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**State/Territory Name:** Illinois

**State Plan Amendment (SPA) #:** IL-21-0014

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**Children and Adults Health Programs Group**

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September 15, 2021

Kelly Cunningham  
Medicaid Administrator  
State of Illinois, Division of Medical Programs,  
Department of Healthcare and Family Services  
201 South Grand Avenue East, 3rd Floor  
Springfield, IL 62763-0001

Dear Ms. Cunningham:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) IL21-0014, submitted on June 30, 2021, has been approved. This SPA revises the state's existing Health Services Initiative (HSI) to extend the postpartum period from 60-days to 12 months for women whose newborns had been covered as targeted low-income children from conception to birth. The benefits provided during this extended postpartum period are identical to the comprehensive benefits provided to Medicaid pregnant women. The SPA has an effective date of March 1, 2020, as permitted under section 1135 of the Social Security Act (the Act).

Section 2105(a)(1)(D)(ii) of the Act and 42 CFR §457.10 authorize use of title XXI administrative funding for expenditures for HSIs under the plan for improving the health of children, including targeted low-income children and other low-income children. Consistent with section 2105(c)(6)(B) of the Act and 42 CFR §457.626, title XXI funds used to support an HSI cannot supplant Medicaid or other sources of federal funding.

The state shall ensure that the remaining title XXI administrative funding, within the state's 10 percent limit, is sufficient to continue the proper administration of the CHIP program. If such funds become less than sufficient, the state agrees to redirect title XXI funds from the support of this HSI to the administration of the CHIP program. The state shall report annually to CMS the expenditures funded by the HSI for each federal fiscal year.

Your title XXI project officer is Dietrich Graham. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid and CHIP Services  
233 N. Michigan Avenue, Suite 600  
Chicago, IL 60601-5505  
Telephone: (312) 353-9355  
E-mail: [Dietrich.Graham@cms.hhs.gov](mailto:Dietrich.Graham@cms.hhs.gov)

Page 2 - Ms. Kelly Cunningham

If you have any questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Amy Lutzky/

Amy Lutzky  
Deputy Director

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: Illinois  
(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))

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(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: Theresa Eagleson Position/Title: Director, Healthcare and Family Services  
Name: Kelly Cunningham Position/Title: Administrator, Division of Medical Programs, HFS  
Name: Tracy Keen Position/Title: Deputy Administrator, Division of Medical Programs, HFS

\*Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO #09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPA #7, SHO #09-012, issued October 7, 2009)
  - Premium assistance (CHIPA #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)
  - 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)); (42 CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the

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

11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

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

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

#### **Medicaid Expansion- CHIP SPA Requirements**

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

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

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

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

#### **Medicaid Expansion- Medicaid SPA Requirements**

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

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

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

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

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

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

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

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

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

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

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

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

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

**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))

**The State assures that expenditures for child health assistance were not claimed prior to receiving legislative authority to operate the Phase I State Plan and Phase II State Plan Amendment. The Phase I State Plan was approved on 1/5/98 and did not require legislative authority. The Phase II State Plan Amendment was approved on 8/12/98. The State received legislative authority for Phase II on 8/12/98.**

**1.3**  Check to provide an assurance that the State complies with all applicable civil rights

requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR 457.130)

**The State assures that it 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.**

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

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

Original Plan

Effective Date: **As described in the table on the next page.**

Implementation Date:

**SPA # 21-0014 Purpose of SPA: To amend the postpartum Health Services Initiative provide reimbursement for the cost of care for 12 months instead of 60 days.**

**To address the Federal COVID-19 public health emergency, the State seeks a waiver under section 1135 of the Act to submit a state plan amendment that took effect in the prior state fiscal year.**

Proposed effective date: **03/01/20**

Proposed implementation date: **03/01/20**

**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.

**To address the COVID-19 public health emergency, the State seeks a waiver under section 1135 of the Act to modify the tribal consultation process by shortening the**

number of days before submission of the SPA. The State provided the tribal consultant 24 hours' notice instead of two weeks.

Tribal notification for the postpartum Health Services Initiative amendment was provided on June 29, 2021.

TN No: Approval Date Effective Date

SPA 21-0014 Effective 03/01/20

State Plan Submission/ Amendments	Purpose	Effective Date	Implementation Date	Approval Date
Phase 1	Original Submission of the Title XXI Plan	1/5/98	1/5/98	4/1/98
Phase 2	1 <sup>st</sup> Amendment: Implementation of KidCare Share and Premium Coverage	8/12/98	10/1/98	3/30/00
#2	Elimination of 3 Month Waiting Period	7/1/02	7/1/02	9/19/02
#3	Coverage of Unborn Children	1/1/03	1/1/103	6/11/03
#4	Eligibility to 200% FPL	7/1/03	7/1/03	8/28/03
#5	Presumptive Eligibility for children	4/19/04	4/19/04	5/21/04
#6	Fluoride Dental Varnish	Withdrawn	---	---
#7	Rescind Amendment 3	Withdrawn	---	---
#8	Eligibility to 300% FPL	7/1/08	7/1/08	6/4/13
	CHIPRA Section 214 Option for Children	4/1/09	4/1/09	6/4/13
	Post-partum Coverage	4/1/09	4/1/09	6/4/13
#9	Increased Cost Sharing	7/1/12	7/1/12	1/27/16
#10	Increased Cost Sharing	4/1/13	4/1/13	3/25/16
IL 14-0006	CHIP MAGI Eligibility & Methods	1/1/14	1/1/14	8/5/15
IL 14-0007	CHIP MAGI Eligibility: Medicaid Expansion	1/1/14	1/1/14	6/6/16
IL14-0008	CHIP MAGI Eligibility: Eligibility Processing	1/1/14	1/1/14	9/8/15
IL 14-0009	CHIP MAGI Eligibility: Non-Financial Eligibility	1/1/14	1/1/14	8/10/16
IL 14-0024	CHIP MAGI Eligibility: Establish 2101(f) Group	1/1/14	1/1/14	8/21/14
IL 15-0012	Cost Sharing by Income Band	7/1/14	7/1/14	10/7/16
IL 18-0002	Mental Health Parity	6/1/18		
IL 19-006	Compliance with Medicaid managed care final rule	7/1/18	7/1/18	8/15/19
IL 20-0006	Disaster Relief – cost sharing and premiums	1/31/20		
IL 21-0014	Postpartum Health Services Initiative Amendment	3/1/20		

Through SPA 15-0012 *Cost Sharing by Income Band*, Illinois updates the federal poverty levels (FPLs) of the premium and copayment bands to the equivalent Modified Adjusted Gross Income (MAGI) eligibility standards. This SPA is consistent with the state's approved MAGI Conversion Plan and the state's implementation of MAGI

**effective January 1, 2014 through Illinois CHIP SPA IL-14-0006.**

Superseding Pages of MAGI CHIP State Plan Material  
State: Illinois

<b>Transmittal Number</b>	<b>SPA Group</b>	<b>Description</b>	<b>Superseded Plan Section(s)</b>
<b>IL-14-0006</b>  Effective/ Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7 Eligibility – Targeted Low Income Children  CS9 Eligibility – Coverage From Conception to Birth  CS13 Eligibility – Deemed Newborns  CS15 MAGI-Based Income Methodologies	Supersedes the current Geographic Area, Age and Income sections 4.1.1, 4.1.2, and 4.1.3  Supersedes the current sections Geographic Area, Age and Income sections 4.1.1, 4.1.2, 4.1.3  New subsection 4.3.3  New subsection 4.3.4
<b>IL-14-0007</b>  Effective/ Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3 Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
<b>IL-14-0024</b>  Effective/ Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14 Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	New subsection 4.1.11
<b>IL-14-0008</b>  Effective/ Implementation Date: October 1, 2013	Eligibility Processing	CS 24 Eligibility Process	Supersedes the current sections 4.3 and 4.4
<b>IL-14-0009</b>  Effective/ Implementation Date: January 1,	Non- Financial Eligibility	CS17 Non-Financial Eligibility – Residency  CS18 Non-Financial Eligibility – Citizenship	Supersedes the current section 4.1.5  Supersedes the current sections 4.1.10

Transmittal Number	SPA Group	Description	Superseded Plan Section(s)
2014		<p>CS19 Non-Financial Eligibility – Social Security Number</p> <p>CS20 Non-Financial Eligibility - Substitution of Coverage</p> <p>CS21 Non-Financial Eligibility – Non-Payment of Premiums</p> <p>CS27 General Eligibility – Continuous Eligibility</p> <p>CS28 General Eligibility – Presumptive Eligibility for Children</p>	<p>Supersedes the current section 4.1.9</p> <p>Supersedes the current section 4.4.4</p> <p>Supersedes the current section 8.7</p> <p>Supersedes the current section 4.1.8</p> <p>Supersedes the current section 4.3.2</p>

## 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))

**Illinois has chosen to target children who are under the age of 19 and who are from families with incomes at or below 133 percent of the federal poverty level (FPL). Health benefits coverage will be provided to these children through a Medicaid expansion that will cover children who are between ages 0 and 19 and who are from families with incomes above the March 31, 1997 Medicaid eligibility standard and at or below 133 percent of the FPL. The expansion will serve an additional 40,400 children. Illinois will implement this expansion on January 5, 1998.**

Estimated Number of Optional Targeted Low Income Children and Estimated Number of Potentially Medicaid-Eligible Children By Age and Family Income Relative to the Federal Poverty Level: Illinois. 1993 – 1996 Average				
POVERTY LEVEL	AGE			TOTAL
	0 – 5	6 – 13	14 – 17	
186 – 200	2,800	5,400	3,700	11,900
151 – 185	13,300	17,100	11,200	41,600
134 – 150	6,300	8,000	5,300	19,600
100 – 133		17,500	10,600	28,100
50 – 99				
< 50	(52,500)	(40,400)	(12,300)	
TOTAL				113,500

**Illinois did not identify a reason to further target children by race, ethnicity or geography. In addition, an estimated 105,200 children are potentially eligible for Medicaid (under the income standards in effect March 31, 1997) and will be targeted for enrollment in the Medicaid program through intensive community-based outreach efforts.**

**These estimates were derived by aggregating the 1993 through 1996 Current Population Surveys and cross-tabulating age (in single years) by income relative to the federal poverty level, controlling for insurance status. Insurance status was determined by an algorithm that combined the responses to several survey items in order to determine that the child was uninsured.**

**Effective August 12, 1998, Illinois began enrolling children under Phase II of its Children's Health Insurance Program. Phase II expands the new children's health insurance program, KidCare, under Title XXI for children under 19 years of age with family incomes above 133% FPL and at or below 185% FPL.**

**With the implementation of KidCare, the State has created a continuum of insurance plans with varying degrees of family financial responsibility. In an effort to reduce the stigma of being on Medicaid and to create health plans that resemble the private sector, KidCare includes five plans. These include:**

