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

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

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

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

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

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

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

Name: Drew Gonshorowski Position/Title: Director; Div of Medicaid & LTC Name: Crystal Georgiana Position/Title: Administrator II; Div of Medicaid & LTC ***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, and Baltimore, Maryland 21244-1850.**
Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA)

renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

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

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

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

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

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

The template includes the following sections:

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

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

7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)

8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of preexisting medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)

9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)

10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)

11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart
I)

12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given

the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

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

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

Medicaid Expansion- CHIP SPA Requirements

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

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

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

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

Medicaid Expansion- Medicaid SPA Requirements

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

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

- 12 (Applicant and Enrollee Protections) indicating State

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

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

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

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

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

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

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

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

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

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))
Children from conception to birth are reviewed for eligibility under Nebraska's separate CHIP referred to as 599 CHIP. Children birth up to age 19 will be reviewed for eligibility under Nebraska's Medicaid expansion program.

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

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

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

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

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

Original Plan

On May 13, 1998, Nebraska submitted a Title XXI State Plan, Kids Connection Phase I, to expand Medicaid eligibility for individuals age 15 through 18 to 100 Percent of the Federal Poverty Level (FPL).

Effective Date: May 1, 1998
Implementation Date: May 1, 1998

Amendment
SPA # 1, Purpose: Implement Phase II of Kids Connection, to expand Medicaid eligibility for children through age 18 up to 185 percent of the Federal Poverty Level (FPL).
Effective Date: August 1, 1998
Implementation Date: September 1, 1998

SPA # 2, Purpose: Updates and amends the CHIP State Plan to indicate the State's compliance with the final CHIP regulations.
Effective Date: June 27, 2002
Implementation Date: August 24, 2001

SPA # 3, Purpose: Expand the income eligibility level for children in CHIP from the current income level of 185% of the Federal Poverty Level (FPL) up to and including 200% of the FPL.

Effective Date: October 1, 2009
Implementation Date: October 1, 2009

SPA # 4, Purpose: Obtain Federal matching funds to expand eligibility to uninsured non-citizen, targeted low-income children who have gross family incomes up to and including 200 percent of the Federal poverty level, and who are lawfully residing in the United States, as permitted by section 214 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009.

Effective Date: July 1, 2010
Implementation Date: July 1, 2010

SPA # 5, Purpose: CMS determined that SPA # 5 was not needed. Nebraska is a Medicaid Expansion state. Nebraska follows the Nebraska Medicaid tribal SPA #11-15 that was approved October 13, 2011 with an effective/implementation date of July 1, 2011.

Effective Date: N/A
Implementation Date: N/A

SPA # 6, Purpose: Provide Federal funding for the Nebraska Regional Poison Center (NRPC) under a health services initiative.

Effective Date: January 1, 2012
Implementation Date: January 1, 2012

SPA # 7, Purpose: Legislative bill 599 instructed Nebraska to create a separate CHIP program for unborn/prenatal coverage. The creation of the new separate CHIP program changed Nebraska from a Medicaid Expansion State to a Combination State.

Effective Date: July 19, 2012
Implementation Date: July 19, 2011

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
NE -13-0008 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS9 CS15	Eligibility – Coverage from Conception to Birth 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
NE-13-0009 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
NE-13-0010 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
NE-13-0011 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
NE-13-0012 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility General Eligibility	CS17 CS18 CS19 CS27	Residency Citizenship Social Security Number Continuous Eligibility	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0; 4.1.1-LR; 4.1.1-LR Supersedes the current section 4.1.9.1 Supersedes the current section 4.1.8

NE-24-0007	General Eligibility	CS27	Continuous Eligibility	Supersedes the current CS27.

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Effective/Implementation Date: January 1, 2024				

SPA # 13, Purpose: Update the State Plan to change the delivery system for the separate CHIP from fee-forservice to managed care.

Effective Date: January 1, 2017
Implementation Date: January 1, 2017

SPA # 14, Purpose: Update the State Plan to comply with Mental Health Parity

Effective Date: October 2, 2017
Implementation Date: October 2, 2017

SPA # 15, Purpose: Update the State Plan to comply with the CHIP Managed Care regulation Effective Date: July 1, 2018
Implementation Date: July 1, 2018

SPA # 16, Purpose: CHIP Disaster SPA
In the event of a disaster, the State will notify CMS of the intent to provide temporary adjustments to tribal notification, State delay in processing the applications, State delay in processing renewals and extension of renewals and deadlines for families, and extend the reasonable opportunity period, temporarily provide presumptive eligibility, the effective dates of such adjustments, and the specific areas impacted by the state or Federal disaster, if applicable.

Effective Date: March 1, 2020
Implementation Date: March 1, 2020
For the COVID-19 public health emergency Nebraska will invoke the flexibilities described above beginning March 1, 2020 through the duration of the State or Federal emergency declaration, whichever is later.

SPA #17, Purpose: Update the State Plan to comply with Section 5022 of the SUPPORT Act.
Effective Date: January 1, 2020
Implementation Date: January 1, 2020

SPA #18: NE-22-0004

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

SPA#19: NE-24-0015

Purpose of SPA: The purpose of this SPA is to assure coverage of age-appropriate vaccines and their administration without cost sharing, and continuous eligibility for children.
Proposed effective date: October 1, 2023 for vaccines, January 1, 2024 for continuous eligibility.
Proposed implementation date: October 1, 2023 for vaccines, January 1, 2024 for continuous eligibility.

SPA #20: NE-25-0006

Purpose of SPA: Update Section 9, Strategic Objectives and Performance Goals and Plan Administration, to align with Section IV of the CHIP Annual Report.

Proposed effective date: December 31, 2024.

Proposed implementation date: December 31, 2024.

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.

Tribal notice was provided to all Nebraska tribes on November 21, 2024. No comments were received.

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))

According to the U.S. Census Bureau, ACS 2015 5-year estimates, found in Table B27016: Health Insurance, Nebraska had 174,000 children below 200% of poverty. Of those, 158,000 had health coverage, and 16,000 did not. Numbers are rounded to the thousands. There was no state-level data available regarding the nature of coverage.

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 457.1005.

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)

Nebraska will use the health services initiative option allowed at 42 CFR 457.10 to support the Nebraska Regional Poison Center (NRPC). Poison treatment advice and prevention through NRPC will be supported using CHIP funds available under the 10 percent federal administrative expenditures cap. NRPC will not supplant or match CHIP Health Services Initiatives (HSI) Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds. The NRPC provides emergency telephone treatment advice, referral assistance, and information to manage exposure to poisonous and hazardous substances. NRPC operates 24 hours a day, seven days a week at no charge to the public with full information and treatment capabilities. At all times, Specialists in Poison Information (SPIs), Certified Specialists in Poison Information (CSPIs), and toxicologist are available to manage cases. The services are provided via a toll-free telephone number to all communities throughout Nebraska, including underserved, low income, and indigent populations. Services are available by use of an

interpreter in over 150 languages and telecommunication devices are used for the deaf and hearing impaired.

NRPC public education programs on poisoning response and prevention direct attention and resources to at-risk children, adolescents and adults living in poverty, including minority and immigrant communities. The NRPC works closely with schools, healthcare organizations, parenting groups, and childcare providers throughout Nebraska to promote poison awareness. It partners with community health programs such as the Nebraska Injury Prevention Coalition and Safe Kids Coalition groups. Each year, the NRPC and its community partners provide education programs to over 30,000 children, parents and caregivers throughout Nebraska. In addition, over 150,000 educational brochures, telephone stickers and magnets are distributed throughout Nebraska each year. Materials have been developed in English and Spanish.

Approximately 17,000 calls from Nebraska are received annually by NRPC. Seventy-two percent of all poisoning exposure calls received by NRPC involve children. Over 27% of the total calls relate to poisoning exposures of children in families whose annual household incomes are no more than 200% FPL. In addition to calls regarding exposures, the NRPC receives over 10,000 calls each year from Nebraskans requesting poison or drug information. These calls are considered preventive.
NRPC calculated the number of children below 200% by tracking the total number of calls; the ages of the person involved and then estimated the number of children below 200% based on The Kids Count Data Center statistics that estimates 38% of Nebraska children are living in household with incomes no greater than 200% FPL.

NRPC intervention resulted in over 90% of the exposure calls (in children less than six years of age) being handled in the home so the children did not have to use an emergency department or need a 911 call and response. Each call to the NRPC significantly reduces costs in other medical spending. A recent study in the Journal of Medical Toxicology showed a median of 36 dollars in unnecessary healthcare charges were prevented for each dollar spent supporting a poison center.

The NRPC public toll-free number is listed in the emergency section of all Nebraska telephone directories. The number is also included in numerous community directories throughout Nebraska.

NRPC nearly closed in 2003 when their primary sponsoring/funding agency was no longer able to continue to support the service. At that time, several agencies in the state (DHHS Dept. of Health, the University of Nebraska Medical Center, The Nebraska Medical Center, and Creighton University) saw the value that the poison center provides to the state and provided last-minute funding to keep the poison center open. Much of the funding was temporary and many of those revenue sources have either been decreased or eliminated. This left NRPC in an unstable funding situation with a $900,000 deficit three

years ago. During 2008, NRPC was able to begin receiving $200,000 from the state's healthcare cash fund. In 2009 they started asking other hospitals for support, which helped decreased their deficit, but additional funding was needed to stabilize NRPC. Unfortunately, the federal funding that poison centers receive through HRSA grants was decreased in 2011. Without the CHIP funding, the Nebraska Regional Poison Center will not have the operating funds to continue to provide services to the citizens of Nebraska. The Nebraska Regional Poison Center will retain 100 percent of the total computable funds (State and Federal) made available each year through the Health Services Initiative (up to the administrative funds cap). The funds provided for the Nebraska Regional Poison Center (NRPC) from the Health Services Initiative will only provide funding for costs that are directly related to the provision of services by the NRPC.

Nebraska will only utilize administrative cap money to help fund NRPC through the University of Nebraska Medical Center (UNMC) cash fund. EFMAP will not be claimed for HSI activities that took place prior to the effective date of the SPA or prior to CHIP funds being incurred for approved costs. These funds will be used to help offset the cost of treatment for low income children. UNMC shall transfer an amount through an Intergovernmental Transfer (IGT), not to exceed $250,000, to DHHS for the state match so that UNMC can receive the federal CHIP matching funds. When the Department receives the transferred amount (or any portion thereof) and the matching federal funds, the Department shall transfer the combined funds to the UNMC Cash Fund for operation of the NRPC. UNMC is a state entity that qualifies for an intergovernmental transfer agreement under Nebraska State law and is the mechanism currently used in the reimbursement of the upper payment limit to UNMC's physician practice under an amendment to the Nebraska State Medicaid Plan. UNMC and NRPC will not supplant or match CHIP Federal funds with other Federal Funds, nor allow other Federal funds to supplant or match CHIP Federal funds. UNMC shall annually report to the Legislative Fiscal Analyst the amounts transferred, on or before October 1st of every year.

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

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

Nebraska follows our Medicaid tribal SPA #11-15 approved October 13, 2011. Nebraska will continue to follow the Medicaid tribal SPA for the separate CHIP.

Nebraska regularly holds tribal consultation calls. These calls are used to discuss the state plan amendments, provide additional information, and answer questions. In person meetings are also held with the tribes on a regular basis.

Section 3. Methods of Delivery and Utilization Controls

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

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

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

3.1.1 Choice of Delivery System

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

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

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

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

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

Beginning January 1, 2017, integrated physical health, behavioral health, and pharmacy services are delivered by a managed care delivery system. This program will be called Heritage Health. Managed care services will be provided by three Managed Care Organization (MCO), state wide as shown in the chart below.

City/County/Region	**Type of Program (PCCM, MCO, PIHP, or PAHP)**
Statewide Lancaster, Douglas and Sarpy, Cass, Dodge, Gage, Otoe, Saunders, Seward, Washington Adams, Antelope, Arthur, Banner, Blaine, Boone, Box Butte, Boyd, Brown, Buffalo, Burt, Butler, Cedar, Chase, Cherry, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dawes, Dawson, Deuel, Dixon, Dundy, Fillmore, Franklin, Frontier, Furnas, Garden, Garfield, Gosper, Grant, Greeley, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Howard, Jefferson, Johnson, Kearney, Keith, Keya Paha, Kimball, Knox, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Morrill, Nance, Nemaha, Nuckolls, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Scottsbluff, Sheridan, Sherman, Sioux, Stanton, Thayer, Thomas, Thurston, Valley, Wayne, Webster, Wheeler, and York counties.	MCO

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))

A primary goal of Heritage Health is to manage utilization more efficiently and effectively. Nebraska Medicaid, through its partnership with the Heritage Health plans ("the plans"), implement various utilization controls.

The plans must employ the appropriate staff. As part of their care management operations, the plans must employ multidisciplinary clinical staff, care coordinators, and care managers to arrange, assure delivery of, monitor, and evaluate basic and comprehensive care, treatment, and services to members. The plans must ensure an adequate ratio of staff to members to perform all care management functions. Sufficient staff must be available to respond at any time to members, their families/caregivers, or other interested parties calling on behalf of a member. The plans must ensure that only licensed clinical staff operating within the scope of their training and professional licenses make decisions regarding medical necessity.

Along with sufficiently employing staff with adequate knowledge, the plans must provide education materials to both providers and members related to utilization. The plans must educate parents/guardians to assist them in making responsible decisions about preventive health care and appropriate utilization of health care services for their children. The plans are also responsible for educating members on the appropriate utilization of ER services, including behavioral health emergencies. In addition, the plans must educate providers regarding the utilization management requirements, including procedures for service authorizations, concurrent review, extensions of lengths of stay, and retrospective reviews for all covered services.

While the plans are largely responsible for the above-mentioned utilization management methods, the plans must apply partnerships to manage utilization better. The plans must establish an internal utilization management committee that focuses on oversight of clinical service delivery trends across its membership, including evaluating utilization/patterns of care and key utilization indicators. The utilization management committee must be chaired or co-chaired by the Medical Director and must report its findings to the quality assurance and performance improvement committee (QAPIC).

As for the QAPIC, the plan must provide a mechanism for the input and participation of members, families/caretakers, providers, Division of Medicaid and Long-Term Care (MLTC), and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes. The plans must also convene additional committees including a utilization management committee.

