,697	\$3,723,697
Cost of Proposed SPA Changes	\$49,500	\$49,500	\$49,500
Federal Share	\$46,179	\$34,738,369	\$34,738,369
State Share	\$3,321	\$2,498,601	\$2,498,601
Total Program Costs	\$49,500	\$37,236,970	\$37,236,970

Budget Assumptions

- Rate of Client growth will increase an average of 2% in FY 2019;
- Capitation rates paid to commercial managed care organizations will increase an average of 8.3% based on new contracts;
- Enhanced Federal FMAP will be 93.29% effective October 1, 2018

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: Sources of non-federal funds are General Funds, transfers from the Dept. of Children, Youth & Families and client premiums.

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. Applicant and Enrollee Protections (Sections 2101(a))

- Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

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

Note: Delaware is using Medicaid Fair Hearing Practices and Procedures for review of eligibility and enrollment, as follows:

Timely written notices of agency actions are provided to applicants and recipients that include a statement of the right to a fair hearing, how to request a hearing, and a statement that he or she may represent him or herself or may be represented by counsel or by another person. An opportunity for a fair hearing will be provided to any individual requesting a hearing who is dissatisfied with a decision of the Division of Social Services, (i.e., denial, suspension, reduction, delays, termination, disenrollment for failure to meet premium payment requirements). If the recipient requests a hearing within the timely notice period, enrollment will not be suspended, reduced, discontinued, or terminated until a decision is reached after a fair hearing.

The hearing officer will be an impartial official and may not have been previously involved with the matters raised at the hearing outside his duties as hearing officer. The notice of the hearing informs the applicant or recipient of the hearing procedures and of the opportunity to examine the record prior to the hearing.

The decision of the hearing officer shall be in writing and shall be sent to the appellant as soon as it is made but not more than 90 days after the date the appeal is filed.

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.

Note: Delaware is using Medicaid Fair Hearing Practices and Procedures for review of health service matters, as follows:

MCOs must give clients due process rights when it denies, reduces, or terminates a client's health service; it must notify the client or his/her authorized representative in writing of the right to file a complaint/grievance. The notice shall explain: 1) how to file a complaint/grievance with the MCO; 2) how to file a complaint grievance with the State; 3) that filing a complaint/grievance through the MCO's complaint grievance process is not a prerequisite to filing for a State hearing; 4) the circumstances under which health services will be continued pending a complaint/grievance; 5) any right to request an expedited complaint/grievance; 6) the right to advised or represented by an ombudsman, lay advocate, or attorney; and, 7) the right to request that a disinterested third party who works for the MCO assist in the writing of the complaint/grievance.

The MCO will notify the client of complaint/grievance resolution or schedule a date for the Grievance Committee non-expedited formal hearing within ten (10) calendar days of receipt of the request for the formal hearing. The complaint/grievance formal hearing must take place within thirty (30) calendar days of receipt of the written complaint/grievance (nonexpedited formal hearing). The MCO must render a decision to the client within thirty (30) calendar days of receipt of the written

complaint/grievance (nonexpedited). If the decision affirms denial, reduction, or termination of a client's health service or in any way denies the resolution sought, the client will be informed of the right to apply for a fair hearing.

The MCO must ensure that the MCO's complaint/grievance system cannot be prerequisite to, nor a replacement for, the client's right to appeal to the Division of Social Services and request a fair hearing in accordance with 42 CFR 431, Subpart E.

The MCO must comply with DSS hearing rules and final hearing decisions.

The MCO will provide for an expedited formal complaint/grievance hearing (twenty-four (24) to forty-eight (48) hours) for any action, which seriously jeopardizes the client's health or well-being.

- 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.

N/A for Delaware