- 1) KidCare Assist – Children with family income at or below 133% of the FPL enroll and receive services through the State's Medicaid Program under Title XIX or through the Medicaid Phase I expansion under Title XXI. This program is publicly known as KidCare Assist. No monthly co-payments or premiums are charged under KidCare Assist. This plan is currently in place under the State's approved Medicaid State Plan and Title XXI State Plan.**
- 2) KidCare Moms and Babies – Pregnant women and their babies up to age one with family income at 200% of the FPL or less, receive benefits with no monthly premiums or co-payments. This program is publicly known as KidCare Moms and Babies. This plan is currently in place under the State's approved Medicaid State Plan.**
- 3) KidCare Share – KidCare Share provides benefits for children with family income over 133% through 150% of the FPL, who are not covered by KidCare Moms and Babies. Under KidCare Share, no monthly premiums are imposed, but modest co-payments for prescriptions, office visits, emergency room visits are required. Co-payments are not required for well-baby visits, well-child visits, or immunizations. This plan is currently in place under the State's approved Title XXI State Plan.**
- 4) KidCare Premium – KidCare Premium provides benefits for children with family income above 150% through 185% of the FPL, who are not covered by KidCare Moms and Babies. KidCare Premium imposes modest premiums and co-payments. Co-payments are not required for well-baby visits, well-child visits, or immunizations. This plan is currently in place under the State's approved Title XXI State Plan.**
- 5) KidCare Rebate – KidCare Rebate is the fifth plan and is not included under this State Plan. KidCare Rebate is available to those with family income above 133% through 185% of the FPL whose children are insured. KidCare Rebate reimburses part or all of the cost of private health insurance for children.**

**The KidCare Share and KidCare Premium Plans provide benefits that mirror the benefits provided for children under the State’s approved plan under Title XIX of the Social Security Act, except for home and community-based waiver services and abortion services. KidCare Share and KidCare Premium utilize the same provider networks, including essential community providers. KidCare Share, KidCare Premium and KidCare Rebate are not considered to be an entitlement.**

**KidCare Rebate is further encouraging coverage of children from working families by providing an insurance rebate to families who have enrolled their children in employer sponsored or private insurance. The rebate is capped at the average Medicaid payment minus the average KidCare premium. This rebate serves as an “anti-crowd out” strategy to discourage employees from dropping current coverage to take advantage of other KidCare plans. This rebate plan is NOT included in this Title XXI State Plan and the following sections of this State Plan will address only KidCare Share and KidCare Premium. At a later date, the State may amend this plan to seek federal financial participation for portions of KidCare Rebate.**

**KidCare Moms and Babies is currently operating under Illinois’ approved Title XIX State Plan. KidCare Assist is currently operating under the approved Medicaid State Plan and under the approved State Plan for Title XXI. The Department’s original submission of this State Plan estimated that 61,200 children with family income above 133% and at or below 185% of the FPL had no health insurance and would be potentially eligible for benefits under Phase II. The census data provided in the initial Title XXI State Plan may be under-counting the number of uninsured children in Illinois. Around 100,000 children could qualify under Phase II. Because of the unreliability of these estimates, the Illinois *Children’s Health Insurance Program Act*, which implemented KidCare, requires the Department to commission a population study to establish regional estimates of the number of children:**

- 1) with and without health insurance coverage;**
- 2) who are eligible for Medicaid;**
- 3) who are eligible for Medicaid and enrolled;**
- 4) with access to dependent coverage through an employer; and,**
- 5) with access to dependent coverage through an employer and enrolled.**

**The study shall also attempt to determine, for the population of children potentially eligible for coverage under KidCare:**

- 1) the extent of access to dependent coverage;**
- 2) the extent to which children are enrolled in private coverage; and**
- 3) the amount of cost sharing related to such coverage.**

**Upon completion of this study, more accurate estimates will be available.**

**The State estimates that 20,000 children with income between 185% and 200% FPL will be eligible as a result of the fourth amendment to the Title XXI plan.**

**Effective January 1, 2003, Illinois began covering unborn children whose mothers are not eligible for Medicaid and whose family income is between 0 and 200% of the FPL.**

**Effective July 1, 2006, the Covering All Kids Health Insurance Act 94-0693 authorized a state funded expansion which eliminated the income limit for KidCare Premium resulting in 7 additional premium levels. The KidCare program was renamed All Kids. KidCare Share became All Kids Share and KidCare Premium became All Kids Premium Level 1.**

**Effective June 30, 2012, Public Act 097-074 increased cost sharing for children receiving All Kids Share and Premium Level 1.**

**Effective July 1, 2011, Public Act 096-1501 eliminated All Kids Premium Levels 3-8, limiting enrollment to children in families with income at or below 300 percent of the federal poverty level.**

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

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

**Any child who appears to qualify for Family Health Plans coverage under Title XIX and Title XXI up to 209% FPL is determined presumptively eligible for the respective Title XIX and Title XXI program. Presumptively eligible children will receive services through the same delivery system under the applicable state plan and receive the same benefit package as described under the state plan. Services provided after an application is submitted but prior to the determination of presumptive eligibility will be covered as a Health Services Initiative for children determined presumptively eligible under both Title XIX and Title XXI. This Health Services Initiative will be funded under the State's ten percent Title XXI administration cap and will assist in improving the health of children by ensuring that they have access to healthcare services.**

**Illinois will use additional CHIP funds, up to 10 percent of the Federal CHIP**

expenditures (after administrative costs for the CHIP population for other child health assistance as authorized under 2105(a)(2) of the Act). Such assistance will cover the costs of uncompensated postpartum care for providers who provided services for mothers of newborns deemed eligible for Medicaid during the 12-month postpartum period. The postpartum services covered are consistent with the comprehensive benefit package provided under Illinois' Medicaid program under Title XIX in terms of the amount, duration and scope of services. **This will directly benefit children's health. Research shows that when mothers do not have access to care for mental health, substance use disorder, or other medical conditions, they have limited resources to fully respond to their child's health needs. Untreated postpartum depression or substance use disorder can lead to child abuse and neglect, disruption in parental attachment, and adversely impact the child's development. Children are less likely to access preventive care, attend well-child visits, complete immunization schedules, and more likely to experience avoidable hospitalizations when their parent does not have access to coverage. The state will report on performance metrics for this Health Services Initiative through CARTS. The state assures that funding under this HSI will not supplant or match CHIP federal funds with other federal funds, nor will it allow other federal funds to supplant or match CHIP federal funds.**

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

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

**Prior to submission of the state plan amendment, the State notifies the Director of American Indian Health Services of Chicago (AIHSC) by email. The email contains a description of the change sought by the state plan amendment and the anticipated impact the change may have on the population served by the AIHSC. The AIHSC is encouraged to respond with any questions or concerns.**

### 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.

**CHIP populations included in managed care are: (1) All Kids Share – above 147% FPL through 157% FLP; (2) Premium Level 1 – above 157% FPL through 209% FPL; (3) unborn children – up to 208%**

**FPL; and (4) individuals covered by the postpartum Health Services Initiative – up to 208% FPL;**

**Excluded from managed care is the CHIP Premium Level 2 population – above 209% through 318% FPL.**

**[Also, please note that the CHIP-funded Medicaid expansion population – All Kids Assist – at or below 147% FPL, participates in managed care.]**

**When individuals are first determined eligible for coverage, they are covered under the fee-for-service delivery system until they are enrolled into a managed care plan. Individuals who receive 90 days of retroactive coverage are covered under the fee-for service delivery system during the period of retroactive coverage.**

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

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

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

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))

**The method of service delivery for CHIP Premium Level 2 is fee-for-service (FFS). Beneficiaries are provided opportunity to select a primary care provider.**

- 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))

**A variety of utilization controls are in place to ensure services are appropriate, including: ongoing Department monitoring for provider abuses; Office of Inspector General activities – clients surveys, investigations of referred concerns; Medicaid Management Information System (MMIS) edits designed to prevent excessive billings; audits of providers with atypical claims activity; toll-free hotline to report problems/concerns; contracted quality improvement organization used for pre- and post-payment medical records reviews and quality reviews; prior approval for certain pharmaceuticals; routine evaluation to determine which pharmaceuticals should be subject to prior approval based upon safety, efficacy, and cost; and prior approval for certain services/supplies.**

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.

**Emergency ground ambulance, services provided through a local education agency (LEA), and early intervention (EI) services are carved out of managed care.**

**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: **Populations described in 3.1.1.1**

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(i) (related to mental health parity).
  - The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
  - The provision against provider discrimination in 42 CFR 457.1208.
  - The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards), and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).
  - The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
  - The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
  - An enrollee's right to a State review under subpart K of 42 CFR 457.
  - Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.

- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

- 3.2.1  The State assures that it provides for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services, including external quality review organizations, in accordance with the procurement requirements of 45 CFR part 75, as applicable. (42 CFR 457.940(b); 42 CFR 457.1250(a), cross referencing to 42 CFR 438.356(e))
- 3.2.2  The State assures that it will include provisions in all managed care contracts that define a sound and complete procurement contract, as required by 45 CFR part 75, as applicable. (42 CFR 457.940(c))
- 3.2.3  The State assures that each MCO, PIHP, PAHP, PCCM, and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contract providers observe and protect those rights (42 CFR 457.1220, cross-referencing to 42 CFR 438.100). These Federal and State laws include: Title VI of the Civil Rights Act of 1964 (45 CFR part 80), Age Discrimination Act of 1975 (45 CFR part 91), Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.
- 3.2.4  The State assures that it operates a Web site that provides the MCO, PIHP, PAHP, and PCCM entity contracts. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(3))

**3.3 Rate Development Standards and Medical Loss Ratio**

- 3.3.1 The State assures that its payment rates are:
- Based on public or private payment rates for comparable services for comparable populations; and
  - Consistent with actuarially sound principles as defined in 42 CFR 457.10. (42 CFR 457.1203(a))

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

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

- 3.3.2  The State assures that its rates are designed to reasonably achieve a medical loss ratio standard equal to at least 85 percent for the rate year and provide for reasonable administrative costs. (42 CFR 457.1203(c))
- 3.3.3  The State assures that it will provide to CMS, if requested by CMS, a description of the manner in which rates were developed in accordance with the requirements of 42 CFR 457.1203(a) through (c). (42 CFR 457.1203(d))
- 3.3.4  The State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs, and PAHPs. (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(a))
- 3.3.5 Does the State require an MCO, PIHP, or PAHP to pay remittances through the contract for not meeting the minimum MLR required by the State? (42 CFR 457.1203(e), cross referencing to 42 CFR 438.74(b)(1))
- No, the State does not require any MCO, PIHP, or PAHP to pay remittances.
- Yes, the State requires all MCOs, PIHPs, and PAHPs to pay remittances.
- Yes, the State requires some, but not all, MCOs, PIHPs, and PAHPs to pay remittances.