Finally, all of these efforts would be futile without applicable utilization data. Data analysis must consider the performance from the previous year, and reported rates must clearly identify the numerator and denominator used to calculate each rate. The data analysis must provide, at a minimum, information about quality of care, service utilization, member and provider satisfaction, and grievances and appeals. The plans must collect the data from administrative systems, medical records, and member and provider surveys. The plans must also collect data on member and provider characteristics as specified by MLTC, and about services furnished to members through the plans' encounter data system. The plans must ensure that data received from providers is accurate and complete by: verifying the accuracy and timeliness of reported data, screening the data for completeness, logicalness, and consistency, collecting service information using MLTC-developed templates.

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.

Non-Emergency Medical Transportation (NEMT) is carved out of the managed care delivery system.

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: Both the MCHIP and SCHIP populations are served under managed care.

☐ Prepaid inpatient health plan (PIHP) (42 CFR 457.10)
  ☐ Capitation payment
  ☐ Other (please explain)
  Describe population served:

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

☐ Prepaid ambulatory health plan (PAHP) (42 CFR 457.10)
  ☐ Capitation payment
  ☐ Other (please explain)
  Describe population served:

☐ Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)

☐ Case management fee
☐ Other (please explain)

☐ Primary care case management entity (PCCM Entity) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Shared savings, incentive payments, and/or other financial rewards for improved quality outcomes (see 42 CFR 457.1240(f))
- ☐ Other (please explain)

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

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

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

3.1.3 Nonemergency Medical Transportation PAHPs

Guidance: Only complete Section 3.1.3 if the State uses a PAHP to exclusively provide non-emergency medical transportation (a NEMT PAHP). If a NEMT PAHP is the only managed care entity for CHIP in the State,

please continue to Section 4 after checking the assurance below. If the State uses a PAHP that does not exclusively provide NEMT and/or uses other managed care entities beyond a NEMT PAHP, the State will need to complete the remaining sections within Section 3.

☐ The State assures that it complies with all requirements applicable to NEMT PAHPs, and through its contracts with such entities, requires NEMT PAHPs to comply with all applicable requirements, including the following (from 42 CFR 457.1206(b)):

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

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

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

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

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

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

☒ Based on public or private payment rates for comparable services for comparable populations; and

☒ Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

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

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

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

3.3.3 ☒ The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance

with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))

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

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

- ☐ No, the State does not require any MCO, PIHP, or PAHP to pay remittances.
- ☒ Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.
- ☐ Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

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

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

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

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

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

3.4 Enrollment

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

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

3.4.1 Enrollment Process

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

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

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

☒ Yes
☐ No

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

☒ The State assigns beneficiaries only to qualified MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities that are not subject to the intermediate sanction of having suspension of

all new enrollment (including default enrollment) under 42 CFR 438.702 and have capacity to enroll beneficiaries. (42 CFR 457.1210(a)(1)(i))

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

3.4.2 Disenrollment

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

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

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

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

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

Guidance: Reasons for disenrollment by the MCO, PIHP, PAHP, PCCM, and PCCM entity must be specified in the contract with the State.

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

3.4.2.5 Enrollee Requests for Disenrollment.

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

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

☒ Yes
☐ No

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

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

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

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

- During the 90 days following the date of the beneficiary's initial

enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;

- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

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

3.5 Information Requirements for Enrollees and Potential Enrollees

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

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

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

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

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

3.5.5 ☒ If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this

box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:

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

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

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

3.5.7 ☒ The State assures that the State or its contracted representative provides the information specified in 42 CFR 457.1207, cross-referencing to 438.10(e)(2), and includes the information either in paper or electronic format, to all potential enrollees at the time the potential enrollee becomes eligible to enroll in a voluntary managed care program or is first required

to enroll in a mandatory managed care program and within a timeframe that enables the potential enrollee to use the information to choose among the available MCOs, PIHPs, PAHPs, PCCMs and PCCM entities:

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

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

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

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

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

- Information that enables the enrollee to understand how to effectively use the managed care program, which, at a minimum, must include:
  - Benefits provided by the MCO, PIHP, PAHP or PCCM entity;
  - How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided; and
  - In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity and how they can obtain information from the State about how to access these services;
- The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided, including:
  - What constitutes an emergency medical condition and emergency services;
  - The fact that prior authorization is not required for

emergency services; and
    - The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care;
- Any restrictions on the enrollee's freedom of choice among network providers;
- The extent to which, and how, enrollees may obtain benefits, including family planning services and supplies from out-of-network providers;
- Cost sharing, if any is imposed under the State plan;
- Enrollee rights and responsibilities, including the elements specified in 42 CFR §438.100;
- The process of selecting and changing the enrollee's primary care provider;
- Grievance, appeal, and review procedures and timeframes, consistent with 42 CFR 457.1260, in a State-developed or State-approved description, including:
    - The right to file grievances and appeals;
    - The requirements and timeframes for filing a grievance or appeal;
    - The availability of assistance in the filing process; and
    - The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee;
- How to access auxiliary aids and services, including additional information in alternative formats or languages;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees; and
- Information on how to report suspected fraud or abuse.

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

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

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

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

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

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

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

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

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

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

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

3.5.18 ☒ The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in

accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

3.6 Benefits and Services

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

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

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

3.6.3 ☒ The State assures that it:

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

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

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

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

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

services. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)

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

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

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

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

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

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

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

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

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

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

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

3.6.13 ☒ The State assures that its contracts with each MCO, PIHP, or PAHP require each MCO, PIHP, or PAHP to notify the requesting provider and

given written notice to the enrollee of any adverse benefit determination to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 CFR 457.1230(d), cross-referencing to 42 CFR 438.210(c))

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

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

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

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services;
- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;
- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and

- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

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

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

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

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

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

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

3.7 Operations

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

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

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

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

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

- ☒ The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;

☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;

☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable subregulatory guidance and contract provisions; and

☒ The subcontractor agrees to the audit provisions in 438.230(c)(3).

3.7.4 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP, adopts and disseminates practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of the MCO's, PIHP's, or PAHP's enrollees; are adopted in consultation with network providers; and are reviewed and updated periodically as appropriate. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(b) and (c))

3.7.5 ☒ The State assures that each contracted MCO and, when applicable, each PIHP and PAHP makes decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines. (42 CFR 457.1233(c), cross referencing 42 CFR 438.236(d))

3.7.6 ☒ The State assures that each contracted MCO, PIHP, and PAHP maintains a health information system that collects, analyzes, integrates, and reports data consistent with 42 CFR 438.242. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of CHIP eligibility. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.7 ☒ The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the

MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

3.7.8 ☒ The State assures that it will submit to CMS all encounter data collected, maintained, submitted to the State by the MCO, PIHP, and PAHP once the State has reviewed and validated the data based on the requirements of 42 CFR 438.242. (CMS State Medicaid Director Letter #13-004)

3.7.9 ☒ The State assures that each contracted MCO, PIHP and PAHP complies with the privacy protections under 42 CFR 457.1110. (42 CFR 457.1233(e))

3.8 Beneficiary Protections

3.8.1 ☒ The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in 42 CFR 438.100. (42 CFR 457.1220, cross-referencing to 42 CFR 438.100(a)(1))

3.8.2 ☒ The State assures that its contracts with an MCO, PIHP, PAHP, PCCM, or PCCM entity include a guarantee that the MCO, PIHP, PAHP, PCCM, or PCCM entity will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources. (42 CFR 457.1201(p))

3.8.3 ☒ The State assures that MCOs, PIHPs, and PAHPs do not hold the enrollee liable for the following:

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

3.9 Grievances and Appeals

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

3.9.1 ☒ The State assures that each MCO, PIHP, and PAHP has a grievance and appeal system in place that allows enrollees to file a grievance and request an appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c))

3.9.2 ☒ The State assures that each MCO, PIHP, and PAHP has only one level of appeal for enrollees. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(b))

3.9.3 ☒ The State assures that an enrollee may request a State review after receiving notice that the adverse benefit determination is upheld, or after an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in 42 CFR 438.408. (42 CFR 457.1260, cross-referencing to 438.402(c))

3.9.4. Does the state offer and arrange for an external medical review?

☐ Yes
☒ No

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

3.9.5 ☐ The State assures that the external medical review is:

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

3.9.6 ☒ The State assures that an enrollee may file a grievance with the MCO, PIHP, or PAHP at any time. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(i))

3.9.7 ☒ The State assures that an enrollee has 60 calendar days from the date on an adverse benefit determination notice to file a request for an appeal to the MCO, PIHP, or PAHP. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(2)(ii))

3.9.8 ☒ The State assures that an enrollee may file a grievance and request an appeal either orally or in writing. (42 CFR 457.1260, cross-referencing to 42 CFR 438.402(a) and 438.402(c)(3)(i))

3.9.9 ☒ The State assures that each MCO, PIHP, and PAHP gives enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below in Section 3.9.10 and in 42 CFR 438.10.

3.9.10 ☒ The State assures that the notice of an adverse benefit determination explains:

- The adverse benefit determination.
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
- The enrollee's right to request an appeal of the MCO's, PIHP's, or PAHP's adverse benefit determination, including information on exhausting the MCO's, PIHP's, or PAHP's one level of appeal and the right to request a State review.
- The procedures for exercising the rights specified above under this assurance.
- The circumstances under which an appeal process can be expedited and how to request it. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(b))

3.9.11 ☒ The State assures that the notice of an adverse benefit determination is provided in a timely manner in accordance with 42 CFR 457.1260. (42 CFR 457.1260, cross-referencing to 42 CFR 438.404(c))

3.9.12 ☒ The State assures that MCOs, PIHPs, and PAHPs give enrollees reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(a))

3.9.13 The state makes the following assurances related to MCO, PIHP, and PAHP processes for handling enrollee grievances and appeals:

☒ Individuals who make decisions on grievances and appeals were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

☒ Individuals who make decisions on grievances and appeals, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the enrollee's condition or disease:
- An appeal of a denial that is based on lack of medical necessity.
- A grievance regarding denial of expedited resolution of an appeal.
- A grievance or appeal that involves clinical issues.

☒ All comments, documents, records, and other information submitted by the enrollee or their representative will be taken into account, without regard to whether such information was submitted or considered in the initial adverse benefit determination.

☒ Enrollees have a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

☒ Enrollees are provided the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals.

☒ The enrollee and his or her representative or the legal representative of a deceased enrollee's estate are included as parties to the appeal. (42 CFR 457.1260, cross-referencing to 42 CFR 438.406(b))

3.9.14 ☒ The State assures that standard grievances are resolved (including notice to the affected parties) within 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(b))

3.9.15 ☒ The State assures that standard appeals are resolved (including notice to the affected parties) within 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. The MCO, PIHP, or PAHP may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or the MCO, PIHP, or PAHP shows that there is need for additional information and that the delay is in the enrollee's interest. (42 CFR 457.1260, cross-referencing to 42 CFR 42 CFR 438.408(b) and (c))

3.9.16 ☒ The State assures that each MCO, PIHP, and PAHP establishes and maintains an expedited review process for appeals that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. The expedited review process applies when the MCO, PIHP, or PAHP

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

3.9.17 ☒ The State assures that if an MCO, PIHP, or PAHP denies a request for expedited resolution of an appeal, it transfers the appeal within the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2). (42 CFR 457.1260, cross-referencing to 42 CFR 438.410(c)(1))

3.9.18 ☒ The State assures that if the MCO, PIHP, or PAHP extends the timeframes for an appeal not at the request of the enrollee or it denies a request for an expedited resolution of an appeal, it completes all of the following:

- Make reasonable efforts to give the enrollee prompt oral notice of the delay.
- Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.
- Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c) and 42 CFR 438.410(c))

3.9.19 ☒ The State assures that if an MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process and the enrollee may initiate a State review. (42 CFR 457.1260, cross-referencing to 42 CFR 438.408(c)(3))

3.9.20 ☒ The State assures that has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

3.9.21 ☒ For all appeals, the State assures that each contracted MCO, PIHP, and PAHP provides written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR 438.10. The notice of resolution includes at least the following items:

- The results of the resolution process and the date it was completed; and

- For appeals not resolved wholly in favor of the enrollees:
  - The right to request a State review, and how to do so.
  - The right to request and receive benefits while the hearing is pending, and how to make the request.
  - That the enrollee may, consistent with State policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(2)(i) and (e))

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

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

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

3.9.25 ☒ The State assures that MCOs, PIHPs, or PAHPs must provide information specified in 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. This includes:
- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a State review after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and
- The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State review within the timeframes specified for filing, and that the enrollee may, consistent with State policy, be required to pay the cost of services furnished while the appeal or State review is pending if the final decision is

adverse to the enrollee. (42 CFR 457.1260, cross-referencing to 42 CFR 438.414)

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

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

3.10 Program Integrity

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

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

3.10.1 The State assures that any entity seeking to contract as an MCO, PIHP, or PAHP under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse, including:

- ☒ Enforcing MCO, PIHP, and PAHP compliance with all applicable Federal and State statutes, regulations, and standards;
- ☒ Prohibiting MCOs, PIHPs, or PAHPs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity; and
- ☒ Including a mechanism for MCOs, PIHPs, and PAHPs to report to the State, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors, providers, or enrollees of an MCO, PIHP, or PAHP and other individuals. (42 CFR 457.1280)

3.10.2 ☒ The State assures that it has in effect safeguards against conflict of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to the MCO, PIHP, or PAHP contracts or enrollment processes described in 42 CFR 457.1210(a). (42 CFR 457.1214, cross referencing 42 CFR 438.58)

3.10.3 ☒ The State assures that it periodically, but no less frequently than once every 3 years, conducts, or contracts for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP. (42 CFR 457.1285, cross referencing 42 CFR 438.602(e))

3.10.4 ☒ The State assures that it requires MCOs, PIHPs, PAHP, and or subcontractors (only to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims) implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following:

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

abuse that the MCO, PIHP, or PAHP identifies to the State Medicaid/CHIP program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit; and

- Provision for the MCO's, PIHP's, or PAHP's suspension of payments to a network provider for which the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23. (42 CFR 457.1285, cross referencing 42 CFR 438.608(a))

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

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

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

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

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

3.10.10 ☒ The State assures that it receives and investigates information from whistleblowers relating to the integrity of the MCO, PIHP, PAHP, PCCM,

or PCCM entity, subcontractors, or network providers receiving Federal funds under this part. (42 CFR 457.1285, cross referencing 42 CFR 438.602(f))

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

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

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

3.10.13 The State assures that:

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

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

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

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

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

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

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

3.11 Sanctions

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

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

3.11.1 ☒ The State assures that it has established intermediate sanctions that it may impose if it makes the determination that an MCO has acted or failed to

act in a manner specified in 438.700(b)-(d). (42 CFR 457.1270, cross referencing 42 CFR 438.700)

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

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

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

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

☐ Yes
☐ No

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

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

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

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

3.12 Quality Measurement and Improvement; External Quality Review

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

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

3.12.1 Quality Strategy

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

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

- The State-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by 42 CFR 438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with 42 CFR 438.236;
- A description of:
  - The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with 42 CFR 438.330(c); and
  - The performance improvement projects to be implemented in accordance with 42 CFR 438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP;
- Arrangements for annual, external independent reviews, in accordance with 42 CFR 438.350, of the quality outcomes and timeliness of, and access to, the services covered under each contract;
- A description of the State's transition of care policy required under 42 CFR 438.62(b)(3);
- The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, and primary language;

- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of 42 CFR Part 438;
- A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity;
- The mechanisms implemented by the State to comply with 42 CFR 438.208(c)(1) (relating to the identification of persons with special health care needs);
- Identification of the external quality review (EQR)-related activities for which the State has exercised the option under 42 CFR 438.360 (relating to nonduplication of EQR-related activities), and explain the rationale for the State's determination that the private accreditation activity is comparable to such EQR-related activities;
- Identification of which quality measures and performance outcomes the State will publish at least annually on the Web site required under 42 CFR 438.10(c)(3); and
- The State's definition of a "significant change" for the purposes of updating the quality strategy under 42 CFR 438.340(c)(3)(ii). (42 CFR 457.1240(e), cross referencing to 42 CFR 438.340(b))

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

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

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

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

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

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

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

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

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

3.12.2 Quality Assessment and Performance Improvement Program

3.12.2.1 Quality Assessment and Performance Improvement Program: Measures and Projects

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

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

- Standard performance measures specified by the State;
- Any measures and programs required by CMS (42 CFR 438.330(a)(2);
- Performance improvement projects that focus on clinical and non-clinical areas, as specified in 42 CFR 438.330(d);

- Collection and submission of performance measurement data in accordance with 42 CFR 438.330(c);
- Mechanisms to detect both underutilization and overutilization of services; and
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State in the quality strategy under 42 CFR 457.1240(e) and Section 3.12.1 of this template). (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(b) and (c)(1))

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

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

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

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

3.12.2.1.3 ☐ The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program

for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4) (related to dual eligibles) do not apply. The assessment and program must include:

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

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

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

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

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

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

- The MCO's, PIHP's, PAHP's, and PCCM entity's performance on the measures on which it is required to report; and
- The outcomes and trended results of each MCO's,

PIHP's, and PAHP's performance improvement projects. (42 CFR 457.1240(b), cross referencing to 42 CFR 438.330(e)(1))

3.12.3 Accreditation

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

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

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

3.12.4 Quality Rating

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

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

Guidance: States will be required to comply with this assurance within 3 years after CMS, in consultation with States and other Stakeholders and after providing public notice and opportunity for comment, has identified

performance measures and a methodology for a Medicaid and CHIP managed care quality rating system in the Federal Register.

3.12.5 Quality Review

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

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

3.12.5.1 External Quality Review Organization

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

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

3.12.5.2 External Quality Review-Related Activities

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

3.12.5.2.1 ☒ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects,

validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1))

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

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

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

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

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

3.12.5.3 External Quality Review Report

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

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

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

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

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

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

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));
- For each EQR-related activity (mandatory or optional)

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

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

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

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

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

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

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

Section 4. Eligibility Standards and Methodology

Guidance: The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Included on the template is a list of potential eligibility standards. Please check off the standards that will be used by the state and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, describe how they will be applied and under what circumstances they will be applied.

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

4.0. ☒ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group: Birth up to age 19, at or below 200% 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))

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

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

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

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

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

4.1.3.1-PC ☒ 0% of the FPL (and not eligible for Medicaid) through__185__% 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): No Asset Test

4.1.5 ☒ Residency (so long as residency requirement is not based on length of
Time in state): Must be a resident of Nebraska.

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: The Nebraska application asks for insurance status of the unborn child. Unborn children with existing health insurance are denied eligibility for Nebraska 599 CHIP. Insurance policies that do not offer prenatal care will be reviewed by Policy staff in order to determine if the unborn has creditable insurance prior to any approval.

4.1.8 ☒ Duration of eligibility, not to exceed 12 months: Eligible unborn children in 599 CHIP with income at or below 185% FPL will have six months of continuously eligibility beginning with the month of determination through the sixth month or birth,

whichever comes first.

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:

Must not be a resident of an institution or a patient in an institution for mental diseases or an inmate living in a public institution.

There is no immigration requirement for the unborn child.

599 CHIP children are not eligible for presumptive, retroactive coverage or spend downs.

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.
A SSN will not be required for an unborn child.

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

4.1.9.2 ☒ Continuous eligibility

At initial eligibility all children birth up to age 18 will have 6 months continuous eligibility. Unborn children will have six months of continuously eligibility beginning with the month of determination through the sixth month or birth, whichever comes first.

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 other words, a State that chooses to cover pregnant women under this option must otherwise cover pregnant women under their State plan as described in 4.1.11. 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 1993(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

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

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
(vi) Aliens currently in deferred action status; or
(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least180 days;
(6) An alien who has been granted withholding of removal under the Convention Against Torture;
(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☒ Elected for children under age ___19__.

4.1.1-LR ☒ The State provides assurance that for an individual whom it enrolls in

Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to

verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

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

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

- **4.2.1.** ☒ These standards do not discriminate on the basis of diagnosis.
- **4.2.2.** ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.
- **4.2.3.** ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

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

- **4.2.1-DS** ☐ These standards do not discriminate on the basis of diagnosis.
- **4.2.2-DS** ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- **4.2.3-DS** ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3 **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered

services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Children from birth through age 18 are eligible for 6 months of continuous medical eligibility from the date of initial eligibility unless: See the CS27 template.

1. A child attaining age 19 who does not meet another level of continuous eligibility;
2. The individual requests voluntary termination;
3. The individual ceases to be a state resident;
4. The agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual; or
5. The individual dies.

No income or resource review is required. This policy also applies to 599 CHIP eligible newborns that are found eligible at birth based on a "passive" review of information reported or known to the Department at the time of birth; a new application will not be required.

At State discretion, requirements related to timely processing of applications may be temporarily waived for CHIP applicants who reside and/or work in a State or Federally declared disaster area.

At State discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area.

At State discretion, the agency may provide for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the State or Federally declared disaster or public health emergency.

At State discretion, the State may temporarily delay acting on certain changes in circumstances affecting CHIP eligibility for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area. The state will continue to act on changes in circumstance related to residency, death, voluntary termination of coverage, and becoming eligible for Medicaid.

At State discretion, the continuous eligibility period is temporarily extended for the duration of the pregnancy that will not exceed 12 months for applicants/ beneficiaries who reside and/or work in a State or Federally declared disaster area.

At state discretion, the state may temporarily implement presumptive eligibility

consistent with the requirements of 42 CFR 457.355 for CHIP applicants working or residing in a state or federally declared disaster area.

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)(4)) (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. *Nebraska noticed the template shows two 4.3.3.3-EL sections.**

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:

At time of application and redetermination, staff first determines whether an applicant or recipient is eligible for Medicaid. If the child is not Medicaid eligible, staff assesses eligibility for CHIP or 599 CHIP, if appropriate. In

addition there are required questions on the application and review form that ask about the child's health insurance status. The State's MMIS system checks the recipient's history for third party insurance.

At application or review a child applying for, or enrolled in, CHIP will not be eligible for the program if they are covered under a group health plan or have creditable health insurance coverage; or are Medicaid eligible. 599 CHIP unborn child(ren) may have creditable health insurance if verification is provided that they have no prenatal or pregnancy coverage. Medicaid Policy staff will confirm upon review that there is no prenatal care or pregnancy related care before approval of an unborn. Following the birth a 599 CHIP child will be required to meet all eligibility criteria before CHIP will be approved.

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.

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))

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

4.4.4. ☒ the insurance provided under the State child health plan does not substitute for coverage under group health plans; states should check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR, 457.805) (42CFR 457.810(a)-(c))

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

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

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

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

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

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

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

Section 5. Outreach and Coordination

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

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

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

In addition to Medicaid, there are other programs and service delivery systems that (1) provide selected services and/or (2) work toward linking families with health services whether it be Medicaid coverage or other community resources.

To promote and provide children and youth with comprehensive services and a full continuum of care through Medicaid, the following direct and indirect outreach efforts are utilized:

- Internal electronic mail and memos are used as a vehicle to notify all staff of changes and updates on eligibility and services.

- Provider bulletins that contain policy changes and clarification and claims processing updates are issued.

- Brochures and other information are distributed to groups when presentations are made to community groups, other agencies, and professional organizations.

- News releases are issued regarding new initiatives and reports as well as when public hearings will be held.

- The Department employs a full-time system advocate accessible through an 800 number to assist individuals with questions or concerns.

- The agency communicates with the Medicaid Medical Care Advisory Committee, client advocacy groups, and other outside agencies during the rulemaking process to address and obtain input regarding policy issues and agency procedures that impact clients and providers. Public hearings are held on all regulation changes.

- The Department has developed a web page that has information about the various programs and services provided. The web page has information on medical services for children.

- The 800 numbers for agency access for information and for applications are currently listed on Insure Kids Now and CMS' website.

- The Department's Customer Service Centers and local office accept electronic, phone, mail-in, faxed and hand-delivered applications for Medicaid and CHIP eligibility.

- In addition, all Title V grantees in Nebraska are provided state-level support to identify and refer potentially eligible families to the Medicaid program whenever possible. Services for prenatal health care, preventive and primary care for children, health education, lead screening, and

adolescent pregnancy prevention and support are all provided to low-income and other at-risk populations in Nebraska through Title V funds. Large proportions of recipients of these services are identified as uninsured and are provided the support necessary to pursue health care coverage.

- Children with special health care needs who do not have health care coverage are often identified through the Medically Handicapped Children's Program (MHCP), which is Nebraska's Title V program dedicated specifically to providing specialty and subspecialty services to this population of children. MHCP services are commonly promoted by communities as a means for getting children with special health care needs into the publicly-funded health care system, particularly Medicaid. All children referred to MHCP clinics or services are screened for Medicaid and CHIP eligibility.

- In addition, the hospitals, schools, and community-based organizations that provide Early Intervention (EI) services to children with special health care needs up to three years of age are an excellent resource for identification and enrollment into Medicaid and CHIP. The EI services coordinators are very familiar with Medicaid rules and regulations, and are able to advocate on behalf of the children with whom they work to get them enrolled.

- The Medicaid agency, as part of the WIC/Medicaid interagency agreement, provides information on coverage and eligibility to WIC staff as tools for them to outreach to families currently receiving WIC benefits. Through collaborative efforts, Medicaid eligible families are contacted and provided with WIC information.

- Many of the state's schools have been enrolled as Medicaid providers of therapy services (physical, speech, and occupational) and, thus, have become more aware of Medicaid coverable services for their families. School health nurses periodically receive information on the HEALTH CHECK (EPSDT) program, and they often refer youth for assistance. School nurses receive ongoing information from the state's School Health Consultant regarding their role in providing outreach for Medicaid to uninsured children, including updates on rules and regulations, brochures, and information on EPSDT rates for the counties served by their school districts.

- With the support of their state-level grantors, immunization clinics and reproductive health clinics encourage recipients of their services who are

potentially eligible to pursue enrollment into Medicaid.

- Staff is also working with tribally-owned and leased clinics to meet the IHS/HCFA (CMS) Memorandum of Agreement terms and provide training and information on services and billing. Presentations and technical assistance have been provided.

- DHHS staff hold quarterly face to face meetings with Tribal representatives, including the Ponca Tribe, the Santee Sioux Tribe, the Omaha Tribe, and the Winnebago Tribe. Monthly phone calls are also held with the tribes. Each of the MCO's also have a fulltime tribal liaison to work directly with each tribe.

- In addition to the outreach efforts noted above the MCO's are also required to provide outreach:

- The Heritage Health plans must have full-time clinical and support staff to conduct daily business in an efficient and effective manner. This includes, but is not limited to, administration; accounting and finance; fraud and abuse; utilization management; quality management and improvement; and, member services, education, and outreach, grievances and appeals, provider services, claims processing, and reporting.
- The Heritage Health plans must have effective outreach/education that informs parents/guardians of the benefits of having their children receive EPSDT screening, diagnosis, and treatment services. This includes:
  - Education to parents/guardians to assist them in making responsible decisions about preventive health care and appropriate utilization of health care services for their children.
  - Continuing and comprehensive health care beginning with the screening.
  - Continuing through diagnosis and treatment for any conditions identified during screenings.
  - Assistance to families in making medical appointments and obtaining needed transportation.
  - The monitoring of provided EPSDT services to ensure that all services are delivered within established time frames.
- The Heritage Health plans must develop and implement a plan detailing the marketing activities it will undertake and materials it will create during the contract period. The Heritage Health plans must submit to MLTC the detailed, proposed plan for review and approval a minimum of 45 calendar days prior to the contract start date.
- The Heritage Health Plans must develop an outreach program to encourage women to seek prenatal services during their first trimester of pregnancy. This outreach program may utilize community and religious organizations and other community groups to develop outreach programs or referral networks, as well as include distribution of brochures and/or periodic articles that emphasize the importance of this care to all members.

- Furthermore, the Heritage Health plans must develop processes and procedures, with designated points of contact, with other entities and programs that serve members including but not limited to:
    - Division of Behavioral Health funded programs.
    - Division of Children and Family Services funded programs that support the safety, permanency, and well-being of children in the care and custody of the State.
    - Division of Developmental Disabilities programs that involve rehabilitative and habilitative services for persons with developmental disabilities.
    - The Nebraska Department of Education Early Development Network.
    - Community agencies including but not limited to the Area Agencies on Aging and League of Human Dignity Waiver Offices.
    - The Office of Probation.
    - Other programs and initiatives within MLTC related to primary care and behavioral health integration/coordination and pharmacy management.
- Along with these efforts, MLTC's enrollment broker has attended numerous events to advertise Heritage Health, provide information to stakeholders, members, and potential members, and answer any questions. The Heritage Health plans have also attended many such events.

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: Currently there is no public private-partnership providing coverage for Nebraska 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) and 2102(c)(2) and 2102(b)(3)(E))(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 described in Section 5.2.

Describe the procedures the state uses to accomplish coordination of CHIP with other public and private health insurance programs, sources of health benefits coverage for children, and 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. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Various amendments have expanded Nebraska eligibility for children through age 18. The outreach efforts currently employed by the agency will be continued.