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

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

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

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

### 3.4 Enrollment

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

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

### 3.4.1 Enrollment Process

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

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

3.4.1.3 Does the State use a default enrollment process to assign beneficiaries to an MCO, PIHP, PAHP, PCCM, or PCCM entity? (42 CFR 457.1210(a))  
 Yes  
 No

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

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

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

from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

### 3.4.2 **Disenrollment**

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

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

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

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

#### 3.4.2.5 **Enrollee Requests for Disenrollment.**

Guidance: The State may also choose to limit disenrollment from the MCO, PIHP, PAHP, PCCM, or PCCM entity, except for either: 1) for cause, at any time; or 2) without cause during the latter of the 90 days after the

beneficiary's initial enrollment or the State sends the beneficiary notice of that enrollment, at least once every 12 months, upon reenrollment if the temporary loss of CHIP eligibility caused the beneficiary to miss the annual disenrollment opportunity, or when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

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

- Yes  
 No

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

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

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

### 3.5 Information Requirements for Enrollees and Potential Enrollees

- 3.5.1  The State assures that it provides, or ensures its contracted MCOs, PAHPs, PIHPs, PCCMs and PCCM entities provide, all enrollment notices, informational materials, and instructional materials related to enrollees and potential enrollees in accordance with the terms of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10.
- 3.5.2  The State assures that all required information provided to enrollees and potential enrollees are in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1))
- 3.5.3  The State assures that it operates a Web site that provides the content specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(g)-(i) either directly or by linking to individual MCO, PIHP, PAHP and PCCM entity Web sites.
- 3.5.4  The State assures that it has developed and requires each MCO, PIHP, PAHP and PCCM entity to use:
- Definitions for the terms specified under 42 CFR 438.10(c)(4)(i), and
  - Model enrollee handbooks, and model enrollee notices. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4))
- 3.5.5  If the State, MCOs, PIHPs, PAHPs, PCCMs or PCCM entities provide the information required under 42 CFR 457.1207 electronically, check this box to confirm that the State assures that it meets the requirements under 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(6) for providing the material in an accessible manner. Including that:
- The format is readily accessible;
  - The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;
  - The information is provided in an electronic form which can be electronically retained and printed;
  - The information is consistent with the content and language requirements in 42 CFR 438.10; and
  - The enrollee is informed that the information is available in paper form without charge upon request and is provided the information upon request within 5 business days.
- 3.5.6  The State assures that it meets the language and format requirements set forth in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(d), including but not limited to:
- Establishing a methodology that identifies the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area;
  - Making oral interpretation available in all languages and written translation available in each prevalent non-English language;

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

### 3.5.7

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

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

42 CFR 457.1218, cross-referencing 42 CFR 438.68;

- The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and
- To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

**3.5.8**

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

**3.5.9**

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

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

**3.5.10**

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

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

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

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

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

- 3.5.13  The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will update any information included in a paper provider directory at least monthly and in an electronic provider directories as specified in 42 CFR 438.10(h)(3). (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(h)(3))
- 3.5.14  The State assures that each MCO, PIHP, PAHP and when appropriate, PCCM entity, will make available the MCO's, PIHP's, PAHP's, or PCCM entity's formulary that meets the requirements specified in 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(i), including:
- Which medications are covered (both generic and name brand); and
  - What tier each medication is on.
- 3.5.15  The State assures that each MCO, PIHP, PAHP, PCCM and PCCM entity follows the requirements for marketing activities under 42 CFR 457.1224, cross-referencing to 42 CFR 438.104 (except 42 CFR 438.104(c)).
- Guidance: Requirements for marketing activities include, but are not limited to, that the MCO, PIHP, PAHP, PCCM, or PCCM entity does not distribute any marketing materials without first obtaining State approval; distributes the materials to its entire service areas as indicated in the contract; does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and does not, directly or indirectly, engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. (42 CFR 104(b))
- Guidance: Only States with MCOs, PIHPs, or PAHPs need to answer the remaining assurances in Section 3.5 (3.5.16 through 3.5.18).
- 3.5.16  The State assures that each MCO, PIHP and PAHP protects communications between providers and enrollees under 42 CFR 457.1222, cross-referencing to 42 CFR 438.102.
- 3.5.17  The State assures that MCOs, PIHPs, and PAHPs have arrangements and procedures that prohibit the MCO, PIHP, and PAHP from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of the MCO, PAHP, or PIHP for the purpose of influencing the individual to enroll with the entity. (42 CFR 457.1280(b)(2))
- Guidance: States should also complete Section 3.9, which includes additional provisions about the notice procedures for grievances and appeals.
- 3.5.18  The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260)

## 3.6

### Benefits and Services

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

- 3.6.1  The State assures that MCO, PIHP, PAHP, PCCM entity, and PCCM contracts involving Indians, Indian health care providers, and Indian managed care entities comply with the requirements of 42 CFR 438.14. (42 CFR 457.1209)
- 3.6.2  The State assures that all services covered under the State plan are available and accessible to enrollees. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)
- 3.6.3  The State assures that it:
- Publishes the State’s network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web site required by 42 CFR 438.10;
  - Makes available, upon request, the State’s network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

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

- 3.6.4  The State assures that each MCO, PAHP and PIHP meet the State’s network adequacy standards. (42 CFR 457.1218, cross-referencing 42 CFR 438.68; 42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206)
- 3.6.5  The State assures that each MCO, PIHP, and PAHP includes within its network of credentialed providers:
- A sufficient number of providers to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities;
  - Women’s health specialists to provide direct access to covered care necessary to provide women’s routine and preventative health care services for female enrollees; and
  - Family planning providers to ensure timely access to covered services. **(42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b))**
- 3.6.6  The State assures that each contract under 42 CFR 457.1201 permits an enrollee to choose his or her network provider. (42 CFR 457.1201(j), cross-referencing 42 CFR 438.3(l))
- 3.6.7  The State assures that each MCO, PIHP, and PAHP provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(3))

**3.6.8**

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

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

**3.6.9**

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

**3.6.10**

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

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

**3.6.11**

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

- Identifying, defining, and specifying the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer; and

- Permitting an MCO, PIHP, or PAHP to place appropriate limits on a service. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(a) except that 438.210(a)(5) does not apply to CHIP contracts)

**3.6.12**

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

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

**3.6.13**

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

**3.6.14**

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

**3.6.15**

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

**3.6.16**

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

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contact their designated person or entity responsible for the enrollee's coordination

of services;

- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each enrollee's 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**  n/a 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 30<sup>th</sup> 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 30<sup>th</sup> of each year. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(i))
- 3.12.5.3.8  The State assures that it provides printed or electronic copies of the information specified in 42 CFR 438.364(a) for the annual EQR technical report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the MCO, PIHP, PAHP, or PCCM, beneficiary advocacy groups, and members of the general public. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(2)(ii))
- 3.12.5.3.9  The State assures that it makes the information specified in 42 CFR 438.364(a) for the annual EQR technical report available in alternative formats for persons with disabilities, when requested. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(c)(3))
- 3.12.5.3.10  The State assures that information released under 42 CFR 438.364 for the annual EQR technical report does not disclose the identity or other protected health information of any patient. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.364(d))

**Section 4. Eligibility Standards and Methodology**

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

**4.0.  Medicaid Expansion**

- 4.0.1. Ages of each eligibility group and the income standard for that group:  
**The Medicaid expansion group includes uninsured children age 6**

**through age 18 whose countable income is above 108% and at or below 142% of the federal poverty level.**

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

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

**All applications for medical coverage are processed through the IES eligibility system. U.S. citizenship is verified using the SSA verification option through the automated clearances via the Federal Data Services Hub. If U.S. citizenship cannot be verified electronically, the family is given a 90 day reasonable opportunity to provide documentation. The reasonable opportunity period may be extended if the family makes a good faith effort to obtain the verification.**

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

**As described in Appendix 1, pp. 1-3.**

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

**As described in Appendix 1, pp. 1-3.**

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

**As described in Appendix 1, p. 3.**

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

**As described in Appendix 1, pp. 1-3.**

4.1.3.1-PC  0% of the FPL (and not eligible for Medicaid) through **208%** of the FPL (SHO #02-004, issued November 12, 2002)

**As described in Appendix 1, p. 3.**

4.1.4  Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources): **No asset limitation is applied. Met spend down cases are not eligible for All Kids Share or All Kids Premium Levels 1-2.**

4.1.5  Residency (so long as residency requirement is not based on length of time in state): **As described in Appendix 1, pp. 12-13.**

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: **Eligibility for benefits will require that:**

- 1) **The child is not a member of a family that is eligible for health benefits covered under the State of Illinois health benefits plan on the basis of a member's employment with a public agency;**
- 2) **The child is not found to be eligible for Medicaid under Title XIX.**

4.1.8  Duration of eligibility, not to exceed 12 months: **As described in Appendix 1, p. 23.**

4.1.9  Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 42 CFR 457.310 and 457.320 that

are not addressed above. For instance:

**At the time of application:**

- a) **The child is not a patient in an institution for mental diseases, or**
- b) **The child is not an inmate of a public institution.**
- c) **The program eligibility is limited by amounts appropriated for All Kids Share and All Kids Premium Levels 1-2. If the plan’s enrollment reaches levels that indicate that fiscal year costs for those currently enrolled are approaching the appropriation, the State will stop taking new applications. The State will again take applications once enrollment levels are reduced or funding becomes available.**

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. **As described in Appendix 1, pp. 17-18.**

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

- 4.1.9.2  Continuous eligibility  
**The duration of financial eligibility for All Kids Share and All Kids Premium Levels 1-2 is 12 months. The 12 months of financial eligibility commences when the first child in a family is covered under a plan. Children added to a plan after the eligibility period begins are eligible for the balance of the 12 month eligibility period. Before any 12 month period of eligibility ends, families are allowed to reapply to determine eligibility for another 12 months.**

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

Guidance: States have the option to cover groups of “lawfully residing” children and/or pregnant women. States may elect to cover (1) “lawfully residing” children described at section 2107(e)(1)(J) of the Act; (2) “lawfully residing” pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant

women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

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

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

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
  - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
  - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
  - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
  - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
  - (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
  - (vi) Aliens currently in deferred action status; or
  - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
- (6) An alien who has been granted withholding of removal under the Convention Against Torture;

- (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
- (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
- (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

- Elected for pregnant women.
- Elected for children under age 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.

4.1.11. Children ineligible for Medicaid as a result of the elimination of income disregards as described in Appendix 1, pp. 7-8. (Section 2101(f) of the ACA and 42 CFR 457.310(d))

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

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

medical condition. This applies to pregnant women as well as targeted low-income children.

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

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

**4.2.2-DS**  Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

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

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

**As described in Appendix 1, pp. 10-11 and additional information is below.**

**All applicants are notified in writing, regarding the outcome of their eligibility determination.**

**Eligibility determinations made by the fifteenth day of the month are effective in the first day of the following month. Eligibility determinations made after the fifteenth day of the month are effective no later than the first day of the second month following that determination. A child eligible for All Kids Share or Premium Level 1 may obtain coverage for the period of time beginning two weeks prior to the date of initial application and continuing until coverage under All Kids is effective.**

**Medical identification cards are issued for each family with a child enrolled under All Kids Share and All Kids Premium Levels 1-2.**

**Illinois is committed to prompt review of All Kids applications. The state standard for approving or denying requests for Medicaid under Title XIX is 45 days. This will also be the target for applications under Title XXI. The Department has established a central unit dedicated to processing All Kids applications and All Kids applications are also processed by eligibility staff working for the Illinois Department of Human Services at 129 local offices throughout Illinois. Most of the increase in applications resulting from All Kids outreach efforts are received centrally in Healthcare and Family Services. The Department has hired 111 permanent and 55 temporary staff for its Bureau of All Kids in Springfield. This fall, a second site opened in Chicago to perform initial data input and currently has**

37 staff. The State is committed to increasing staffing further as necessary to handle All Kids applications expeditiously. Note, all eligibility determinations are made by State employees.

The State has also streamlined the eligibility data system to make All Kids eligibility determination processing by the Department significantly more efficient.

**Disaster-Related Emergency Temporary Processes**

During the Federal COVID-19 PHE, requirements related to timely processing of applications, renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP applicants or beneficiaries.

The State will temporarily delay acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by the Federal COVID-19 PHE such that processing the change in a timely manner is not feasible. The state will continue to act on the required changes in circumstance discussed in 42 CFR 457.342(a) cross-referencing 42 CFR 435.926(d).

During the Federal COVID-19 PHE, the state may temporarily increase the allowable number of presumptive eligibility periods from one to two within a calendar year for CHIP applicants.

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

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

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

**The State does not have an enrollment cap for state fiscal year 2003. HFS staff monitor All Kids Share and Premium spending and compare spending to appropriated amounts. If spending is at a level close to the level that staff estimate could not be sustained throughout the state fiscal year, the Department will institute an enrollment cap. Similarly, if the Governor's budget office or the legislature directs the Department to reduce All Kids Share and Premium spending because of fiscal problems, HFS will institute an enrollment cap. In either case, the cap will have no effect on current enrollees, unless they leave the program.**

**If All Kids Share/Premium enrollment approaches levels that cannot be sustained through the end of the year or if the state's fiscal situation requires a slow-down in new enrollments, Illinois will stop enrolling children into All**

**Kids Share or Premium until the situation is resolved. Using the public notice timeframe options under Title XXI, Illinois will notify the public before starting an enrollment cap. Public notice of this change would be accomplished through statewide press, All Kids Application Agents, and community partners. Illinois will also notify the Centers for Medicare and Medicaid Services as soon as possible before implementing an enrollment cap. An All Kids Share and Premium enrollment cap would only apply to new enrollees. If such a cap were implemented, those currently enrolled would remain in All Kids Share/Premium as long as they continued to be eligible and met program requirements.**

**Once new enrollments are stopped, all applications received will be processed and those families determined eligible for Medicaid will be enrolled. Applications for families determined eligible for All Kids Share or Premium will be returned to the families. The State will use the same methods to notify the public when new enrollments begin again.**

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)  
**As described in Appendix 1, pp. 24-25.**

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

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

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

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

**4.3.3.3-EL** List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in

budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

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

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

4.3.4. Deemed newborns—Children born to targeted low-income pregnant women are deemed to have applied for and be eligible for CHIP or Medicaid until the child turns one: **as described in Appendix 1, p. 4.** (Section 2112(e) of the SSA and 42 CFR 457.360)

4.3.5. MAGI-Based Income Methodologies—The CHIP agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups: **as described in Appendix 1, pp. 5-6.** (Section 2102(b)(1)(B)(v) if the SSA and 42 CFR 457.315)

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), 42 CFR 457.350(a)(1) and 457.80(c)(3))

**4.4. Eligibility screening and coordination with other health coverage programs**  
States must describe how they will assure that:

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

**The single application process described above assures that all children applying for All Kids are considered for eligibility under Title XIX. Where they are found to be eligible for Medicaid, they are enrolled in All Kids Assist under Title XIX or Title XXI as appropriate. A child who is pregnant at the time of application for All Kids or an infant whose mother is eligible under Title XIX at the time of birth is enrolled in Moms and Babies.**

**If a child enrolled in All Kids Share or All Kids Premium Level 1 becomes pregnant, she is terminated from either plan and enrolled under Moms and Babies (Title XIX funded) under the following circumstances: 1) upon the request of the pregnant child or her family she is reviewed for Title XIX eligibility, and if found eligible, is enrolled in Moms and Babies; 2) upon reapplication for All Kids Share or All Kids Premium Level 1, a pregnant child is enrolled in Moms and Babies when the 12 month eligibility period for All Kids Share or All Kids Premium Level 1 ends; or 3) upon the family seeking to enroll the infant in All Kids, the State reviews the mother's status and if determined to be eligible under Title XIX, both mother and infant are enrolled in Moms and Babies.**

**When an All Kids Share or Premium Level 1 enrolled child becomes pregnant and is therefore likely to be eligible for Medicaid under Title XIX, she will be enrolled in Moms and Babies after her family income has been reviewed to determine that she in fact meets the Moms and Babies financial eligibility criteria. The time it takes to complete the review will depend on the responsiveness of the pregnant girl and her family. Once any necessary information is obtained, the financial review can be completed in a day or two. Once Medicaid eligibility is determined, it may be established retroactively for three months, pursuant to Medicaid policy. She will also be disenrolled from All Kids at that time; therefore, benefits will continue in an uninterrupted fashion.**

**The State has great concern that coverage not be interrupted because a family fails to provide information necessary to make a determination of the child's eligibility for Medicaid when her eligibility for All Kids Share or Premium Level 1 remains in force. Therefore, the State will maintain the**

**child's enrollment in All Kids Share or Premium Level 1 until either she is enrolled in Medicaid or she is otherwise disenrolled from the program as described in Section 4.1.8. The State will claim FFP under Title XXI for services she receives while she is enrolled in All Kids Share or Premium Level 1.**

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)) **As described in Appendix 1, pp. 10-11.**

4.4.4.  the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42 CFR, 457.805) **As described in Appendix 1, pp. 19-21.**

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

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

**Any American Indian or Alaska Native child who applies for All Kids and who meets the eligibility requirements will be enrolled in All Kids. No premiums or co-payments are required for American Indian or Alaska Native children.**

**There is a single American Indian health center in the State, which is located in Chicago. This health center is recognized as a Federally Qualified Health Center (FQHC) under the Department's Title XIX program. The facility provides primary care services and makes referrals for other services. At the inception of All Kids, the Department consulted with this facility concerning All Kids outreach and enrollment strategies that would be appropriate for reaching American Indian Children.**

**Subsequent attempts to solicit input from American Indian groups have been unsuccessful.**

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

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

requirements:

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

## **Section 5. Outreach and Coordination**

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

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

**Outreach to low income children and pregnant women for the Medicaid program is conducted the State's Maternal and Child Health (Title V) program in the Illinois Department of Human Services. *The Family Case Management* program conducts outreach and case management activities for low-income families that include a pregnant woman, infant or young child. Medicaid matching funds are claimed for outreach activities and for case management activities conducted with Medicaid-eligible families for Medicaid-covered services. The program has been operating since 1986 and has been a Medicaid-MCH partnership since 1990. The program's current budget is \$45.7 million, of which \$4.1 million is used for outreach activities.**

**Family Case Management activities are carried out by local agencies: local health departments, community health centers, other FQHCs and other community-based organizations. “Outreach” activities include any activity to find and inform potential program participants of the health services available through the Medicaid program. Outreach, therefore, can include community campaigns as diverse as door-to-door canvassing, production and distribution of handbills, design and publication of newspaper announcements, and production and broadcast of public service announcements or paid advertising on radio or television. Projects also target outreach activities to employers that do not offer health insurance coverage for their employees. Presentations are made to church groups, service clubs, and other community groups. Local agencies develop networks of community health care providers, hospitals, clinics, emergency rooms, pharmacies and other agencies to distribute information on the Medicaid program. The primary objective of outreach activities is to inform potential program participants of available services, eligibility criteria and methods of accessing services (for example, the name, address and phone number of the provider). This is not to preclude the use of nontraditional methods of outreach.**

**Once identified through outreach activities, the Family Case Management program then helps eligible families to enroll in Medicaid. Many of the local provider agencies are also qualified to conduct Medicaid Presumptive Eligibility determinations for pregnant women. The Family Case Management providers either are WIC providers or have a linkage with the WIC Program. WIC identifies potentially eligible Medicaid clients and refers them for eligibility determination. Local providers have also established good working relationships with the eligibility determination staff at local DHS offices and can assist families in making appointments for eligibility interviews and in providing or arranging transportation and child care if necessary.**

**The Family Case Management program services about 140,000 families each year. This total includes currently Medicaid-eligible families as well as targeted low income children who will become eligible through the Medicaid expansion under Title XXI.**

**Health care services – The Maternal and Child Health program pays for primary health care services to Medicaid ineligible targeted low income children through two programs: Family Case Management, and a “Maternal and Child Health Mini-Block Grant” to the Chicago Department of Health.**

**A portion of the grant funds awarded to each Family Case Management agency is earmarked for primary care services. These funds may be used to purchase health care for either pregnant women or children. To use these**

**funds, the family must be ineligible for Medicaid and not have insurance that will cover primary care services. The Chicago Department of Health uses its “Mini-Block Grant” to pay for primary health care services provided through its community-based clinics to uninsured women of reproductive age (for family planning services), pregnant women (for prenatal care) and children (for pediatric primary care). All of these funds are used only for ambulatory, preventive and primary care; they are not used for specialty or inpatient care. During SFY’97, these programs used \$1.6 million to pay for approximately 85,200 pediatric encounters.**

**In Illinois, 106 FQHC site locations provide medical services to families with little or no income. The FQHC staff identify potentially eligible Medicaid clients and assist them in completing the eligibility process. In 1991, the Department of Healthcare and Family Services implemented procedures for Medicaid eligibility application processing for pregnant and postpartum women and children under age 19 at designated locations other than the local DHS offices. Those locations include FQHCs and disproportionate share hospitals.**

**In Illinois’ continuing effort to improve the health status of school-aged children, the Project Success Program coordinates social and health services with parental involvement in approximately 200 designated school sites throughout the State. Project Success sites refer potentially eligible Medicaid children for eligibility determination. Additionally, sixteen school based/linked clinics provide services to school-aged children, their siblings and preschool aged children in the district. The clinics are required to assess income levels and refer those children who appear to be Medicaid eligible for eligibility determination while at the same time providing needed medical services.**

**In addition, Illinois has established All Kids Application Agents (AKAAs) that assist families in completing the State’s All Kids Application. AKAAs received a technical assistance payment for each complete application that results in enrollment of children into any of the All Kids plans. Technical Assistance Payments ended July 1, 2012 with the enactment of P.A. 097-0689. Organizations that have been enrolled as AKAAs include hospitals, Federally qualified health centers (FQHCs), local health departments, faith based organizations, Women, Infant and Children (WIC) program sites, Family Case Management agencies, Community Action agencies, Early Intervention agencies, Child Care Resource & Referral agencies, and licensed insurance agents. Organizations must enter into a written agreement with the State and participate in a training session before becoming a AKAAs.**

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 this section but may instead update this section as appropriate.

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

**The State of Illinois is not directly involved in a public-private partnership concerning health insurance for children. A local public-private partnership, however, operates in suburban Cook County. The Suburban Primary Health Care Council operates the Access to Care Program in suburban Cook County. This public-private partnership includes the Community and Economic Development Association of Cook County, Inc., the Cook County Department of Public Health; the Northwest Suburban Health Care Council; and the Park Forest Health Department. Approximately 4,500 uninsured or under-insured children from suburban Cook County (outside of Chicago) will be served during 1997.**

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

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

**Illinois’ Title XXI program will be fully integrated with the State’s Medicaid program. Procedures currently employed in the Illinois Medicaid program will be used for the identification of third party coverage for optional targeted low income children.**

**Coordination with public programs is attained through the single application process for all plans. The dual approach of providing eligible children with either All Kids Share and All Kids Premium Levels 1-2, or All Kids Rebate assures coordination with private sector programs.**

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

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, out-stationed eligibility workers, translation and transportation services, assistance with

enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

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

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

**Illinois will conduct an outreach campaign and target an enrollment strategy to children throughout the State who are likely to be eligible either for Medicaid under Title XIX or for expanded Medicaid under Title XXI. This strategy will encourage these children to enroll, utilize and stay in the health care system. This will be achieved in the following manner:**

- 1) Healthcare and Family Services (HFS) will review its automated records and notify the families of eligible children who are currently in the Medicaid system as unmet spenddown of their eligibility under the new income thresholds and will enroll the children.**
- 2) HFS will develop a new simplified application process and the procedures to support widespread offsite enrollment.**
- 3) MPE and MCH offsite enrollment sites including FQHCs, disproportionate share hospitals, local health departments and WIC sites will be utilized to conduct offsite enrollment of uninsured children into the new program.**
- 4) County health departments, Family Case Management and WIC sites will be asked to utilize existing records on the Cornerstone system of the Department of Human Services to review their records and identify children who are in their programs and likely to be eligible for health benefits coverage.**
- 5) HFS will send a notice to all non-assistance Child Support families informing them of the program and of locations where the family could enroll the child.**
- 6) Outreach will be coordinated with the Illinois child care resource and referral networks and larger child care of Head Start providers.**
- 7) School districts will be recruited for identifying children likely to be eligible for health benefits coverage, and wherever possible, offsite enrollment, according to the school census of the number of children receiving free and**