Promotional materials have been developed and provided to community agencies, schools, Customer Service Centers and local offices to use to outreach to families. Annually a mass mailing is sent to every school district in the state.

Title V/MCH Block Grant community-based grantees plan their programs for the upcoming year with CHIP in mind. As providers of services geared toward low-income and uninsured families, these grantees want to assure they are able to do their part to recruit uninsured children where they live, play, and go to school and church.

Community Support Specialists employed by the Department provide outreach to community action agencies, child care providers, refugee resettlement sites; human service agencies, homeless/runaway shelters, domestic violence/emergency shelters, family preservation and support teams, reproductive health clinics, faith communities, social security offices, employers, job service offices, employee assistance programs, WIC offices, Early Intervention service coordinators, community mental health providers, food pantries and distribution centers, soup kitchens, immunization clinics, child-serving recreational programs (Boy Scout/Girl Scout, YMCA, etc.), Head Starts and Early Head Starts, Child Care Food Program sponsors, minority advocacy programs, HUD housing authorities, county extension programs, community colleges, technical training programs, GED programs, juvenile court officers, school nurses, and parent/teacher organizations.

Nebraska currently has two Customer Service Centers (CSC) dedicated to Medicaid and CHIP in addition to local offices (LO). Both the CSC's and LO's determine eligibility and are able to answer questions and provide referrals for needed resources. Applications are available via paper, online, phone, or fax. One application is used for both Medicaid and CHIP.

Children with special health care needs will continue to be identified and enrolled in Medicaid or CHIP through the same avenues as are currently being used.

An emphasis is made to reach out to minority groups and organizations representing clients. A list of state and local organizations is available to the Community Support Specialist to be used as a data base for outreach.

Since Nebraska's Title XXI chosen option is a Medicaid expansion for children birth to age 18 and 599 CHIP is a separate CHIP program for unborn children; there are no other state-only or public-private partnership insurance programs enrolling only children, there will be no need for a referral mechanism at this time. Coordination without stationed eligibility services has already been addressed in Section 5.1.1.

Vaccines for Children

Since targeted low income children will be provided coverage through the Medicaid expansions, these children will receive the same benefits as other children receiving coverage under the Nebraska Medicaid Program. This includes full coverage of Vaccine for Children benefits.

Potential for Substitution

Although Nebraska's Title XXI proposal in 1998 to expand Medicaid to cover all uninsured children age 18 and younger with family incomes at or below 185 percent of the federal poverty level, was not anticipated that there will be a significant crowd-out effect - families substituting Kids Connection coverage for family coverage. Crowd-out is still not anticipated because family coverage for persons in this income group is not affordable. The national rate of family health insurance premiums is estimated to be in excess of $3,500 annually. It is unlikely that employers provide family health insurance to workers earning wage rates that are consistent with an income of the current 200 percent of FPL, especially given the relatively large number of small businesses in the State. Therefore, substitution is not likely despite the relatively high overall level of health insurance in Nebraska.

Should crowd out ever prove to be an issue that needs to be remedied, the Department will consider appropriate action, such as a three-month or six-month waiting period, premiums, copayments, or tax credits to families who maintain private coverage. These items would have to be authorized in statute.

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.

5.3 Strategies

Guidance: 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 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.

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.

LB 1063 requires each public school district to provide written information to every student describing the availability of services under CHIP. This information is provided by the Department and must be distributed annually, at the beginning of the school year.

LB 1063 requires each hospital to provide written information about CHIP to the mother of every child born in the hospital at the time of birth. The written information is to be provided by DHHS and DHHS Finance & Support and will describes the availability of health services under CHIP.

LB 1063 requires the Director of the Department of Health and Human Services and the Director of Finance and Support to develop and implement other activities designed to increase public awareness of the availability of health services under CHIP. These activities may include public service announcements, the development and distribution of printed materials describing the program, periodically locating agency staff at public health sites outside the HHSS offices to receive applications for the program, contracting with organizations to assist the public in applying for Kids Connection benefits and to receive referrals for medical services as deemed necessary, and other activities deemed appropriate by the Directors. These activities will include materials and efforts designed to increase participation in the program by minority populations.

LB 1063 required the Department to establish a toll-free help line for this program. Nebraska does have a toll-free number that is operational.

LB 1070 provides funding that may be used for hiring school nurses by

educational service units, school districts, public health entities, or partnerships between schools and public health entities, with one purpose being to identify children for Medicaid eligibility.

LB 1070 authorized DHHS to contract with health clinics of Nebraska's federally recognized Native American tribes, Indian health organizations, or other public health organizations that have a substantial Native American clientele, to provide educational and public health services targeted to Native American populations. The activities include identifying and enrolling children in state and federal programs providing access to health insurance and health care, including Medicaid and CHIP.

Outreach efforts will continue. These include:

1. Single application for Medicaid and CHIP.
2. Allowing on-line, phone, and mail-in application forms;
3. Established two Customer Service Centers dedicated to Medicaid and CHIP to provide better access;
4.
5. Working with advocacy agencies in disseminating information on eligibility, the application process, etc. to the low income community; and
6. Written and on-line information is available.

For additional information on outreach efforts, please refer to sections 2.2.1 and 2.3.

LB 603, which was passed by the 2009 Nebraska Legislature and signed into law by Governor Heineman on May 22, 2009, contained a provision to include as eligible for Medical Assistance under Title XXI, children under nineteen years of age with a family income equal to or less than two hundred percent (200%) of the OMB Income Poverty Guideline. LB603 became effective October 1, 2009, and will be codified at Nebraska Revised Statutes Sec. 68-915.

LB 599, which was passed into law on April 18, 2012, contained a provision to establish a separate CHIP program for unborn children of otherwise ineligible pregnant women with family income equal to or less than one hundred eighty-five percent (185%) of the OMB Income Poverty Guideline. LB 599 becomes effective July 19, 2012, and will be codified at Nebraska Revised Statutes Sec. 68-915.

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

☐ Check here if the State elects to use funds provided under Title XXI only to

provide expanded eligibility under the state's Medicaid plan, and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

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

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

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

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

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

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

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

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

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

benefits description.)

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

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

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

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or

categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. **(**Section 2103(a)(2))

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

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 8/5/97 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)** Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth. Services not covered under include medical issues separate to the mother and

unrelated to pregnancy.

6.1.4.1. ☐ Coverage the same as Medicaid State plan

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

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

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)

No alterations are being made to Nebraska's current ability to provide expanded eligibility under the state's Medicaid plan to CHIP children.

The state elects to provide pregnancy related benefits covered under Title XXI through the 599 CHIP (separate CHIP) program. Professional services, antepartum care and delivery services including associated tests and procedures such as ultrasounds, non-stress tests, amniocentesis and other pregnancy specific tests, procedures and services as covered under Title XIX are provided as medically necessary to support optimal pregnancy outcomes, and are billed using the appropriate CPT/HCPC codes. In addition, visits with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes.

Services not covered include medical issues separate to the mother and unrelated to pregnancy.

Under Heritage Health the MCO's are required to provide all Medicaid and CHIP covered services. However, the MCO's can provide additional services at their discretion with Departmental approval.

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))
Inpatient services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

6.2.2. ☒ Outpatient services (Section 2110(a)(2))
Outpatient services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

6.2.3. ☒ Physician services (Section 2110(a)(3))
Physician services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth. Professional services, antepartum care and delivery services (including associated tests and procedures such as ultrasounds, non-stress tests, amniocentesis and other pregnancy specific tests, procedures and services as covered under Title XIX) are provided as medically necessary to support optimal pregnancy outcomes, and are billed using the appropriate CPT/HCPC codes. In addition, visits with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes.

6.2.4. ☒ Surgical services (Section 2110(a)(4))
Surgical services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
Clinic services coverage for eligible Unborn Children enrolled in the 599

CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))
Prescription drug coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))
Over-the-counter medications for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))
Laboratory and radiological services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
Prenatal care services and supplies coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth. Professional services, antepartum care and delivery services (including associated tests and procedures such as ultrasounds, non-stress tests, amniocentesis and other pregnancy specific tests, procedures and services as covered under Title XIX) are provided as medically necessary to support optimal pregnancy outcomes, and are billed using the appropriate CPT/HCPC codes. In addition, visits with specialists and subspecialists and the related tests and procedures will be covered to provide evaluation and management of maternal or fetal conditions, diseases and disorders that may impact the pregnancy, and/or maternal/fetal outcomes. Eligible Unborn Children will receive the services described in 6.1.4.7 and 6.2 with fee-for-service reimbursement.

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

services (Section 2110(a)(10))

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

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
DME coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

6.2.13. ☒ Disposable medical supplies (Section 2110(a)(13))
Disposable medical supplies coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

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 (See instructions) (Section 2110(a)(14))

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

6.2.15. ☒ Nursing care services (Section 2110(a)(15))
Nursing care services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth. This service remains fee-for-service and is not covered by the MCO's.

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)
Emergency Dental Services covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth. Dental services are carved out of Heritage Health.

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

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

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

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

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
Coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

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

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

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
Other services coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout

the pregnancy and birth. Services not covered include medical issues separate to the mother and unrelated to pregnancy.

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

6.2.26. ☒ Medical transportation (Section 2110(a)(26))
Coverage for eligible Unborn Children enrolled in the 599 CHIP (separate CHIP) program will be covered as medically necessary and only when services benefit the health of the unborn child throughout the pregnancy and birth.

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

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
Non-emergency transportation will be covered as medically necessary and only when the services benefit the health of the unborn child throughout the pregnancy and birth.

6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this Section (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.

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

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

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)

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4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

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

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

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

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

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

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

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

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

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

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

☒ International Classification of Disease (ICD)

☒ Diagnostic and Statistical Manual of Mental Disorders (DSM) Behavioral health only

☐ State guidelines (Describe:)

☐ Other (Describe:)

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

☐ Yes

☒ No

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

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to

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

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

☐ Yes

☐ No

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

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

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐ All children covered under the State child health plan.

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

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

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

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the

Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.2.3.1.1 MHPAEA The State assures that:

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

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

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish

between office visits and other outpatient services?

☐ Yes

☐ No

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

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

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

6.2.3.2 MHPAEA The State assures that:

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

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

Annual and Aggregate Lifetime Dollar Limits

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

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

benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☐ No dollar limit is applied

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

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

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

☐ Yes (Type(s) of limit:)

☐ No

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

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

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

Guidance: Please include the state's methodology to calculate the portion of

covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

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

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

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

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

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

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

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

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

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs

comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

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

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

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

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

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

☐ Yes

☐ No

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

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

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

strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

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

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

☐ State

☐ Managed Care entities

☐ Both

☐ Other

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

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

☐ State

☐ Managed Care entities

☐ Both

☐ Other

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

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. Previously 8.6.

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

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

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

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

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

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

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

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

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the

amount, duration, and scope of each covered behavioral health benefit.

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

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))
Initial Diagnostic Interview: The initial diagnostic interview (IDI) is used to identify the problems and needs, develop goals and objectives, and determine appropriate strategies and methods of intervention for the individual. The IDI shall include a history, mental status, and a disposition. The IDI may be done annually or as medically necessary. A second IDI may be appropriate if there has been a break in services of at least several months or a new independently licensed practitioner assumes the members care.

Functional Behavioral Assessment (FBA): A Functional Behavioral Assessment (FBA) refers to a range of strategies used in the process of determining why an individual engages in significant behavioral disruption and how the behavior relates to the environment. The focus of a FBA is on identifying significant, individual-specific factors associated with the occurrence (and non-occurrence) of specific behaviors. FBAs provide the practitioner with information necessary to develop a clinical formulation as to why the individual engages in the behavior, when the individual is most likely to demonstrate the behavior, and situations in which the behavior is most likely and least likely to occur. Generally, individuals with behavioral issues or functional impairments cannot adequately communicate why they are displaying particular behaviors or what they need to improve functional skills. By gathering data and conducting evaluations of environmental variables on the individual's behaviors, the assessor can decipher the meaning of a behavior, why it is occurring and help to design and recommend a program of behavioral intervention with the individual and their caregivers that can help the individual acquire needed skills and reduce problematic behaviors. One assessment per year; one addendum to the assessment per 6 month period.

Psychological Evaluation and Testing: Psychological testing involves the culturally and linguistically competent administration and interpretation of standardized tests to assess an individual's psychological or cognitive functioning.
Prior to testing, the client must be assessed by a licensed psychologist using best practices and a standard model of care.

- Psychological testing is considered when a diagnostic interview and behavioral
- observations are not able to differentially diagnose.
- Requests for psychological testing should include which elements of a diagnosis are in question and an explanation as to why these elements cannot be determined by an interview or through observation.
- Testing may also be viewed as a potentially helpful second opinion for treatment strategies and/or difficult to diagnose cases.

- Requested tests must be standardized, valid and reliable.
- The instrument must be age, developmentally, linguistically and culturally appropriate to the client.
- Testing requests must meet medical necessity criteria.
- The time per test will be a maximum of one and one-half the time the standard time it takes to administer the test
- The service is inclusive of the administration, observation, scoring, interpretation and report writing.
- Results of psychological testing must include the following:
    - demographic information,
    - dates of services,
    - the presenting problem,
    - results of the testing,
    - interpretation and explanation of the validity of the results,
    - Diagnostic recommendations derived from the testing.

Adult Substance Use Disorder Assessment: The adult substance use disorder assessment is an evaluation through utilization of validated tools to guide the process of the assessment in determining if a substance use disorder exists and if so, what appropriate level of intervention is recommended. The substance use disorder assessment is completed prior to initiation of services and should be updated yearly. A substance use addendum may be completed if determined to be medically necessary
The assessment report is comprised of the following three components:
1) ASSESSMENT AND SCREENING TOOLS AND SCORES
All initial adult substance use disorder assessment reports will include the use and results of at least one nationally accepted screening instrument.
One example of an acceptable instrument is the Substance Abuse Subtle Screening Inventory (SASSI). The Addiction Severity Index (ASI) is required to be used as a face-to-face structured interview guide, to be scored and utilized to provide information for the bio psychosocial assessment/substance use disorder evaluation and the multidimensional risk profile.
2) COMPREHENSIVE PSYCHOSOCIAL ASSESSMENT
All initial adult substance use disorder assessment will include the following:

- Demographics
    - Identify provider name, address, phone, fax, and e-mail contact information
    - Identify individual name, identifier, and other demographic information of the individual that is relevant
- Presenting problem/chief complaint
- External leverage to seek evaluation
- When the individual was first recommended to obtain an evaluation
- Synopsis of what led the individual to schedule the evaluation
- Medical and work/school/military history

- Alcohol/drug history and summary
  - Frequency and amount
  - Drug and alcohol of choice
  - History of all substance use and substance use disorders
  - Use patterns
  - Consequences of use (physiological, interpersonal, familial, vocational, etc.)
  - Periods of abstinence, when and why
  - Tolerance level
  - Withdrawal history and potential
  - Influence of living situation on use
  - Addictive behaviors (e.g. gambling)
  - IV drug use
  - Prior substance use disorder evaluations and findings
  - Prior substance use disorder treatment
  - Individual's family chemical use history
- Legal history
- Criminal history and other information
- Drug testing results
- Simple screening instrument results
- Nebraska Standardized Reporting Format for Substance Abusing
- Offenders
- Family/social/peer history (including trauma history)
- Psychiatric/behavioral history
  - Previous mental health diagnoses
  - Prior mental health treatment
- Collateral information
  - Resources may include family, friends, and community systems
  - (e.g. legal system)
  - Any reports about the individual's use history, pattern and/or consequences learned from other sources
  - Prior mental health treatment
- Summary of evaluation
  - Behavior during evaluation (agitated, mood, cooperation)
  - Motivation to change
  - Level of denial or defensiveness
  - Personal Agenda
  - Discrepancies of information provided
- Diagnostic impression (including justification) to include a DSM (current
- edition) diagnosis
- Strengths of individual and family identified
- Problems identified
- Complete the ASAM Clinical Assessment and Placement Summary
- assuring that collateral contacts with significant others (e.g. former and

- current healthcare providers, friends, court contacts) is made to verify
- medical history, substance usage, and legal history

3) MULTIDIMENSIONAL RISK PROFILE

Recommendations for individualized treatment, potential services, modalities, resources, and interventions are to be based on the ASAM national criteria multidimensional risk profile. The provider is responsible for referring to the ASAM criteria for the full matrix when applying the risk profile for recommendations.

- All Medicaid eligible individuals will be screened for co-occurring
- conditions throughout the assessment. If the clinician is a LADC or a
- PLADC and suspects a possible mental health condition, a referral is to be
- made to a clinician capable of diagnosing/treating co-occurring mental
- health and substance use disorders.
- All staff will be educated/trained in recovery principles and trauma
- informed care.

Youth Substance Use Assessment: Screening and assessment for indicators of substance use for which a treatment plan is developed.

- A multidimensional individual assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.
- ASAM – The five levels of addiction treatment.
- According to the widely used ASAM adolescent placement criteria, there are five basic levels of teen addiction treatment.
- To determine an appropriate level of care, professionals look at the situation across six assessment dimensions, which include:
  - Acute intoxication and withdrawal
  - Biomedical complications
  - Emotional, behavioral and cognitive conditions or complications
  - Readiness to change
  - Relapse or continued use potential
  - Recovery environment
- The Comprehensive Addiction Severity Index for Adolescents (CASI-A) is required to be used as a face-to-face structured interview guide, to be scored and utilized to provide information for the bio psychosocial assessment/substance use disorder evaluation and the multidimensional risk profile.
- A comprehensive psychosocial assessment obtained through collateral contacts with significant others or family members to gather relevant information about individual and family functioning and through collateral contacts with former and current healthcare providers, friends, and court contacts to verify medical history, substance usage, and legal history.

6.3.1.1- BH ☒ The state assures that all developmental and behavioral

health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

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

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

Nebraska has policies and procedures that outline use of standardized, age-appropriate, and validated behavioral health screening tools in both primary care settings as well as behavioral health care settings. These requirements are also outlined in Contract with MCOs. The MCOs are tasked with educating providers on the screening tool requirements as well as care coordination and service referrals if member needs cannot fully be met by the attending provider. The MCOs have provider relations teams that make contact with providers regularly and make themselves available any time providers have questions on these tools. MCOs will also send out mass notifications as warranted as well as utilize their websites and/or provider newsletters to provide timely updates on programmatic requirements, including those related to screening tools.

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

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

6.3.2.1- BH ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Psychotherapy: MH/SUD: Length of treatment is individualized and based on clinical criteria for admission, the progress in the treatment, and the individual's ability to benefit from individual treatment/recovery goals. Outpatient individual psychotherapy is therapeutic encounters between the licensed clinician and the individual for the purposes of treating a mental health /youth substance use disorder condition through scheduled therapeutic visits. The focus of outpatient

therapy is to improve or alleviate symptoms that may significantly interfere with functioning in at least one life domain of the individual (e.g. familial, social, occupational, educational, etc.).

MH:

- An initial diagnostic interview (IDI) is completed prior to the beginning of treatment and will include an initial diagnosis and plan for treatment.
- Treatment will address mental health needs and mental health and/or emotional issues identified in the IDI as being related to the medically necessary condition.
- The treatment plan must be individualized to the individual and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress.

SUD:

Specific to Youth SUD counseling:

- A substance use disorder (SUD) assessment must be completed prior to the beginning of treatment.
- All individuals must be screened for co-occurring conditions throughout the assessment. If the clinician is a LADC or a PLADC, and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders.
- If there is a supervising practitioner involved, their involvement must be reflected in the SUD assessment.

Required for Adult and Youth Therapy and Youth SUD Services:

- The treatment plan must be individualized and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates and methods for evaluating the individual's progress.
- The treating clinician must consult with and/or refer to other providers for general medical, psychiatric, and psychological needs as indicated.
- Services must be trauma informed, culturally sensitive, age and developmentally appropriate, and incorporate evidence based practices when appropriate.

Family Therapy: Length of treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the individual’s ability to benefit from group treatment and recovery goals.

MH/SUD: Outpatient family therapy is for the treatment of mental health and substance use disorders (youth only) through scheduled therapeutic visits between the therapist, the individual, and the nuclear or the extended family. The specific objective of treatment shall be to alter the family system to increase the functional level of the identified individual and family by focusing services/interventions on the systems within the family unit. This therapy is typically provided with the family members and the identified individual. Outpatient family therapy is for the treatment of mental health and substance use disorders (youth only) through scheduled therapeutic visits between the therapist, the individual, and the nuclear or the extended family. The specific objective of treatment shall be to alter the family system to increase the functional level of the identified individual and family by focusing services/interventions on the systems within the family unit. This therapy is typically provided with the family members and the identified individual.

Specific to Mental Health Therapy:

- An initial diagnostic interview (IDI) will be completed prior to the beginning of treatment and will include an initial diagnosis and plan for treatment.
- If another provider has completed an IDI, and it includes a current diagnosis and level of care recommendation and all information is still clinically relevant to the member's condition, it can serve as the admission assessment; otherwise, an IDI addendum would be warranted to update the previous assessment as necessary.
- If there is a supervising practitioner involved, their involvement will be reflected in the IDI.

Specific to Youth SUD counseling

- A substance use disorder (SUD) assessment will be completed prior to the beginning of SUD treatment.
- If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information than an SUD addendum would be necessary.
- All individuals will be screened for co-occurring conditions throughout the assessment. If the clinician is a LADC or a PLADC, and suspects a possible mental health condition, a referral will be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders.

Required for Adult and Youth Therapy and Youth SUD services

- The family assessment is conducted at the onset of therapy.
- The treatment plan will be individualized and will include the specific

problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates and methods for evaluating the family's progress.
- The treatment plan will be developed with the individual and the identified, appropriate family members as part of the outpatient family therapy treatment planning process.
- Treatment plans will be reviewed every 90 days or more often if clinically indicated.
- The treating clinician will consult with and/or refer to other providers for general medical, psychiatric, and psychological needs as indicated.
- After hours crisis assistance is to be available.
- Services are to be trauma informed, culturally sensitive, age and developmentally appropriate, and incorporate evidence based practices when appropriate.

SUD:
- Adult outpatient family substance use disorder therapy describes the professionally directed evaluation, treatment and recovery services for individuals and their families who are experiencing a substance related disorder that causes moderate and/or acute disruptions in the individual's life. Outpatient family SA therapy is a therapeutic encounter between the licensed treatment professional and the individual, the nuclear and/or the extended family.

Community Support: Length of treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the individual's ability to benefit from group treatment and recovery goals.

MH:
- Community support services provide rehabilitative and support services for individuals with a primary mental health diagnosis. Such services include treatment for substance issues when that is an identified need. Community support workers provide direct rehabilitation and support services in the community with the intention of supporting the individual to maintain stable community living and preventing exacerbation of their mental illness and admission to higher levels of care. Service is not provided during the same service delivery hour of other rehabilitation services.

SUD:
- Community support is a rehabilitative and support service for individuals with primary substance use disorders. Community support workers provide direct rehabilitation and support services to the individual in the community with the

intention of supporting the individual to maintain abstinence, stable community living, and prevent exacerbation of illness and admission to higher levels of care. Service is not provided during the same service delivery hour of other rehabilitation services.

Group Therapy: Length of treatment is individualized and based on clinical criteria for admission and continued treatment, as well as the individual's ability to benefit from group treatment and recovery goals.

MH/SUD: Outpatient group therapy is the treatment of psychiatric/substance use disorders through scheduled therapeutic visits between the therapist and the Medicaid eligible individuals in the context of a group setting including participants with a common goal. The focus of outpatient group therapy is to improve an individual's ability to function as well as alleviate symptoms that may significantly interfere with their interpersonal functioning in at least one life domain (e.g. familial, social, occupational, educational, etc.). Group therapy will provide active treatment for a primary DSM (current edition) diagnosis. The goals, frequency, and duration of outpatient group treatment will vary according to individual needs and response to treatment.

Specific to Mental Health Therapy:

- An Initial Diagnostic Interview (IDI) will be completed prior to the beginning of treatment and will include an initial diagnosis and plan for treatment.
- If another provider has completed an IDI, and it includes a current diagnosis and level of care recommendation and all information is still clinically relevant to the member's condition, it can serve as the admission assessment; otherwise, an IDI addendum would be warranted to update the previous assessment as necessary.
- If there is a supervising practitioner involved, their involvement will be reflected in the Initial Diagnostic Interview.

Specific to Youth SUD counseling

- A Substance Use Disorder (SUD) assessment will be completed prior to beginning substance use disorder treatment.
- If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan it can serve as the admission assessment. If the prior assessment is not relevant or does not contain the necessary information than an SUD addendum would be necessary.
- All individuals will be screened for co-occurring conditions. If the clinician is a LADC or a PLADC and suspects a possible mental health condition, a referral is to be made to a clinician capable of diagnosing/treating co-occurring mental health and substance use disorders.

Required for Adult and Youth Therapy and Youth SUD services

- The treatment plan will be individualized and will include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates and methods for evaluating the individual's progress.
- Treatment plans will be reviewed every 90 days or more often if clinically indicated.
- The treating clinician will consult with and/or refer to other providers for general medical, psychiatric, and psychological needs as indicated.
- After hours crisis assistance is to be available.
- Services will be trauma informed, culturally sensitive, age and developmentally appropriate, and incorporate evidence based practices when appropriate.
- Assessments and treatment should address mental health/substance use needs, and mental health and/or emotional issues related to medical conditions.

SUD:

- Outpatient substance use disorder group therapy is the treatment of substance related disorders through scheduled therapeutic visits between the therapist and the individual in the context of a group setting of at least three and no more than twelve individual participants with a common goal. The focus of outpatient group substance use disorder treatment is substance related disorders which are causing moderate and/or acute disruptions in the individual's life. Group therapy is to provide active treatment for a primary substance use disorder (SUD) DSM (current version) diagnosis. The goals, frequency, and duration of outpatient group treatment will vary according to individual needs and response to treatment.

Therapeutic Community: Length of service is individualized and based on clinical criteria for admission and continuing stay, but individuals typically require this service for up to one year for maximum effectiveness. A minimum of 30 hours of treatment and recovery focused services weekly including individual, family, and group psychotherapy, educational groups, motivational enhancement and engagement strategies is provided.

SUD:

- Therapeutic community is intended for adults with a primary substance use disorder for whom shorter term treatment is inappropriate, either because of the pervasiveness of the impact of substance use disorder on the individual's life or because of a history of repeated short-term or less restrictive treatment failures. This s~~em~~ervice provides psychosocial skill building through a set of

longer term, highly structured treatment strategies that define progress toward individual change and rehabilitation. The individual's progress is to be marked by advancement through these phases to less restriction and more personal responsibility.

Multisystemic Therapy(MST): MST is an evidenced based intensive treatment process that focuses on diagnosed behavioral health disorders and on environmental systems (family, school, peer groups, culture, neighborhood and community) that contribute to, or influence an individual's involvement, or potential involvement in the juvenile justice system. The therapeutic modality uses family strengths to promote positive coping activities, works with the caregivers to reinforce positive behaviors, and reduce negative behavior, and helps the family increase accountability and problem solving. Beneficiaries accepting MST receive assessment and home based treatment that strives to change how the individuals, who are at risk of out-of-home placement, or who are returning home from an out of home placement, function in their natural settings to promote positive social behavior while decreasing anti-social behavior. MST's therapeutic model aims to uncover and assess the functional origins of adolescent behavioral problems by altering the individual's behavior in a manner that promotes prosocial conduct while decreasing aggressive/violent, antisocial, substance using and/or delinquent behavior by keeping the individual safely at home, in school and out of trouble. Treatment is used at the onset of behaviors that could result in (or have resulted in) criminal involvement by treating the individual within the environment that has formed the basis of the problem behavior. Length of treatment is individualized and based on the progress of the individual and family according to their treatment goals. Services are rendered in a professional office, clinic, home or other environment appropriate to the provision of psychotherapy services. Duration of treatment is an average of four months with an expected range of three to five months.

6.3.2.2- BH ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

- Up to two tobacco cessation sessions in a 12-month period. A tobacco cessation session includes (a) visits to the primary practitioner for evaluation, particularly for any contraindications for drug product(s) and to obtain prescription(s) if tobacco cessation products are needed (all FDA approved medications for tobacco cessation are available), and (b) up to a total of four tobacco cessation counseling visits with a physician, licensed nurse practitioner or pharmacist tobacco cessation counselor. These visits may be a combination of intermediate and intensive counseling. All limits may be exceeded based on medical necessity.

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

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

6.3.2.3.1- BH ☐ Opioid Use Disorder

6.3.2.3.2- BH ☐ Alcohol Use Disorder

6.3.2.3.3- BH ☒ Other

In addition to behavioral health services, Nebraska Medicaid provides the following medications for MAT under the pharmacy benefit subject to the preferred drug list. Requirements regarding non-preferred drugs are listed below.