**reduced cost lunch. This will be coordinated with Project Success and School Attendance Initiative sites.**

- 8) Special efforts will be made to identify eligible:**
  - a) migrant children through community agencies such as the Illinois Migrant Council or migrant health clinics;**
  - b) homeless children through community-based organizations such as those who provide shelter or emergency food services, and clinics which target these populations;**
  - c) children with special health care needs through the Division of Specialized Care for Children and through children's hospitals; and,**
  - d) children in rural areas through the efforts of county health departments, rural health clinics and FQHCs.**
  
- 9) Community-based organizations will be asked to disseminate information about the program and the referral process to potentially eligible families. These organizations include, but are not limited to:**
  - Project SUCCESS sites;**
  - Places of worship;**
  - Day care facilities, Child Care Resource and Referral Networks;**
  - Early Intervention sites;**
  - Head Start, Early Head Start sites;**
  - Community-based organizations (YWCA, etc.); and**
  - HFS's Neighborhood Education Contractors**
  
- 10) Other efforts to promote the program will include a program fact sheet and a provider notice explaining the new eligibility levels and a listing of enrollment sites.**

**In addition to the tasks already described, Illinois is conducting an outreach campaign to increase public awareness of the State's health care programs for children. The campaign has been developed with the assistance of the Outreach Advisory Committee. This committee includes representatives from social services agencies, churches, schools, provider groups, community groups, fraternal organizations, local government employer groups, HCFA and State agency personnel.**

**This outreach campaign is designed to reach eligible children in All Kids Share, All Kids Assist, All Kids Premium, Moms and Babies and All Kids Rebate. Outreach to all of these plans will be accomplished by 1) identifying targeted populations; 2) publicizing the available benefits; 3) motivating families to take advantage of available plans; and 4) providing applications and assisting people with the application process. The enrollment process itself is more accessible and streamlined by expanding the number of offsite enrollment locations, using a**

**combined application for all plans, and through the use of mail-in applications. Through this coordinated approach, all outreach efforts target all children potentially eligible under both Titles XIX and XXI.**

**Other specific outreach activities that are being implemented include the following:**

- 1. Distribute informational brochures and implement a toll-free number for interested parties to learn more about the plans and receive assistance in completing and submitting applications;**
- 2. Develop a media campaign to promote public awareness of the plans. The campaign will include radio, print and promotional advertising. The State is investing considerable resources into making materials attractive, interesting and easy to follow;**
- 3. Educate employers, unions and trade associations about the plan;**
- 4. Establish strong community outreach through churches, immigrant organizations and community based organizations. Medical providers, including doctor's offices, local health departments, emergency rooms, Federally Qualified Health Centers and Rural Health Clinics are also being enlisted. To assist community providers, the Department has developed an income screening tool that persons in the community can use to determine whether families appear to be eligible for All Kids and for which plan they may be eligible;**
- 5. Complete an electronic cross-match of participants in the WIC, school lunch and child care programs to identify families who meet the income criteria for All Kids, but have not enrolled. Families in an unmet spend-down status are invited to apply;**
- 6. Pilot the use of eligibility for the free lunch program as a determination of presumptive eligibility for All Kids Assist;**
- 7. Establish educational partnerships to assist the State in promoting public awareness of All Kids. Such partnerships will include Americorp and Vista programs, Headstart programs, Project Success (a program that coordinates social services through local schools), and coordination with the Illinois Departments of Human Services, Commerce and Community Affairs, Aging, Natural Resources, Revenue, and the State offices of Secretary of State, Attorney General and Comptroller, as well and through legislative offices.**
- 8. Therefore, the Department may release a Request for Proposals to contract with multiple entities to identify and implement creative outreach strategies to locate and enroll identified hard-to-reach populations that may be eligible for All Kids and Medicaid. If implemented, the Department will provide**

multiple small grants for this project and has committed up to \$500,000 in total spending. Hard-to-reach populations that may be targeted through these grants include:

- a) **Children in families with limited English proficiency and other language barriers such as illiteracy;**
- b) **Children with special needs. This includes children who are visually impaired, hearing impaired, and children with other chronic conditions such as emotionally, physically, or developmentally challenged children;**
- c) **Families who are difficult to reach because of various cultural barriers;**
- d) **Families who have multiple jobs;**
- e) **Families whose members are healthy and are, therefore, not motivated to apply for health insurance coverage; Families residing in rural areas of the State where medical provider services are limited or non-existent;**
- f) **Migrant children;**
- g) **Homeless children; and**
- h) **Other hard-to-reach populations that may be defined by the contractors.**

9. **Effective April 12, 1999, the State began reimbursing All Kids Application Agents \$50 for each completed All Kids application that results in enrollment in the program.**

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

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

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

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.

**The benchmark plan is actuarially equivalent to the State employees group health plan. The actuarial report is attached.**

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

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

and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

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

6.1.4.  Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)  
Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

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

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

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

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

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in §457.420, plus additional coverage. Under this

option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4.  Coverage that includes benchmark coverage plus additional coverage.

6.1.4.5.  Coverage that is the same as defined by existing comprehensive state-based coverage applicable only in New York, Pennsylvania or Florida. (under 42 CFR 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 coverage under one of the benchmark plans specified in 457.420, through the use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

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

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

6.1.4.7.  Other. (Describe)

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

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

for pregnant women. (Section 2112)

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

**All Kids Share and All Kids Premium Levels 1-2 mirror the benefits of the Medicaid program in terms of the amount, duration and scope of services covered, except as noted below. The only exceptions are that home and community-based waiver services that are provided to Medicaid eligible persons as an alternative to institutionalization are not a part of All Kids Share or All Kids Premium Levels 1-2, and no abortion services are included. All Kids Share and All Kids Premium Levels 1-2 include the following services in all primary, preventive, acute and chronic circumstances:**

- 6.2.1.  Inpatient services (Section 2110(a)(1))
- 6.2.2.  Outpatient services (Section 2110(a)(2)), **including emergency services.**
- 6.2.3.  Physician services (Section 2110(a)(3))
- 6.2.4.  Surgical services (Section 2110(a)(4))
- 6.2.5.  Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6.  Prescription drugs (Section 2110(a)(6))
- 6.2.7.  Over-the-counter medications (Section 2110(a)(7)) **Over-the-counter medications are only covered if prescribed by a physician.**
- 6.2.8.  Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9.  Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10.  Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11.  Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))

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

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

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

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

**All services available under the State’s Title XIX State Plan that are provided to participants of home and community based waivers are included under All Kids Share and All Kids Premium Levels 1-2. Only the specialized services unique to these waivers are excluded from these plans. The waiver programs themselves have been specifically excluded for the following reasons:**

- 1) **All Kids Share and All Kids Premium Levels 1-2 are designed to be broadly applicable and are not intended to focus on the unique circumstances addressed through the home and community based waivers;**
- 2) **Each of the waiver programs have specialized eligibility objectives, several of which include income standards above those allowed under All Kids Share and All Kids Premium Levels 1-2; and**
- 3) **All of the waiver programs have enrollment caps.**

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

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

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

**No abortion services are covered by All Kids Share and All Kids Premium Levels 1-2. A child who is pregnant when she applies is not enrolled in these plans but instead enrolled under Title XIX if income is at or below 208% of the FPL. If a child who becomes pregnant while she is enrolled under All Kids Share or All Kids Premium Level 1 chooses to have an abortion, she must enroll under Title XIX to**

**have abortion services covered. Abortion service limitations are defined in the Illinois Medicaid State Plan.**

- 6.2.17.  Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
- 6.2.18.  Vision screenings and services (Section 2110(a)(24))
- 6.2.19.  Hearing screenings and services (Section 2110(a)(24))
- 6.2.20.  Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.21.  Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.22.  Case management services (Section 2110(a)(20)) **Limited to children diagnosed with mental illness and children under the age of three who are receiving early intervention services.**
- 6.2.23.  Care coordination services (Section 2110(a)(21))
- 6.2.24.  Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.25.  Hospice care (Section 2110(a)(23))
- Guidance: See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.
- 6.2.26.  EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act
- Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
- 6.2.27.  Any other medical, diagnostic, screening, preventive, restorative,

remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

**Home health care services**

- **Audiology services**
- **Optometric services**
- **Family planning services**
- **All EPSDT services**
- **Chiropractic services**
- **Podiatric services**
- **Renal dialysis**
- **Services of Intermediate Care Facilities for the Mentally Retarded,**
- **Skilled pediatric nursing facility services**
- **Early Intervention services, including case management, for children who meet eligibility requirements established in the State's approved plan pursuant to Part C of the Individuals with Disabilities Education Act**

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

6.2.29.  Medical transportation (Section 2110(a)(26)) **Non-emergency medical transportation is limited to children in All Kids Share and All Kids Premium Level 1.**

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

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

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

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

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

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

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

**6.2.2.1-DC**  FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT<sup>2</sup> 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)

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

**6.2-DS**  **Supplemental Dental Coverage-** The State will provide dental coverage to children

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

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

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

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

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

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

- International Classification of Disease (ICD)
- Diagnostic and Statistical Manual of Mental Disorders (DSM)
- State guidelines (Describe: Medicaid State Plan, Waiver authorities and provider handbooks.)
- 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.

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

- 6.3.1.**  The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
- 6.3.2.**  The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

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

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

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

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

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income

children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42 CFR, 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)) (42 CFR 457.1005(a))

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

- 6.4.2.1.** Purchase of family coverage is cost-effective. The State’s cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2)

The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

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

**Not applicable at this time.**

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

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

- Yes  
 No

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

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

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

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

**6.4.3.2.1-PA** If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not

covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

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

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

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

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

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

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

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

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

- Yes  
 No

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

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

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

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

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

## **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)) (42 CFR 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. (2102(a)(7)(A)) (42CFR 457.495(a))

**The Department has established access to quality care, and the appropriateness of care, as performance measures for All Kids Share and All Kids Premium Levels 1-2. These performance goals and methods of assuring their attainment are more fully described in Section 9. Methods to measure quality and appropriateness of care include the following:**

**Managed Care**

**For clients enrolled in managed care, the Department establishes and provides**

monitoring and oversight to ensure that quality control requirements are met. Managed Care Entities (MCEs) are required to have a quality assurance system in place that focuses on quality improvement. System activities include:

- Collecting systematic data on performance and patient results;
- Monitoring health care services through medical records review, clinical studies, physician peer review, and monitoring of health outcomes;
- Developing and monitoring of health education and outreach for clients
- Establishing and monitoring member services to handle client issues;
- Establishing mechanisms for preauthorization and review of denials;
- Monitoring access standards;
- Monitoring fraud and abuse;
- Establishing and monitoring a client grievance and complaint resolution system;
- Evaluating client satisfaction;
- Providing information to providers, evaluating provider satisfaction and resolving provider concerns; and
- Establishing procedures for ongoing quality improvement with written procedures for taking appropriate remedial action and correcting deficiencies.

The Department has established quality control mechanisms for managed care which include ongoing monitoring of contract compliance, including the areas of covered services; service delivery; access standards; health education and outreach; pharmacy formulary; linkages to other services; records requirements; care standards; encounter reporting on encounters and quality assurance/improvement activities; marketing; member services; health outcomes, including measuring HEDIS indicators; minimum required performance standards; and financial stability. The Department contracts with a Quality Assurance Organization to assist in the oversight of managed care under both Title XIX and Title XXI. The Contractor's responsibilities include but are not limited to, medical records review, technical assistance, health outcome analysis and quality assurance monitoring of each managed care entity.