- Suboxone
    - Non-Preferred (Bunavail, buprenorphine SL, Buprenorphine/naloxone SL, Zubsolv) criteria:
        - Diagnosis of Opioid Use Disorder, not approved for pain management
        - Verification of "X" DEA license number of prescriber
        - No concomitant opioids
        - Failed trial of preferred drug or patient-specific documentation of why preferred product not appropriate for patient.
- Naloxone syringe, vial, naltrexone tablet, narcan (naloxone) spray
    - Non-preferred agents will be approved with documentation of why preferred products within this drug class are not appropriate for the patient.

The State does not have any limitations or restrictions on the type, duration, frequency, etc… of the behavioral health services provided with MAT.

The State confirms there is at least one form of all FDA approved medications included in the states preferred drug list.

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

MH/SUD: As identified by the individual, the treatment team, and as determined medically necessary. Peer support services will be available during times that meet the need of the individual and when applicable the individual's family/caregiver, which may include evenings, weekends or both. The peer support provider must ensure the individual and their parent/caregiver (if applicable) have on call access to a licensed mental health or substance use counselor 24 hours a day, seven days per week.

- Complete an Initial Diagnostic Interview (IDI) if one has not been completed within the 12 months prior to initiating peer support services. The IDI will serve as the initial treatment plan until the comprehensive plan of care is developed. An IDI is not necessary if peer support services are provided for treatment of a substance use disorder. An IDI must be completed by a licensed clinician authorized to perform that service;
- Complete a Substance Use Disorder (SUD) assessment, if one has not been completed by a licensed clinician prior to initiating peer support services. A SUD assessment is not necessary if peer support services are provided for treatment of a mental health disorder;
- The treatment plan is to be developed through shared decision making inclusive of the individual and must identify specific areas to be addressed; clear and realistic goals and objectives; strategies, and recovery support services to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; a discharge plan, wellness plan, and crisis prevention plan that includes defining early warning signs and triggers;
- The individual treatment plan shall be completed within 30 days following admission, reviewed and updated every 90 days, or as often as clinically necessary thereafter while receiving services. The individual shall sign the plan to indicate involvement in the planning; refusal to sign will be noted on the treatment plan. The supervisor is responsible for reviewing and signing off on the treatment plan;
- Development of a mutual set of expectations for the peer relationship within one month of admission;
- Peer support services are provided in conjunction with one or more behavioral health services.
- Peer support services are based on the relationship between the Certified Peer Support Provider and the individual. Activities of the peer support provider are to serve and support individuals through sharing their knowledge, beliefs and experiences that promote recovery and wellness are possible, and that the individuals being served have the ability to manage their behavioral health symptoms successfully;
- Peer support services are designed as a means of supporting individuals on their recovery journey as that individual defines it by utilizing the following recovery support services as applicable:
    - o Peer coaching to facilitate system navigation, accessing community

resources, and engagement with formal and informal resources and supports, all of which are designed to enhance the individual's resilience and ability to achieve their individual goals;
o Building on current strengths of the individual to empower them with advocacy and self-help skills to enhance their process of recovery and increase their capacity to utilize wellness options available;
o Assist clients to locate and join existing self-help groups;
o Educating the individual about the peer support relationship to include topics such as healthy personal boundaries, individual rights, and the significance of shared decision making;
o Sharing of experiences, skills, strengths, supports, and resources used in order to benefit the individual by demonstrating wellness through their own effective symptom management;
o Meeting the individual "where they are at" in their recovery process and encouraging engagement into services;
o Model and present self-help activities that cultivate the individual's ability to make informed, independent choices and decisions as well as activities designed to assist in developing a personal network of support, enhance problem solving abilities, and to build the personal confidence necessary to enhance and improve health and well-being;
o Serve as a recovery agent by providing the opportunities and advocating for any effective services that will aid in daily living, coping, or symptom management;
o Collaborate with the individual served as a treatment team member to develop a person centered treatment plan that incorporates the elements identified above and assist by determining the steps needed in order to achieve the goals identified in the treatment plan;
o Specific to youth services: the peer support provider will include the individual's caregiver/family in order to help them understand the role of the peer support provider in their child's care.

- Group setting: the peer support provider develops relationships with individuals to share their experiences, skills, strengths, supports and resources used in order to show that recovery is an achievable lifelong process; and model and share problem solving skills;
- Exploration of community resources related to the individual's independence and recovery, and assist the individual through the relationship developed to become empowered to work towards goals as defined by the individual.

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

MH/SUD: The goal of Caregiver Support is to support and strengthen the parent

(caregiver) and child relationship and is covered in the following services:

- Crisis outpatient psychotherapy: immediate short term individual or family therapy limited to two sessions In order to assist an adult in crisis.
- Multisystemic therapy: The therapeutic modality uses family strengths to promote positive coping activities, works with the caregiver to reinforce positive parenting practices.
- Outpatient Family Therapy: Treatment focuses on altering the family system by focusing on services and interventions on the systems within the family unit.
- Parent Child interaction therapy (PCIT): The emphasis is on improving the quality of the parent /child relationship through changing parent-child interaction patterns.
- Peer Support: Core development is the development of a relationship based on shared lived experience and mutuality between the peer support worker and the individual. Provision is for all individuals and their parents in individual and group settings.
- Psychiatric Nursing: Primary nursing services in the home of an adult experiencing a mental health issue. The services may include prescribing medication (this is dependent of the scope of practice of the nurse) or administering psychotherapy.
- Adult outpatient individual therapy: Treatment of a mental health condition to improve or alleviate the symptoms that interfere with individual functioning.

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

MH/SUD: Respite care is not an independent service but is provided for parents/caretakers in support services that are performed in the absence of the child. These services are:

- Peer support – See 6.3.2.4.
- Outpatient individual therapy – See 6.3.2.1
- Psychiatric nursing – See 6.3.4 - Subacute Inpatient Hospitalization
- Crisis outpatient psychotherapy – See 6.3.5.1.
- Multisystemic therapy – See 6.3.2.

SUD Specific: All ASA services ranging from individual outpatient therapy to the highest level of residential treatment are considered as providing respite services.

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

MH/SUD: Intensive in-home services are not independent services. They are

covered in the following services:

- Peer Support – See 6.3.2.4.
- Multisystemic therapy – See 6.3.2.
- Intensive Outpatient – See 6.3.2.8.
- Community Support – See 6.3.2.
- Family Therapy – See 6.3.2.1.
- Group Therapy - See 6.3.2.1.
- Therapeutic Community – See 6.3.2.
- Day Treatment (SUD, Youth MH/SUD) – See 6.3.3.

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

MH/SUD: Length of service is individualized and based on clinical criteria for admission and continuing stay. The frequency and duration varies according to the needs of the individual and the individual's response to the day-to-day treatment intervention. Services include:

- An Initial Diagnostic Assessment (IDI) and when applicable, for co-occurring disorders, a Substance Use Disorder (SUD) assessment by a licensed clinician prior to the beginning of IOP treatment.
- Individualized treatment/recovery plan, including discharge and relapse prevention, developed with the individual within 14 days of admit.
- Therapies/interventions may include individual, family, and group psychotherapy, educational groups, motivational, enhancement and engagement strategies.
- Provision of nine or more hours per week of skilled treatment, with at least three hours of availability per day. Scheduled hours at minimum are three times per week, and may be available up to seven days per week. The hours and days of treatment are to be reduced as clinically defined when an individual nears completion of the program.
- Review and update of the treatment/recovery plan under clinical guidance with the individual and other approved family/supports every 30 days or more often as medically indicated.
- Access to a licensed mental health/substance abuse professional on a 24/7 basis for crisis management.
- Monitoring stabilized comorbid medical and psychiatric conditions.
- Consultation and/or referral for general medical, psychiatric, needs.

Intensive Outpatient – Youth Mental and SUD: Intensive outpatient (IOP) services are non-residential, intensive, structured interventions consisting of counseling and education to improve the mental health, sexually harmful behavior, substance use disorder and /or eating disorder symptoms that may significantly interfere with functioning in at least one life domain (e.g. familial,

social, occupational, educational, etc.). IOP interventions may include: ongoing assessment, individual, group, and family psychotherapy and other treatment modalities as defined for each individual. Services are goal oriented interactions in preparing the individual to apply learned skills in "real world" environments.

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

MH/SUD:
Community Support: Community Support is a rehabilitation recovery service delivered by a skilled, trained community support worker under the supervision of a licensed mental health practitioner to individuals suffering from Severe and Persistent Mental Illness (SPMI). The service is delivered by a provider, enrolled individually or with a group, that has achieved and maintained national accreditation by a nationally recognized accrediting organization. Provided a minimum of three hours a day, five days a week.

- Assist in coordination of a medical and mental health service.
- Coordination of all communication with community based supports.
- Monitor medication adherence and report any barriers.
- Understand and support use of client's relapse prevention plan.
- Assist in restoring problem solving skills and age appropriate independence
- Restoring medication and health management skills;
- Restoring skills that are impacted by the individual's mental health diagnosis;
- Restoring adult activities of daily living and instrumental adult activities of daily living in the client's home environment.

SUD:
Psychosocial rehabilitation is covered under the following services:

- Peer Support – See 6.3.2.4.
- Intensive Outpatient – See 6.3.2.8.
- Community Support – See 6.3.2.
- Family Therapy – See 6.3.2.1.
- Group Therapy - See 6.3.2.1.
- Therapeutic Community – See 6.3.2.
- Day Treatment (SUD, Youth MH/SUD) – See 6.3.3.

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

6.3.3- BH ☒ Day Treatment

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Youth MH/SUD: Psychiatric/substance use day treatment is a service in a continuum of care designed to prevent hospitalization or to facilitate the movement of the acute psychiatric and/or substance use disorder individual to a status in which the individual is capable of functioning within the community with less frequent contact with the psychiatric health care provider. Provide a minimum of three hours a day, five days a week. Length of service is individualized and based on clinical criteria for admission and continuing stay.

- Services are community based, family centered, culturally competent and developmentally appropriate.
- Services involve the family in assessment, treatment planning, updating of the treatment plan, therapy and transition/discharge planning. Family involvement, or lack thereof, shall be documented in the clinical record.
- Meetings/sessions are be scheduled in a flexible manner to accommodate including weekends and/or evenings.
- The program shall identify an on-call system of licensed practitioners available for crisis management when the individual is not in the program's scheduled hours and/or the program is not in session.
- An Initial Diagnostic Interview (IDI) is completed prior to the beginning of treatment and functions as the initial treatment plan until a comprehensive treatment plan is developed.
- The following services are required to be included in a program for day treatment to be approved for participation in the Nebraska Medicaid:
    - One billable session of psychotherapy and/or substance use counseling services, per scheduled treatment day, that demonstrate the individual is receiving active treatment for their psychiatric condition. These services may include: individual psychotherapy, group psychotherapy, and family psychotherapy if appropriate.
    - Nursing services: medical services are provided by a qualified registered nurse who evaluates the medical nursing needs of each individual and provides for their medical care and treatment. In a hospital based day treatment setting a nursing medical assessment is be completed within 24 hours of admission or the first business day.
    - Clinically appropriate assessments, as determined necessary, to assess the individual for substance use disorders, eating disorders, sex offender behavior, or other specialized treatment needs.
    - Psychological diagnostic services include testing and evaluation services be performed by a licensed psychologist, or a specially licensed psychologist and contribute to the diagnosis and plan of care for the individual.
    - Pharmaceutical services: If medications are dispensed by the program,

pharmacy services will be provided under the supervision of a registered pharmacy consultant, or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of a registered nurse.
    - Dietary services are provided and/or contracted with a registered dietitian when meals are provided by a day treatment program.
    - Transition and discharge planning begins at admission, is based on transitioning the individual to a different level of care, and addresses the individual's ongoing treatment needed to maintain and/or continue age appropriate physical and mental development post discharge.
- Provide at least two of the following optional services. The individual is required have a need for the services, a supervising practitioner has to order the services, and the services have to be a part of the individual's treatment plan:
    - The following is provided or supervised by a licensed or certified therapist: recreational therapy; speech therapy; occupational therapy; vocational skills therapy; and self-care services.
    - Educational services provided by a teacher specially trained to work with individuals experiencing mental health or substance use problems (services, when required by law, will be available, though not necessarily provided by the day treatment program).
    - Social work provided by a bachelor level social worker (case management activities).
    - Social skills building.
    - Life survival skills. Substance use disorder prevention/ intervention; or treatment by an appropriately certified alcohol and drug abuse counselor.
- Medication management will be available to all individuals participating in a day treatment service when medication is prescribed by an appropriately licensed practitioner. This service shall be medically and clinically necessary for the mental health and/or substance use disorder requiring treatment. The practitioner prescribing the medication, whether within the program or outside of the program, shall consult with the program periodically and may bill for all directly delivered medication management services separate from the payment to the program for day treatment services.

MH: Services available for a minimum of three hours but up to five hours per day, five days per week. Specific services may be offered on weekends and evenings according to client need. Service availability limitations may be exceeded based on medical necessity.

- One billable session of psychotherapy services, per scheduled treatment day,

that demonstrate the individual is receiving active treatment for their psychiatric condition. These services may include: individual psychotherapy, group psychotherapy, and family psychotherapy if appropriate.

- Pharmaceutical services: If medications are dispensed by the program, pharmacy services will be provided under the supervision of a registered pharmacy consultant, or the program may contract for these services through an outside licensed/certified facility. All medications must be stored in a special locked storage space and administered by a physician, registered nurse, licensed practical nurse or a medication aid under the direction and monitoring of a registered nurse.
- Dietary services will be provided and/or contracted with a registered dietitian when meals are provided by a day treatment program.
- Nursing services: A registered nurse will evaluate and provide for the care and treatment of the individuals medical nursing needs when medically indicated. In a hospital based day treatment setting a nursing medical assessment will be completed within 24 hours of admission or the first business day.
- Clinically appropriate assessments, as determined necessary, to assess the individual for substance use disorders, eating disorders, or other specialized treatment needs.
- Transition and discharge planning will begin at admission, be based on transitioning the individual to a different level of care, and address the individuals ongoing treatment needs.
- Provide at least two of the following optional services. The individual must have a need for the services, a supervising practitioner must order the services, and the services must be a part of the individual's treatment plan:
    - The following will be provided or supervised by a licensed or certified therapist: recreational therapy, speech therapy, occupational therapy, vocational skills therapy, and self-care services;
    - Social work provided by a bachelor level social worker (case management activities);
    - Social skills building; and/or
    - Life survival skills

SUD: Services available half day (three hours a day, five days a week) or full day (six hours a day, five days a week). May be available seven days a week with a minimum availability of five days a week including days, evenings and weekends. The length of stay is at least two to six weeks, depending on the severity of the individual’s substance use disorder.

Treatment offers person-centered, culturally and linguistically appropriate, comprehensive, coordinated, and structured treatment services and activities. A day treatment program consists of a scheduled series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency in order to assist the individuals served in achieving the goals identified in their

individualized treatment/recovery plan. This level of care is designed to offer highly structured intensive treatment to those individuals whose condition is sufficiently stable so as not to require twenty-four-hour per day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention. Day Treatment may also be referred to as Partial Hospitalization.

- A SUD assessment and mental health screening conducted by a licensed clinician at admission with ongoing assessment as needed. If a prior SUD assessment is determined to be clinically relevant and includes a current diagnosis, level of care recommendation and a discharge plan it can serve as the admission assessment for treatment. All clients will be screened for co-occurring conditions during the assessment. If the clinician is a LADC or a PLADC and suspects a possible psychiatric condition, a referral is to be made to a clinician capable of diagnosing and treating co-occurring psychiatric and substance use disorders;
- Individualized treatment/recovery plan, including discharge and relapse prevention, developed under clinical supervision with the client (consider community, family and other supports) within 14 days of admission;
- Review and update of the treatment/recovery plan with the client and other family/supports every seven days or more often as medically indicated;
- Day treatment programs are offered four or more days per week for at least three hours, typically with support available in the evenings and on weekends;
- Provision for 20 hours of skilled treatment per week in a structured program;
- Skilled treatment will include individual, family (as clinically indicated and with permission from the individual being served), group psychotherapy, psycho-educational groups, motivational enhancement engagement strategies, and peer support;
- Emergency services available 24-hours a day, seven days a week when the program is not in session;
- Monitoring co-occurring mental health problems to include providing for, or arranging for psychiatric services to meet the needs of the individual;
- Monitoring to promote successful reintegration into regular, productive daily activity such as work, school or family living;
- Consultation and/or referral for general medical, psychiatric, psychological, nutritional and laboratory needs.

6.3.3.1- BH ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

MH: Day Treatment may also be referred to as Partial Hospitalization (See Day Treatment above).

SUD: Adult Substance Use Disorder (SUD) Day Treatment offers person-centered, culturally and linguistically appropriate, comprehensive, coordinated, and structured treatment services and activities. A day treatment program consists of a scheduled series of structured, faceto-face therapeutic sessions organized at various levels of intensity and frequency in order to assist the individuals served in achieving the goals identified in their individualized treatment/recovery plan. This level of care is designed to offer highly structured intensive treatment to those individuals whose condition is sufficiently stable so as not to require twenty-four-hour per day monitoring and care, but whose illness has progressed so as to require consistent near-daily treatment intervention. Day Treatment may also be referred to as Partial Hospitalization (See Day Treatment above). The length of stay is at least two to six weeks, depending on the severity of the individual's substance use disorder.

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

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Aceute Inpatitent Hospitalization:

MH: An acute inpatient program is designed to provide medically necessary, intensive assessment, psychiatric treatment and support to individuals with a DSM (current edition) diagnosis and/or co-occurring disorder experiencing an acute exacerbation of a psychiatric condition. The acute inpatient setting is equipped to serve individuals at imminent risk of harm to self or others and in need of a safe, secure, lockable setting. The purpose of the services provided within an acute inpatient setting is to stabilize the individual's acute psychiatric conditions. A number of days driven by the medical necessity for an individual to remain at this level of care.

- The following assessments must be conducted: Initial Diagnostic Interview (IDI), nursing assessments, laboratory, radiological, substance use disorder; physical and neurological exams and other diagnostic tests as necessary.
- The IDI shall serve as the initial treatment plan until the comprehensive plan of care is developed.
- Family members are encouraged to participate in the assessment/treatment of the individual as appropriate and approved by the individual, and their participation or lack of participation is documented in the individual's record.
- Provide an intensive and comprehensive active treatment program that includes professional psychiatric, medical, surgical, nursing, social work,

psychological, and activity therapies required to carry out an individual treatment plan for each individual and their family.
- Develop and implement an active treatment plan with provisions for: resolution of acute mental health and medical problems; evaluation of, and needs assessment for, medications; protocol to ensure individual's safety; discharge plan initiated at the time of admission.
- Face to face evaluation and treatment by a physician, or a physician extender, six out of seven days.
- Psychiatric nursing interventions are available to individuals 24/7.
- Provide medication management services for the provision and monitoring of psychotropic medications.
- Individual, group, and family therapy is available and offered as tolerated and/or appropriate.
- Provide social services to engage in discharge planning and help the individual develop community supports and resources and consult with community agencies on behalf of the individual.

Subacute Inpatient Hospitalization:
MH/SUD: The purpose of subacute care is to provide stabilization, engage the individual in comprehensive treatment, rehabilitation and recovery activities, and transition them to the least restrictive setting as rapidly as possible.
- The following assessments must be conducted: Initial Diagnostic Interview (IDI), nursing assessments, laboratory, radiological, substance use disorder, physical and neurological exams and other diagnostic tests as necessary.
- Family members are encouraged to participate in the assessment/treatment of the individual as appropriate and approved by the individual and their participation or lack of participation is documented in the individual's record.
- Flexible meetings schedule to include evenings and weekends to facilitate family participation.
- Develop and implement a treatment plan designed to address the needs identified by the assessments. The treatment plan must include a specific, realistic and individualized discharge plan. The treatment plan must be reviewed three times a week.
- Provide an intensive and comprehensive active treatment program that includes professional psychiatric, medical, surgical, nursing, social work, psychological, and activity therapies required to carry out an individual treatment plan for each patient and their family.
- Face to face evaluation and treatment by a psychiatrist three times a week or more often as necessary.
- Psychiatric nursing interventions are available to patients 24/7.
- Qualified staff must be available to provide treatment intervention, social interaction and experiences, education regarding psychiatric issues such as medication management, nutrition, signs and symptoms of illness, substance

abuse education, recovery, appropriate nursing interventions and structured milieu therapy.
- Available services must include individual, group, and family therapy, occupational and recreational therapy and other prescribed activities to maintain or increase the individual's capacity to manage his/her psychiatric condition and activities of daily living.
- Medication management services for the provision and monitoring psychotropic medications.
- Individual, group, and family therapy available and offered as tolerated and/or appropriate.
- Social services to engage in discharge planning and help the individual develop community supports and resources and consult with community agencies on behalf of the individual.

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

6.3.4.1- BH ☒ Residential Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

MH:
Residential Rehabilitation is a 24-hour program that allows a client suffering from severe and persistent mental illness to recover in a rehabilitative setting which includes 20 hours of on-site rehabilitation services and 25 hours off-site services. Service availability limitations may be exceeded based on medical necessity.

- Assist in arranging medical and psychiatric care and management of appointments.
- Teaching relapse prevention skills and revisiting the relapse plan with the client.
- Teaching time management and daily living skills.
- Social skill development through encouraging healthy relationship building and social activities.
- Teaching survival skills, such as meal preparation, nutrition, housekeeping activities and other daily management.
- Money management and budgeting.
- Prevocational skill development.

MH/SUD:
Secure Residential Treatment: Secure residential treatment is intended to provide individualized recovery, psychiatric rehabilitation, and support as determined by a strengths-based assessment for individuals with a mental illness and/or co-

occurring substance use disorder demonstrating a high-risk for harm to self/others and in need of a secure, recovery/rehabilitative/therapeutic environment. Length of service is individualized and based on clinical criteria for admission and continuing stay, as well as the individual's ability to make progress on treatment/recovery goals. An individual may decline continuation of the service, unless under mental health board commitment, court order, or at the direction of their legal guardian.

- History and physical within 24 hours of admission by a physician or Advanced Practice Registered Nurse (APRN). A history and physical may be accepted from previous provider if completed within the last three months. An annual physical is required.
- Initial Diagnostic Interview (IDI) within 24 hours of admission by a psychiatrist, (if necessary).
- Nursing assessment within 24 hours of admission.
- Other assessments as needed, and on an ongoing basis all of which should integrate mental health and substance use disorder treatment needs. • Initial treatment/recovery plan completed within 24 hours of admission with the psychiatrist as the supervisor of clinical treatment and direction.
- An individual recovery/discharge/relapse prevention plan developed with the individual and chosen supports' input (with informed consent) within 14 days of admission and reviewed weekly by the individual and recovery team.
- Integration of substance use disorder and mental health needs and strengths in assessment, treatment/recovery plan, and programming.
- Consultation services available for general medical, dental, pharmacology, psychological, dietary, pastoral, emergency medical, recreation therapy, laboratory and other diagnostic services as needed.
- Face-to-face with a psychiatrist at a minimum of every 14 days or as often as medically necessary.
- 42 hours of active treatment available/provided to each individual weekly, seven days per week.
- Access to community-based rehabilitation/social services to assist in transition to community living.
- Medication management (administration and self-administration), and education.
- Psychiatric and nursing services.
- Individual, group, and family therapy and substance use disorder treatment as appropriate.
- Life skill services including daily living, social skills, community living, family education, transportation to community services, peer support services, advance directive planning, and self-advocacy, recreation, vocational and financial.

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

SUD: Social detoxification provides intervention in substance use disorder emergencies on a 24 hour per day basis to individuals experiencing acute intoxication. This service has the capacity to provide a safe residential setting with staff present for observation and implementation of physician approved protocols designed to physiologically restore the individual from an acute state of intoxication when medical treatment for detoxification is not necessary. - Generally two to five days.

- A biophysical medical screening (includes at a minimum the vital signs, detoxification rating scale, and other fluid intake) conducted by appropriately trained staff at admission with ongoing monitoring, as needed, with licensed medical consultation available.
- The implementation of physician approved protocols.
- An addiction focused history is obtained and reviewed with the physician if protocols indicate concern.
- A physical exam is to be completed prior to admission if the individual will be self-administering detoxification medication. This is not necessary if the program has 24-hour nursing, and nursing administers individual medications according to the physician's protocols.
- The monitoring of self-administered medication.
- Sufficient screening is completed to determine the level of care in which the individual should be placed.
- Prior to discharge, the staff and the individual will develop a discharge plan which will include a specific referral and relapse strategy.
- A consultation and/or a referral for general medical, psychiatric, psychological, and/or other needs is provided.
- Interventions will include a variety of educational sessions and motivational and enhancement strategies for the individual and their family.
- Individual participation is based on the medical biophysical condition and ability of the individual.
- To assist individuals in establishing social supports to enhance recovery.

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

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

MH/SUD: Emergency services are available 24-hours a day, seven days a week.

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

MH/SUD:
Crisis outpatient individual or family therapy is an immediate, short-term treatment service provided to an individual. An individual is eligible to receive crisis outpatient services of no more than two sessions per episode of crisis.

- Includes active family involvement unless contraindicated.
- Services will be trauma informed and sensitive to potential personal safety risks such as suicidal intention.
- The therapist/provider will coordinate care with the individual's primary medical provider and the therapy provider if ongoing therapy is authorized.
- The intervention/safety plan identifies the crisis with steps for further resolution, outlines an individualized safety plan for the individual and/or family, and identifies additional formal and informal supports. The clinician will assist in making appropriate referrals.

Treatment Crisis Intervention level of care provides a facility-based program where patients in urgent need can receive crisis stabilization services in a safe, structured setting. It provides continuous 24-hour observation and supervision for individuals who do not require
intensive clinical treatment in an inpatient psychiatric setting and would benefit from emergency services prior to ongoing services being established. The primary objective of the crisis stabilization service is to promptly conduct an assessment of the patient and to develop a treatment plan with emphasis on crisis intervention services necessary to stabilize and restore the patient to a level of functioning that requires a less restrictive level of care. Duration - until the individual is stabilized and meets the conditions of the discharge plan. Not to exceed seven days.

- Services at this level of care include crisis stabilization, care management, medication management, and mobilization of family support and community resources.
- Complete an initial diagnostic interview (IDI) if one has not been completed within the preceding 12 months, or if one is not available.
- If the IDI was completed within 12 months prior to admission, and is available, a licensed professional should review and update as necessary

via an addendum to ensure the information is reflective of the individual's current status and functioning.
- Substance use disorder assessment if deemed necessary in the IDI.
- A crisis stabilization plan, which includes relapse/crisis prevention and discharge plan components (consider community, family and other supports), developed within 24 hours of admission and adjusted as needed.
- Addictions treatment initiated and integrated into the treatment/recovery plan for co-occurring disorders identified in initial assessment process as appropriate.
- Discharge planning begins at admission.
- Individual, group, and family therapy services if medically necessary.
- Ancillary service referral as needed (dental, optometry, physical health, other mental health and/or social services, etc.)

6.3.6- BH ☒ Continuing care services

Provided for: ☒ Mental Health ☒ Substance Use Disorder

MH/SUD: Continuing care services, care coordination, care transition services, and intensive wraparound are not independent services for Nebraska CHIP. Rather, these services are part of any benefit provided. When a client enters treatment, an individualized comprehensive treatment plan is established whereby care is formulated by clinical staff under the direction of a supervising practitioner. The treatment plan validates the necessity and appropriateness of services and outlines the service delivery needed to meet the identified needs, reduce problem behaviors, and improve overall functioning. This treatment plan is used by all providers working with the client or family. There is not a standard minimum or maximum time frame for treatment as it is based on the client's individual needs.

The treatment plan is based upon an assessment of the client's problems and needs in the areas of emotional, behavioral, and skills development. The treatment plan includes the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the client's progress; and the responsible professional.

The goals and objectives documented in the treatment plan must reflect the recommendations from the Initial Diagnostic Interview, the supervising practitioner, and the therapist. Evaluation of the treatment plan by the therapist and the supervising practitioner should reflect the client's response to the treatment interventions based on the recommendations, goals and objectives.

The treatment plan is reviewed and updated by the treatment team according to the client's level of functioning. The purpose of this review is to ensure that services and treatment goals continue to be appropriate to the client's current needs, and to assess the client's progress and continued need for psychiatric and SUD services.

Whenever a client is transferred from one level of care to another, transition and discharge planning must be performed and documented by the treating providers, beginning at the time of admission.