#### **Primary Care Case Management (PCCM)**

For client enrolled in PCCM, the Department has established and provides monitoring and oversight to ensure that the quality improvement initiatives and outreach and education efforts for both client and providers under the contract are met.

#### **Client Initiatives**

- Educating clients on the importance of EPSDT appointments
- Assisting clients that are due for a Healthy Kids checkup with making an appointment with their PCP.
- Sending annual reminder notices (based on recipient's birthday) for Healthy Kids appointments due.
- Performing outreach to clients who missed appointments.
- Assisting parents in finding primary care providers and specialists for their

**children through the Illinois Health Connect Client Helpline.**  
**-Evaluating Client Satisfaction.**

### **Provider Initiatives**

- Providing providers with access to the following Quality Improvement Tools to assist providers in improving quality for clients: Monthly Panel Rosters, Claims History Report, Semi-annual Provider Profiles, and a Bonus for High Performance program.**
- Quality Assurance Nurses in the field meeting with providers to discuss their provider profiles and to help connect providers to various resources.**
- Provider Service Representatives in the field working with providers on a one-to-one basis through outreach and education efforts. The education efforts are necessary to assist providers in understanding the components and frequency of well-child exams under EPSDT, appropriate billing and coding for preventive care, and resources available to coordinate care for kids.**
- On-going communication and feedback from providers through training initiatives, committee meetings, webinar sessions, pilot projects, and conducting provider satisfaction surveys.**

### **Fee-For-Service**

**Quality assurance mechanisms in the fee-for-service Medicaid system are listed below. These are employed under fee-for-service for All Kids Share and All Kids Premium Levels 1-2. Through these mechanisms, quality problems are identified and addressed. Providers found to have quality problems are asked to prepare quality improvement plans.**

- 1. Staff from the Division of Medical Programs watch for provider abuses of the Medicaid system. Such abuses are referred to the Office of the Inspector General (OIG) for review.**
- 2. OIG has many tasks to assure medical quality.**
  - a. Face-to-face client surveys regarding quality of care and access to care.**
  - b. Investigations of referrals from within HFS; the Department of State Police; the Department of Public Health; and from the state's peer review organization.**
  - c. Audits of providers who fall outside accepted norms for claims activity.**
  - d. Peer review coordination of medical necessity and over-utilization issues.**
- 3. The state's Medical Management Information System (MMIS) includes many edits to prevent abuse and excessive billings. New ones are created regularly.**
- 4. HFS operates a toll-free hotline for clients to report any problems or concerns they may have.**
- 5. The Department's peer review organization, conducts prepay and postpay medical records reviews on certain hospital inpatient and outpatient claims.**
- 6. Special reviews are conducted on pharmacy claims to identify duplicate therapy, refill-too-soon, potential drug interactions, and abnormal dosages. Prior approval is required for high risk medication and drugs likely to be**

abused.

**7. Prior approval is required for durable medical equipment and many medical supply items.**

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

7.1.1.  Quality standards

**The Department has established quality control mechanisms, including the monitoring of contract compliance, covered services, service delivery, access standards, health education and outreach, coordination with other services, and quality assurance and improvement activities. Specific goals for maintaining quality standards and measures of their attainment are described in Section 9.**

7.1.2.  Performance measurement

**Performance measures include improving the health status of children by reducing infant mortality, lead poisoning, and school absenteeism; extending health coverage to more Illinois children; and assuring appropriateness of, and access to, necessary health care. These performance measurements and specific criteria for assessing their attainment are more fully described in Section 9.**

7.1.2 (a)  CHIPRA Quality Core Set

7.1.2 (b)  Other

7.1.3.  Information strategies

**The Department is expanding its client health care hotline and promoting the hotline as a place for families to call with concerns and questions. The Department is also incorporating a satisfaction survey for families participating in All Kids. Under both of these efforts, information is being collected and used to directly monitor and improve health care access and quality.**

7.1.4.  Quality improvement strategies

**The Department is establishing procedures for ongoing quality improvement in written procedures for taking appropriate remedial action and correcting deficiencies.**

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: (2102(a)(7)(B)) (42CFR

457.495)

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

**In addition to the methods described in Sections 7.2 and 9, the State pays enhanced rates for certain maternal and child health services to providers who meet certain participation requirements.**

**Healthcare and Family Services collaborates with sister agencies on initiatives related to access to care for children. The Department of Human Services provides case management services, including assisting participants in accessing health care services, to pregnant women and families of infant and high risk older children who are eligible for All Kids. Children who receive WIC services are referred for preventive and primary care. The Department works in cooperation with the Department of Public Health to ensure a coordinated effort at increasing the rate of childhood immunizations, lead screening, lowering infant mortality and improving birth outcomes.**

**As detailed in Section 9, the State measures its performance in several key preventive areas for children, including, but not limited to percent of children with an identified primary health care provider, rate at which primary and preventive health care providers participate in the program, EPSDT participation rate, immunization rate, lead screening rate, rate of ambulatory sensitive hospitalizations, and rate of enrolled pregnant teens delivering a very low birth weight baby.**

- 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))

**The same methods used for assuring access to covered services in Title XIX are used in Title XXI. The State has adopted the definition of emergency services assigned in 42CFR 457.402 in Title XIX and Title XXI. No prior authorization is required for emergency services.**

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

**Under the fee-for-service delivery system, enrollees may see any enrolled provider. The State's managed care contract specifically addresses complex and serious medical conditions as well as access/timeliness standards. Managed care contractors are required to provide covered services, which could mean making referrals to out-of-network providers when the network**

**is not adequate for the enrollee's condition. The methods used to monitor access to services are described in 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 decisions on services requiring prior authorization are made within 14 days after receipt of a request for services in the managed care delivery system. In the fee-for-service delivery system, the State renders decisions within 21 or 30 days as required by Administrative Rules and consent decrees for all services other than pharmaceuticals. There is a process in place for expedited approvals whereby decisions must be made within twenty-four hours of receipt.**

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

**Through SPA 15-0012 *Cost Sharing by Income Band*, Illinois updates the federal poverty levels (FPLs) of the premium and copayment bands to the equivalent Modified Adjusted Gross Income (MAGI) eligibility standards. This SPA is consistent with the state's approved MAGI Conversion Plan and the state's implementation of MAGI effective January 1, 2014 through Illinois CHIP SPA IL-14-0006.**

- 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. All Kids Share and All Kids Premium Levels 1-2 impose cost sharing under this plan. Coverage for unborn children does not impose any cost sharing.**

**During the Federal COVID-19 PHE, all premiums and co-payments will be waived for CHIP applicants and/or beneficiaries who meet income and other eligibility requirements.**

8.1.2.  No, skip to question 8.8.

8.1.1-PW  Yes

8.1.2-PW  No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as

implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

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

8.2.1. **Premiums: A family with a family income above 142% and at or below 157% of the FPL (All Kids Share) has no premium requirements, as required by federal law. A family with an income above 157% through 209% of the FPL (All Kids Premium Level 1) is charged a monthly premium of \$15 for one child, \$25 for two children, \$30 for three children, \$35 for four children and \$40 for five or more children.**

**A family with an income above 209% through 313% of the FPL (All Kids Premium Level 2) is charged a monthly premium of \$40 for one child and \$80 for two or more children.**

**Premiums are not charged for unborn children.**

8.2.2. Deductibles: **None.**

8.2.3. Coinsurance or co-payments: **Co-payment requirements under All Kids comply with federal regulations.**

**A family with a family income above 142% and through 157% of the FPL (All Kids Share) has the following co-payments:**

**Co-payments for practitioner office visits, outpatient hospital encounters and a 1-day to 30-day supply of brand name prescription drugs may be adjusted annually and, if adjusted, shall be equal to the nominal co-payment amount as defined in 42 CFR 447.52 and 42 CFR 447.53 in accordance with section 2103(e)(3)(A) of the Social Security Act and which, for federal fiscal year 2013, is \$3.90;**

**Co-payment per prescription for a 1-day to 30-day supply of generic drugs, including over-the-counter drugs, is \$2.00 and may be adjusted annually to an amount less than the nominal co-payment as defined in 42 CFR 447.53 and;**

**Co-payment for inpatient hospitalization may be adjusted annually and, if adjusted, is a daily amount equal to the non-institutional nominal rate as defined in 42 CFR 447.52 in accordance with section 2103(e)(3)(A) of the Social Security Act which shall not exceed the institutional rate in 42 CFR 447.52, and which,**

**for federal fiscal year 2013, is \$3.90; and  
There is no co-payment for emergency room.**

**A family with an income above 157% through 209% of the FPL (All Kids Premium Level 1) has the following copayments:**

**Co-payments for practitioner office visits, outpatient hospital encounters and a 1-day to 30-day supply of brand name prescription drugs are \$5.00;**

**Co-payment for inpatient hospitalization is \$5.00 per day;**

**Co-payment per prescription for a 1-day to 30-day supply of generic drugs, including over-the-counter drugs is \$3.00; and**

**Co-payment for non-emergency use of the emergency room is \$25.00.**

**A family with an income above 209% and through 313% of the FPL (All Kids Premium Level 2) has a \$10 co-payment for medical visits, a \$3 co-payment for generic and \$7 for brand name prescriptions, \$100 per inpatient hospital admission, \$30 per emergency room visit and 5% of the All Kids payment rate for outpatient hospital services.**

**All families have an annual copayment cap for all copayments; the copayment caps are listed by program level below.**

**All Kids Share and All Kids Premium Level 1 is \$100 per family;**

**All Kids Premium Level 2 is \$500 per child for hospital services.**

**No copayments are charged for well-baby, well-child, or immunization services in any plan. In addition, no copayments are charged for visits to health care professionals or hospitals solely for lab or radiology services or routine preventive and diagnostic dental services. American Indian/Alaska Native children are not required to make copayments or pay premiums. Unborn children are not required to make copayments or pay premiums.**

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))

**Potential enrollees are notified of cost sharing requirements during the enrollment process and through outreach efforts. The combined application and the Fact Sheet describe cost-sharing requirements. The application requires applicants to attest that they understand and will comply with the requirements. The All Kids brochure and Member Handbook both describe cost-sharing requirements, including the cumulative maximum. All of these documents are available in hard copy form and on the All Kids website, [www.allkids.com](http://www.allkids.com)**

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

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

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

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

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

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

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

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

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance

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

Yes (Specify:)

No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

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

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

Yes

No

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

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

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

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

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

Yes

No

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

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

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

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

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

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

**All Kids copayment limits for Share and Premium Levels 1 are established as a family cap for all individuals, both children and adults, who are enrolled in All Kids or FamilyCare coverage of parents and other caretaker relatives. Copayment limits for children enrolled in All Kids Premium Level 2 are established by individual child.**

**All copayment caps are set low enough to assure that very few, if any, families**

would ever come close to paying 5 percent of income for a child's medical care during the child's 12 month period of eligibility. In addition, to account for the rare possibility that copayments for a child's care could exceed the cap, all families receive information at enrollment and at any time that cost sharing for the child changes such as at the annual renewal, of both their cost sharing obligations and copayment annual limits. Families receive a co-pay tracking form with instructions for collecting all receipts and listing co-payments. When the limit is reached, the family sends the copay tracking form with receipts to the All Kids unit for processing.