Providers must meet the following standards regarding transition and discharge planning:

1. Transition and discharge planning must begin on admission;
2. Discharge planning must be based on the treatment plan to achieve the client's discharge from the current treatment status and transition into a different level of care;
3. Transition and discharge planning must address the client's need for ongoing treatment to maintain treatment gains and to continue normal physical and mental development following discharge;
4. Discharge planning must include identification of and clear transition into developmentally appropriate services needed following discharge;
5. Treatment providers must make or facilitate referrals and applications to the next level of care or treatment provider;
6. The current provider must arrange for prompt transfer of appropriate records and information to ensure continuity of care during transition into the next level of care; and
7. A written transition and discharge summary must be provided as part of the medical record.

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

MH/SUD: See 6.3.6

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

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

MH/SUD: See 6.3.6

6.3.8- BH ☒ Case Management

Provided for: ☒ Mental Health ☒ Substance Use Disorder

MH/SUD: Case management is an intergral part of the covered mental health and substance use disorder services covered by Nebraska CHIP.

Case management activities designed to assist CHIP-eligible clients include the following:

- Client assessment a. Receive referrals or client request for case management services. b. Conduct information gathering and assessment interviews. c. Conduct an assessment to determine client's needs for individual support and services. d. Arrange for additional specialized needs assessment as required to provide a full assessment of clients' needs for individual support and services.
- Service Planning a. Together with the client or his/her representative develop a plan which includes types of services to be provided to meet the client's needs, resources selected to provide the services, frequency and duration of service provision, etc. b. Arrange for support and services identified in the plan, consistent with Section 1902(a)(23) of the Social Security Act. c. Contact, coordinate, and confirm the client's service provision with providers of service. d. Provide follow-up, ongoing monitoring of service delivery, and periodic reviews to assess suitability of client's plan.
- Accessing Resources a. Determine appropriate resources to meet the client's needs b. Assist clients in applying for appropriate programs within the Department of Social Services (e.g., Low Income Energy Assistance Program, Child Support, Food Stamps) and outside of the Department (e.g., community action, housing authority, legal aid, public health nurses, social security administration, veterans administration, vocational rehabilitation). This may include assisting the client to make an appointment or arranging transportation to the resources.

6.3.9- BH ☐ Other

Provided for: ☐ Mental Health ☐ Substance Use Disorder

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 (Section 2103(f)). Describe: Previously 8.6

6.4- BH Assessment Tools

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

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

☐ InterQual
☐ Mental Health ☐ Substance Use Disorders

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

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

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

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

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

Managed care entities may use Nebraska Medicaid specific definitions for behavioral health and substance use disorders which may include ASAM guidelines. These definitions may be accessed at: http://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx#InplviewHashef510dad-20dd-4a57-a254-85c91569baf5=Paged%3DTRUE-p_FileLeafRef%3DInitial%2520Diagnostic%2520Interview%252epdf-p_ID%3D16-FolderCTID%3D0x012001-PageFirstRow%3D31

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

☐ Other (please describe)

☐ Mental Health ☐ Substance Use Disorders

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

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

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

The State requires the MCOs to submit a plan that details the use of validated assessment tools for the treatment of behavioral health conditions. This plan must be approved by the state as well as any updates to the plan in the future.

The State will require the MCOs to provide examples of their training for review and approval. The State will require the MCOs to provide examples of the provider education during the annual on-site reviews.

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

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10% 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 6.6.2.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.

6.5-Vaccine Coverages

Guidance: States are required to provide coverage for age-appropriate vaccines and their administration, without cost sharing. States that elect to cover children under the State plan (indicated in Section 4.1) should check box 6.5.1 States that elect to cover pregnant individuals under the State plan should also check box 6.5.2. States that elect to cover the from-conception-to-end-of-pregnancy population (previously referred to as the "unborn") option under the State plan should also check box 6.5.3.

6.5.1- Vaccine coverage for targeted-low-income children. ☐ The State provides coverage for age-appropriate vaccines and their administration in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), without cost sharing. (Section 2103(c)(1)(D)) (42CFR 457.410(b)(2) and 457.520(b)(4)).

6.5.2- Vaccine coverage for targeted-low-income pregnant individuals. ☐ The State provides coverage for approved adult vaccines recommended by the ACIP, and their administration, without cost sharing. (SHO # 23-003, issued June 27, 2023); (Section 2103(c)(12)).

6.5.3- Vaccine coverage for from-conception-to-end-of-pregnancy population option. ☒ The state provides coverage for age appropriate (child or adult) vaccines and their administration in accordance with the recommendations of the ACIP, without cost- sharing, to benefit the unborn child.

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.)

Pertaining to 7.1.1 through 7.2.4 below.

The Heritage Health plans must develop a Quality Assurance and Performance Improvement (QAPI) program that, at a minimum, must comply with State and Federal requirements (including 42 CRF 438.330) and UM program requirements described in 42 CFR 456. The QAPI program must:

- Ensure continuous evaluation of the plan's operations. The plan must be able to incorporate relevant variables as defined by MLTC.
- At a minimum, assess the quality and appropriateness of care furnished to members.
- Provide for the maintenance of sufficient encounter data to identify each practitioner providing services to members, specifically including the unique physician identifier for each physician.
- Maintain a health information system that can support the QAPI program. The plan's information system must support the QAPI process by collecting, analyzing, integrating, and reporting data required by the State's Quality Strategy. All collected data must be available to the plan and MLTC.
- Make available to its members and providers information about the QAPI program and a report on the plan's progress in meeting its goals annually. The plan must submit the information or reports to MLTC for review and approval prior to distribution.
- Solicit feedback and recommendations from key stakeholders, providers, subcontractors, members, and families/caregivers, and use the feedback and recommendations to improve the quality of care and system performance.

Furthermore, the plan must develop, operationalize, and implement the outcome and quality performance measures with the Quality Assurance and Performance Improvement Committee (QAPIC), with appropriate input from, and the participation of, MLTC, members, family members, providers, and other stakeholders.

The plan must form their QAPIC no later than one month following the contract's start date. The plan's Medical Director must serve as either the chairperson or co-chairperson of the QAPIC. The plan must include, at a minimum, the following as members of the committee:

- The plan's QM Coordinator.
- The plan's Performance and Quality Improvement Coordinator.
- The plan's Medical Management Coordinator.
- The plan's Member Services Manager.
- The plan's Provider Services Manager.
- Family members/guardians of children or youth who are Medicaid members.
- Adult Medicaid members.
- Network providers, including PCPs, specialists, pharmacists, and providers knowledgeable about disability, mental health and substance use disorder treatment of children, adolescents, and adults in the State. The provider representatives should have experience caring for the Medicaid population, including a variety of ages and races/ethnicities, and rural and urban populations.

Furthermore, the plan's QAPIC must:

- Review and approve the MCO's QAPI Program Description, Work Plan, and Program Evaluation prior to submission to MLTC.
- Review the Cultural Competency Plan.
- Require the MCO to study and evaluate issues that the MLTC or the QAPIC may identify.
- Establish annual performance targets.
- Review and approve all member and provider surveys prior to their submission to MLTC.
- Define the role, goals, and guidelines for the QAPIC, set agendas, and produce meeting summaries.
- Provide training; participation stipends; and reimbursement for travel, childcare, or other reasonable participation costs for members or their family members. The plans should only provide participation stipends if the individuals are not otherwise paid for their participation as staff of an advocacy or other organization.
- Annually, and as requested, provide data to MLTC's Quality Committee, which meets annually to review data and information relevant to the Quality Strategy. The MCO must incorporate recommendations from all staff and MCO committees, the results of PIPs, other studies, improvement goals, and other interventions into the QAPI Program, the QAPI Program Description, the QAPI Work Plan, and the QAPI Program Evaluation.

The plan must include Quality Management (QM) processes in its operations to assess, measure, and improve the quality of care provided to and the health outcomes of its members. The plan's QM functions must comply with all State and Federal regulatory requirements, as well as those requirements identified in this RFP, any other applicable law, and any resulting contract. The plan must support and comply with MLTC's Quality Strategy, including all reporting requirements in formats and using data definitions provided by MLTC after contract award. MLTC is in process of revising its Quality Strategy to reflect changes in the managed care delivery system. MLTC will provide the plans with the final Quality Strategy when CMS approves it. The plan must have a sufficient number of qualified personnel to comply with all QM requirements in a timely manner, including external quality review activities. The plan's QM program must include:

- A quality assurance and performance improvement (QAPI) program.
- Performance improvement projects (PIPs).
- Quality performance measurement and evaluation.
- Member and provider surveys.
- MCO accreditation requirements, including a comprehensive provider credentialing and re-credentialing program, as described in Sections IV.C Business Requirements and IV.I Provider Network Requirements of this RFP.

The plan must ensure that the QM unit within the organizational structure is separate and distinct from other units, such as Utilization Management and Care Management. MLTC expects the plan to integrate QM processes, such as tracking and trending of issues, throughout all areas of the organization. The plan must provide a mechanism for the input and participation of members,

families/caretakers, providers, MLTC, and other stakeholders in the monitoring of service quality and determining strategies to improve outcomes.

Finally, MLTC and CMS may inspect and audit any records of the MCO or its subcontractors. There is no restriction on the right of MLTC or the Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness, or timeliness of services, and reasonableness of costs.

7.1.1. ☒ Quality standards
Refer to section 7.1.

7.1.2. ☒ Performance measurement
7.1.2 (a) ☐ CHIPRA Quality Core Set
7.1.2 (b) X Other
Refer to section 7.1.

7.1.3. ☒ Information strategies
Refer to section 7.1.

7.1.4. ☒ Quality improvement strategies
Refer to section 7.1.

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) Refer to section 7.1.

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))
Refer to section 7.1.

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))

Refer to section 7.1.

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))

Refer to section 7.1.

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 assures that prior authorization of health services are completed in a timely manner and in accordance with state law. The state takes into consideration the urgency of care in responding to prior authorization requests.

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% 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-.59). For families with incomes of 150% of poverty and above, cost sharing for all children in the family cannot exceed 5% 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) &(c), 457.515(a)&(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) &(c), 457.515(a)&(c))

8.2.1. Premiums:
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))

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))

8.5 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))

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)

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))

Guidance: Section 8.8.1is 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. (42CFR 457.570(a))

☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

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

☐ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

☐ 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))

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

The strategic objective for Nebraska's CHIP program is to reduce the number of uninsured children within the state.

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

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.

As noted in 9.1 the strategic objective is to decrease the number of uninsured children in Nebraska. The performance goal to meet this objective is to decrease the total number of uninsured low-income children under 200% FPL in the state by 5% annually until the total percentage of uninsured children in the state is at 5% or below. This performance goal will then be maintained each year once the initial target is met.

The baseline number of total uninsured children under 200% FPL per the American Community Survey data is 10,000 children from 2023. Reducing this total number by 5% will result in a goal of 9,500 uninsured children in the state after the first year.

A second performance goal to evaluate the program's effectiveness is to maintain the distribution of CHIP informational materials to 100% Nebraska's Public School Districts by or near the beginning of each school year.

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))

Goal 1 progress will be measured by American Community Survey data, as indicated in the Health Insurance Coverage table HI-11 ACS.

Goal 2 progress will be measured by manual tracking via the School Based Services Coordinator. The School Based Services Coordinator receives a school district list from the Nebraska Department of Education and materials are prepared. CHIP informational mailers are sent to each of the school districts in Nebraska.

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.

- CMS child core measures
- CAHPS 5.0H.is used to measure the following:
  - Children with chronic conditions measuring satisfaction with the respective health plans.
  - Parents measuring their children's care satisfaction

These measures are reported on annually.

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

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

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary

requires. (Section 2107(b)(1)) (42CFR 457.720)

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

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

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

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

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

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

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

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

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

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))
All federally recognized tribes, Tribal Clinics, Tribal Health Departments, Indian Health Service Hospital, Indian Health Service contracts and the Nebraska Urban Indian Health Coalition within the State are notified of proposed State Plan Amendments (SPA) regardless of the assumed impact to the Tribal entities. Tribal entities have 30 days from the date of the notice to provide comment back to the Department. If no comment is received during the 30 day period, the Department submits the SPA.

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 CFR457.65(b) through (d).
Regulations will be developed to implement this change and a public hearing will be held during the regulation development process. Public notice will be provided 30 days prior to the hearing, as required by Nebraska state statutes.

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.
Nebraska has not implemented Express Lane eligibility.

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 SPA Budget		
STATE:	**FFY Budget**	**FFY Budget**
Federal Fiscal Year	**2012**	**2013**
State's enhanced FMAP rate	**69.65%**	**69.03%**
Benefit Costs		
Insurance payments		
Managed care		
per member/per month rate		
Fee for Service		
Health Services Initiatives		
Cost of Proposed SPA changes	**1,245,040**	**6,294,465**
Total Benefit Costs	**1,245,040**	**6,294,465**
(Offsetting beneficiary cost sharing payments)		
Net Benefit Costs		
Administration Costs		
Personnel	22,736	90,944
General administration		
Contractors/Brokers		
Claims Processing	4,083	16,332
Outreach/marketing costs		

Other		
Total Administration Costs	**26,819**	**107,276**
10% Administrative Cap	**138,338**	**699,385**
Federal Share	885,850	4,419,122
State Share	386,009	1,982,619
Total Costs of Approved CHIP Plan	**1,271,859**	**6,401,741**
NOTE: Include the costs associated with the current SPA.		
The Source of State Share Funds: Legislative Appropriation		

NE 18-0014 CHIP SPA has no budgetary impact and therefore a budget submission is not necessary.

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

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

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

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

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

- **11.2.1.** ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- **11.2.2.** ☒ Section 1124 (relating to disclosure of ownership and related information)
- **11.2.3.** ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- **11.2.4.** ☒ Section 1128A (relating to civil monetary penalties)
- **11.2.5.** ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- **11.2.6.** ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

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

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. Nebraska will follow the review and appeal process used by Medicaid.

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 comply with 42 CFR 457.1120. Nebraska will follow the review and appeal process used by Medicaid.

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

Key for Newly Incorporated Templates

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

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

CMS Regional Offices				
CMS Regional Offices	**States**		**Associate Regional Administrator**	**Regional Office Address**
Region 1-Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2-New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3-Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4-Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
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Region 6-Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7-Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8-Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9-San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103

Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from SEC. 2110. DEFINITIONS.

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

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

21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
    a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
    b. performed under the general supervision or at the direction of a physician, or
    c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

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

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

means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under Section 1902(l)(2) for the age of such child.

5. TARGETED LOW-INCOME PREGNANT WOMAN.—The term ‘targeted low-income pregnant woman’ means an individual—‘‘(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; ‘‘(B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and ‘‘(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

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