Upon receiving the copayment tracking form and receipts from a family, the All Kids Unit confirms the cap was reached by tallying the receipts submitted and immediately generates a written notice to the family. Such a designation is also made in the data system. The Department's electronic eligibility verification systems are updated to reflect that the copayment cap has been reached. Families that make a copayment before the system is updated or before they receive notification from the Department may recover their copayment from the provider.

- 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)

**The All Kids application contains a question on race/ethnicity with a check box for American Indian/Alaska Native. If this box is checked, the children will be coded in the Department's system as American Indian/Alaska Native. This coding ensures that no co-payment messages appear on the medical card. All AI/AN families are notified that they are not required to pay co-payments or premiums. Health care providers have been notified that they are not required to pay co-payments or premiums. All Kids outreach materials, including the application, brochure, and fact sheet state that co-payments and premiums are not required for AI/AN children. The Member Handbook also includes this information.**

- 8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c)) **As described in Appendix 1, p. 22.**

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

- 8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect

to payment of premiums. (Section 2103(e)(3)(C))

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

**Upon approval for All Kids Premium Levels 1-2, a statement is sent informing the family of the monthly premium amount, the due date, and the children covered. The initial statement informs the family that the premium must be paid even if the children do not receive services during the month of coverage. Statements are sent to families monthly. If an account becomes past due, the message on the monthly statement changes. If an account is 31-60 days past due, the statement (which is mailed on the 5<sup>th</sup> day of the month) informs the family that the premium must be paid by the end of the month to avoid cancellation of insurance coverage. If an account is more than 61 days past due, the statement informs the family that the account will be turned over to a collection agency if payment is not received by the end of the month. In reality, if payment is received and posted by the 10<sup>th</sup> of the following month, the coverage will continue.**

**The All Kids Member Handbook includes information on the consequences of not paying premiums.**

**During the Federal COVID-19 PHE, premiums and premium balances will be waived for CHIP applicants and/or beneficiaries who meet income and other eligibility requirements.**

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

**Upon approval and at annual renewal, families receive a notice that informs them that they can report decreases in family income. The All Kids Member Handbook also encourages families to report decreases in income. If, during the disenrollment process, the family reports a decrease in family income, the case will be reviewed to assess whether the family will be eligible for a plan with less or no cost sharing.**

**8.7.1.3. ☒** In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42 CFR 457.570(b))

**If a decrease in income is reported by the family, the child's eligibility will be reviewed and the child will be enrolled in All Kids Assist, All**

**Kids Share or All Kids Premium Level 1, depending on family income, and continued eligibility. All Kids Assist requires no cost sharing, All Kids Share requires minimal co-payments and All Kids Premium Levels 1-2 require a small monthly premium and co-payments based on family income.**

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

**As described in Section 12.1, enrollees are afforded the opportunity for an impartial review on eligibility and enrollment matters.**

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

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

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

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

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

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

**8.8.6.**  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)) (42 CFR 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))

**Illinois has established five strategic objectives:**

- 1. Improve the health status of Illinois' children;**
- 2. Extend health benefits coverage to optional targeted, low income children;**
- 3. Improve access to quality health care for optional targeted low income children enrolled in the Title XXI program;**
- 4. Assure appropriate health care utilization by optional targeted low income children enrolled in the Title XXI program; and**
- 5. Implement a statewide outreach and public awareness campaign regarding the importance of preventive and primary care for well-children and the availability of health benefits coverage through XXI.**

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

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

- 1. Improve the health status of Illinois' children.**
  - 1.1 Reduce the infant mortality rate.**
  - 1.2 Reduce the prevalence of childhood lead poisoning exceeding 25mg/dL.**
  - 1.3 Reduce school absenteeism in grades K-8.**
- 2. Extend health benefits coverage for optional targeted low income children.**
  - 2.1 By January 1, 2000, increase the percentage of children enrolled in the program who are eligible at the Medicaid standard in effect on March 31, 1997. Illinois will conduct a baseline survey. For this calculation, an unduplicated count of children enrolled at any time during calendar year 1999 will be compared to the number enrolled during the baseline year. The performance goal will be to enroll one-third of the number of children identified by the survey as eligible but not enrolled.**
  - 2.2 By January 1, 2000, enroll in Title XXI at least 50 percent of the estimated 40,400 optional targeted low income children with family income above the Medicaid standard in effect on March 31, 1997, but at or below 133 percent of the FPL.**
  - 2.3 By January 1, 2000, it is the State's goal to enroll in All Kids at least 50 percent of the children whose family income is at or below 185% of the FPL. The actual number of children represented within this goal will be determined upon the completion of the population study described in Section 2.1.**
  - 2.4 By January 1, 2000, enroll in Title XXI at least 50 percent of the estimated 40,400 optional targeted low income children with family income above the Medicaid standard in effect on March 31, 1997, but at or below 133 percent of the FPL.**
  - 2.5 By January 1, 2000, it is the State's goal to enroll in All Kids at least 50**

percent of the children whose family income is at or below 185% of the FPL. The actual number of children represented within this goal will be determined upon the completion of the population study described in Section 2.1.

- 2.6 By January 1, 2000, reduce the rate per year of hospitalizations of enrolled children for the ambulatory care sensitive conditions of childhood asthma and dehydration/non-infectious gastroenteritis as compared to the baseline population.
  - 2.7 By January 1, 2000, reduce the rate of enrolled pregnant teens who deliver a very low birth-weight baby as compared to the baseline population.
3. **Improve access to quality health care for optional targeted low income children enrolled in the Title XXI program.**
    - 3.1 By January 1, 2000, 60 percent of the enrollees will have an identified primary health care provider (medical home).
    - 3.2 By January 1, 2000, increase by 5 percent the rate at which primary and preventive health care (EPSDT) providers participate in the program.
  4. **Assure appropriate health care utilization by optional targeted, low income children enrolled in the Title XXI program.**
    - 4.1 By January 1, 2000, 80 percent of enrolled children will be appropriately immunized at age two.
    - 4.2 By January 1, 2000, 80 percent of enrolled children will participate in EPSDT and receive a well-child visit, as measured by the HCFA 416 participation ratio.
    - 4.3 By January 1, 2000, reduce the rate per year of hospitalizations of enrolled children for the ambulatory care sensitive conditions of childhood asthma and dehydration/non-infectious gastroenteritis as compared to the baseline population.
    - 4.4 By January 1, 2000, reduce the rate of enrolled pregnant teens who deliver a very low birth-weight baby as compared to the baseline population.
  5. **Implement a statewide outreach and public awareness campaign regarding the importance of preventive and primary care for well-children and the availability of health benefits coverage through Title XXI.**
    - 5.1 Launch a statewide outreach campaign through the coordinated efforts of the Illinois Departments of Healthcare and Family Services and Human Services.
    - 5.2 Increase the number of community based sites certified by DPA to accept eligibility applications for forwarding to and eligibility determination by the local DHS office.

**By January 1, 2000, it is the State's goal to enroll in All Kids at least 50 percent of the children whose family income is at or below 185% of the FPL. The actual**

**number of children represented within this goal will be determined upon the completion of the population study described in Section 2.1.**

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

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

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

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

**Illinois will measure performance by establishing a baseline for each performance goal through various methods including: conducting a baseline population-based survey; using State vital records, hospital discharge and claims information; and using other Medicaid and non-Medicaid data bases that provide relevant information. For each performance goal, the method of measurement will be established and reports will be generated to monitor, on an ongoing basis, Illinois' progress toward meeting the goal.**

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

- 9.3.1.  The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2.  The reduction in the percentage of uninsured children.
- 9.3.3.  The increase in the percentage of children with a usual source of care.
- 9.3.4.  The extent to which outcome measures show progress on one or more of

- the health problems identified by the state.
- 9.3.5.  HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6.  Other child appropriate measurement set. List or describe the set used.
- 9.3.7.  If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1.  Immunizations
- 9.3.7.2.  Well childcare
- 9.3.7.3.  Adolescent well visits
- 9.3.7.4.  Satisfaction with care
- 9.3.7.5.  Mental health
- 9.3.7.6.  Dental care
- 9.3.7.7.  Other, list:
- **Infant mortality**
  - **Childhood lead poisoning**
  - **School absenteeism**
  - **Hospitalization of enrolled children for ambulatory sensitive conditions of gastroenteritis/dehydration and asthma**
  - **Very low birth-weight babies born to adolescents**
- 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)) (42 CFR 457.750)

**In the first year of the program, Illinois will finalize the overall design and plan for the required annual assessment of the effectiveness of the elements of the State plan. Illinois will focus first upon further refining what is known about the demographic characteristics of children in families whose income is below 200 percent of poverty. The State will seek to collect sufficient baseline data to complete the chart for the State's annual report as proposed in this draft Title XXI plan. Illinois will also establish the baseline levels for all performance measures established in Section 9 of the Plan. Most performance measures selected by the State are related to established**

**data reporting systems. The data for establishing baseline levels will be drawn from existing data sources such as vital records, Medicaid claims records, hospital discharge data and school attendance records among others. Where necessary, Illinois will supplement existing data sources by conducting a population-based survey.**

**The first year's annual assessment will report the results of efforts made to establish baseline levels for all measures and will report the State's progress in providing health benefits coverage to optional targeted low income children. In subsequent years, the annual assessment will provide updated information on performance on all measures. State staff will complete each year's annual assessment and will monitor ongoing progress toward meeting all performance goals.**

**In the first year of the program, the State will develop specifications for an evaluation of the program. The results of the evaluation will be submitted to the Secretary of DHHS by March 31, 2000. The evaluation will include an assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage. This evaluation will include a comprehensive examination of the characteristics of children receiving health benefits coverage under the plan and will encompass such factors as ages of children, family income, and the children's health insurance status after their eligibility for the Title XXI program ends.**

**Through analysis of the patterns of utilization of services under the plan and the effectiveness of the plan as demonstrated through the performance measures established in Section 9, the evaluation will assess the overall quality and outcome of health benefits coverage provided under the plan. The provision of services, as an expansion of Medicaid, will be fully encompassed by all quality control mechanisms in place in Illinois' Medical Assistance program.**

**The evaluation will also include a complete description of the policy and processes established by the State for the Title XXI program. This will include the amount and level of assistance provided by the State and the mechanisms by which such assistance was provided; the service area; any time limits for coverage; the State's choice of health benefits coverage and other methods used for providing child health assistance; and the sources of non-Federal funding used for the program.**

**The State's plan will be considered effective if it achieves the performance goals established in Sections 9.2.1 and 9.2.2.**

- 9.6.  The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42 CFR 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. (42 CFR 457.710(e))

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

**State staff have conducted an exhaustive set of discussions with a wide variety of interested parties concerning the implementation of Title XXI. These efforts have occurred in four principle forums as described below: All recommendations received through these avenues were considered in the development of Illinois' Title XXI plan.**

#### **Governor's Office**

**In September and October, 1997, staff of the Office of the Governor, Directors of the Departments of Healthcare and Family Services and Public Health and the Secretary of the Department of Human Services held a lengthy series of meetings with a wide variety of consumer advocacy and provider groups to discuss how Illinois should implement Title XXI. The organizations that participated in the meetings include:**

#### **Advocacy Groups**

**Voices for Illinois Children**

**Maternal and Child Health Coalition**

**Don Moss & Associates (United Cerebral Palsy)**

**Campaign for Better Health Care  
Southside Health Consortium  
Chicago Hispanic Health Coalition  
Rural Health Association  
Illinois Public Health Association**

**Government Groups**

**Chicago Department of Health  
Cook County Bureau of Health Services  
DuPage County Health Department  
Will County Health Department  
Illinois Association of Public Health Administrators**

**Health Care Provider Groups**

**Illinois State Medical Society  
Illinois Hospital and Health Systems Association  
Illinois Primary Health Care Association  
Illinois Association of Health Maintenance Associations  
Children's Memorial Hospital  
Blue Cross/Blue Shield of Illinois  
St. Louis Children's Hospital  
Cardinal Glennon Hospital  
LaRabida Hospital  
Wyler's Children's Hospital  
Rush Presbyterian St. Luke's Children's Hospital  
Lutheran General Children's Hospital  
Christ Hospital  
Human Resource Development Institute  
Lawndale Christian Health Center  
Metropolitan Chicago Healthcare Council  
Illinois Alcoholism and Drug Dependence Association  
Rush Prudential HMO**

**Others**

**Head Start Collaboration Project  
Project Success  
Chicago Public Schools  
National Association of Social Workers  
Children's Home and Aid Society of Illinois  
Illinois State Chamber of Commerce  
Illinois Retail Merchants Association  
Federation of Independent Business  
Illinois Manufacturers Association  
Shattuck and Associates**

**Illinois General Assembly**

**On October 29, 1997, the Illinois House of Representatives Children and Youth Committee, held a public hearing to hear testimony concerning Title XXI. The Departments of Healthcare and Family Services and Human Services participated both in presenting testimony and witnessing the testimony of other interested parties.**

**A special legislative task force has been formed to consider Title XXI program options. The Children's Health Insurance Task Force includes four members of the Senate, four members of the Illinois House of Representatives, representatives of the Office of the Governor, advocates and members of the medical community. At the task force's first meeting on December 17, 1997, the details of this plan were discussed. The task force will continue to meet to discuss options for further expansion of child health insurance under Title XXI.**

#### **Health and Medicine Policy Research Group Seminar**

**On September 11, 1997, the Medicaid Administrator and the Assistant Secretary of the Department of Human Services participated in a half-day seminar hosted in Chicago by the Health and Medicine Policy Research Group, an independent organization generally concerned with issues of access to health care by low income individuals. The seminar was widely advertised throughout Chicago and well over a hundred individuals participated. The seminar included a lengthy audience participation period during which participants were able both to comment to and question the State's representatives concerning Illinois' opportunities for implementing the children's health insurance program.**

#### **Medicaid Advisory Committee**

**Title XXI was the subject of lengthy discussions by two the Department of Healthcare and Family Services' Medical Assistance Advisory groups. All meetings of both groups are open to the public. On September 19, 1997 as a result of lengthy discussion, the Medicaid Advisory Committee resolved in part that "... the MAC recommends to the Director of HFS that he support the earliest feasible expansion of Medicaid eligibility to take full advantage of the immediate availability of federal funds at a 35% (state) match."**

**Title XXI was also discussed at three meetings of the Managed Care Subcommittee of the MAC on September 2, 1997, October 7, 1997, and November 4, 1997. These meetings were each attended by approximately 50 interested parties in addition to committee members. At each meeting, the Department presented updated information concerning the opportunities presented by the new law and the possibilities for program design. Committee members as well as interested parties asked questions and made comments concerning the direction they thought the state should take in program design.**

**In addition to the advisory committees already described, the Department held public hearings on this proposed State Plan in both Chicago and Springfield. The Department submitted state administrative rules to implement the program. Prior**

to the adoption of any state administrative rule, state law requires a public notice process, the consideration of any comments, and a public hearing. The Outreach Advisory Committee will continue to assist the Department in implementing All Kids.

Ongoing public involvement will be accomplished in the following ways:

- Legislative changes will be debated in the Illinois General Assembly
- Public input through the State's Administrative Rules process
- News coverage
- Continued partnerships with advocacy groups such as Covering Kids Illinois
- Ongoing relationship with All Kids Application Agents who are hospitals, Federally qualified health centers, local health departments, community based organizations, faith based organizations, WIC sites, Family Case Management agencies, Community Action agencies, Early Intervention agencies, Child Care Resource & Referral agencies, and licensed insurance agents
- Input from the Medicaid Advisory Committee
- Input from the State Medical Advisory Committee

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

**Only one Indian Health Care facility currently operates in Illinois. Pursuant to Section 1861 of the Social Security Act, this facility is recognized as a FQHC under the Department's Title XIX program. Under All Kids, this facility will continue to operate as a fully integrated FQHC, providing primary care services itself and referrals for other services. The Department has consulted with this facility concerning All Kids outreach and enrollment strategies that are appropriate for reaching American Indian children.**

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

**For SPA #8, an Informational Notice dated 6/27/06 *All Kids Health Insurance-Cost Sharing* which announced the All Kids expansion effective 7/1/06 was distributed to all FQHCs including American Indian Health Services of Chicago.**

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

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

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected 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

**State source funding will be from the State’s General Revenue Fund (GRF) and local funds from Cook County. The primary sources into GRF are personal income taxes, corporate income taxes, and sales tax receipts.**

Dollars shown in millions

FFY 2020

Total Benefit Costs	\$626.8
(Offsetting beneficiary cost sharing payments)	(\$23.4)
Net Benefit Costs	\$603.4
Administration Costs	
Personnel	\$11.9

General administration	\$12.7
Contractors/Brokers (e.g., enrollment contractors)	
Claims Processing	
Outreach/marketing costs	
Other	\$2.4
Administration Costs Total	\$27.0
Health Services Initiatives, subject to 10% administrative cap	
Health Services Initiatives - SCHIP Presumptive Eligibility	\$1.4
Health Services Initiatives - Unborn Postpartum Coverage (FFS + MC)*	\$7.3
Total Health Services Initiatives	\$8.7
Federal Title XXI Share	\$508.7
State Share	\$130.4
<b>TOTAL COSTS OF APPROVED SCHIP PLAN</b>	<b>\$639.1</b>

TOTAL ADMINISTRATION COSTS	\$35.7
10% Title XXI Administrative Cap	\$66.6
Room Under 10% Administration Cap	\$30.9

<b>TOTAL PROGRAM COSTS (State Plan and Administration)</b>	<b>\$639.1</b>
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Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	\$807.4
FFY'20 allotment	\$414.7
Previous FFY allotment available (2019)	\$392.7
Total Federal Title XXI Program Costs (State Plan + Administration)	\$508.7
Total Federal Title XXI Funding after costs	\$298.7
Unused Title XXI Funds Expiring (Allotment or Reallocated)	-
Increased state \$	-
Remaining Title XXI Funds to be Carried Over (Available Funding - Costs - Expiring Funds)	\$ 298.7

*\*Illinois estimates the cost of amending the postpartum HSI to extend covering the cost of coverage from 60 days to 12 months at \$40 million annually (\$10 million per quarter). At a match rate of 70% the federal budget impact would equal \$7 million per quarter or \$28 million annually, subject to the 10% Title XXI Administrative Cap.*

## 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 1<sup>st</sup> 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)) (42 CFR 457.750)

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

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

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

10.3-DC  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

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)) (42 CFR 457.935(b)) (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)

- 11.2.1.  42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2.  Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3.  Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4.  Section 1128A (relating to civil monetary penalties)
- 11.2.5.  Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6.  Section 1128E (relating to the National health care fraud and abuse data collection program)

**Section 12. Applicant and enrollee protections**

- 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.

**The Medicaid fair hearing process is used for All Kids Share and All Kids Premium Levels 1-2 participants. Appeals may be filed regarding any eligibility and enrollment matter, including denial of eligibility, failure to make a timely determination of eligibility and suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. Appeals can be filed in writing, by fax or in person or by calling a toll-free telephone number. Appeals must be filed within 60 calendar days after the decision (action) being appealed. Benefits are continued if the enrollee requests that benefits be continued and files the appeal by the date of change or the 10<sup>th</sup> calendar day after the decision being appealed, whichever is later. A pre-hearing review must be held within 7 days after the appeal is filed. If the decision is not changed during the pre-hearing review, a pre-hearing meeting, an informal meeting with the enrollee, must take place within 10 days after the appeal is received. If the decision is not changed or the enrollee does not withdraw the appeal, an appeal hearing is held with a neutral hearing officer presiding. The enrollee or their representative must attend the hearing and has the opportunity to review documents to be used at the hearing, both before and during the hearing. During the hearing, the enrollee has the opportunity to present the case or have it presented by their representative, bring witnesses, present arguments without interference, question or prove wrong any testimony or evidence, confront and cross-examine adverse witnesses, and submit evidence. The final hearing decision must be approved by the HFS Director and sometimes also by the DHS Secretary, and must be put into effect within 90 days of the date the appeal is filed, barring any approved hearing delays. The enrollee is notified of the final hearing decision in writing.**

**Denial and cancellation notices include the reason for denial or cancellation, and an explanation of appeal rights including time frames for review, and how to request a review.**

**Notices are automatically centrally generated the day after the determination is made and are mailed within 1-3 days of being generated. Cancellation notices include information on how to request continuation of benefits during appeal. The All Kids application includes an explanation of appeal rights and how to request a review. The All Kids Member Handbook includes an explanation of appeal rights including time frames, how to request a review, a description of the appeal process, and an appeal form.**

**There is not an expedited review process for health service matters under the fee-for-service delivery system. If an appeal is filed on a decision, and there is an immediate need for health services, the services will be provided during the appeal process. Under the managed care delivery system, the appeal process includes expedited review for health service matters. The managed care plan must make a decision or request additional information needed to make a decision within twenty-four hours of receipt of the appeal. If additional information is requested, the managed care plan must make a decision within twenty-four hours after receipt of the information.**

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

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

**The Medicaid fair hearing process is used for All Kids Share and All Kids Premium Levels 1-2 participants under fee-for-service. Appeals may be filed regarding health services matters using the process described in Section 12.1 above.**

**The managed care delivery system complies with the fair hearing process in the Balanced Budget Act of 1997 and State law (Section 45 of the Managed Care Reform and Patient Rights Act) and meets the requirements of 42 CFR 457.1130(b). Appeals may be filed regarding health services matters and final decisions may be appealed by the enrollee to the State under its appeals process described in Section 12.1 above.**

**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.

**Not applicable.**

### **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**

<b>CMS Regional Offices</b>	<b>States</b>		<b>Associate Regional Administrator</b>	<b>Regional Office Address</b>
Region 1- Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal <a href="mailto:richard.mcgreal@cms.hhs.gov">richard.mcgreal@cms.hhs.gov</a>	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 <a href="mailto:michael.melendez@cms.hhs.gov">michael.melendez@cms.hhs.gov</a>	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3- Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher <a href="mailto:ted.gallagher@cms.hhs.gov">ted.gallagher@cms.hhs.gov</a>	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 <a href="mailto:jackie.glaze@cms.hhs.gov">jackie.glaze@cms.hhs.gov</a>	Atlanta Federal Center 4 <sup>th</sup> Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5- Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson <a href="mailto:verlon.johnson@cms.hhs.gov">verlon.johnson@cms.hhs.gov</a>	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6- Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks <a href="mailto:bill.brooks@cms.hhs.gov">bill.brooks@cms.hhs.gov</a>	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7- Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott <a href="mailto:james.scott1@cms.hhs.gov">james.scott1@cms.hhs.gov</a>	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 <a href="mailto:richard.allen@cms.hhs.gov">richard.allen@cms.hhs.gov</a>	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 <a href="mailto:gloria.nagle@cms.hhs.gov">gloria.nagle@cms.hhs.gov</a>	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103
Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly <a href="mailto:carol.peverly@cms.hhs.gov">carol.peverly@cms.hhs.gov</a>	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 pre-pregnancy 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.