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: Colorado
(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))

Tracy L. Johnson 5/7/2021

Tracy Johnson, Medical Director, Health Programs Office / 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: Kim Bimestefer	Position/Title: Executive Director, Colorado Department of Health Care Policy and Financing
Name: Bettina Schneider	Position/Title: Director of the Office of Financial and Administrative Services

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

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

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

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

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

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

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

The template includes the following sections:

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

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

required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

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

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

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

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

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

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

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

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

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

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

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

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

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

Guidance: The effective date as specified below is defined as the date on which the State begins to

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

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

Original Plan

Date Plan Submitted:	**October 14, 1997**
Date Plan Approved:	**February 18, 1998**
State Plan Effective Date:	**April 22, 1998**

On October 14, 1997, Colorado submitted a Title XXI State Plan to expand children's access to health coverage by building on the experience and infrastructure of the Colorado Child Health Plan (CCHP), an existing State-only program providing basic medical services to low-income children, and established Child Health Plan + (CHP+), a separate child health program. Coverage was initially provided to children through age 17 with family incomes at or below 185 percent of the Federal Poverty Level (FPL).

Date Amendment # 1 Submitted:	**January 19, 1999**
Date Amendment # 1 Approved:	**September 21, 1999**
Date Amendment # 1 Effective:	**April 22, 1998**

Effective April 22, 1998, Colorado amended its Title XXI State Plan to expand coverage to children through age 18 with family incomes at or below to 185 percent of the FPL.

Date Amendment #2 Submitted:	**December 20, 2000**
Date Amendment #2 Approved:	**March 28, 2001**
Date Amendment #2 Effective:	**October 1, 2000**

Colorado submitted its second amendment on December 20, 2000, to eliminate premiums and implement an annual enrollment fee for families with incomes between 151 and 185 percent of the FPL.

Date Amendment #3 Submitted: **December 27, 2000**
Date Amendment #3 Approved: **March 28, 2001**
Date Amendment #3 Effective: **October 1 2000**

On December 27, 2000, Colorado submitted an amendment to its Title XXI State Plan to make changes in its application and enrollment process and in its service delivery system.

Date Amendment #4 Submitted: **June 28, 2002**
Date Amendment #4 Approved: **April 24, 2003**
Date Amendment #4 Effective: **February 1, 2002**

Colorado submitted its fourth amendment on June 28, 2002, to update and amend the SCHIP State Plan to indicate compliance with the final SCHIP regulations and to add dental benefits for children. The addition of the dental benefit was effective February 1, 2002.

Date Amendment #5 Submitted: **December 17, 2003**
Date Amendment #5 Approved: **March 9, 2004**
Date Amendment #5 Effective: **November 1, 2003**

On December 10, 2003, Colorado submitted its fifth amendment to provide Colorado with the authority to implement and to subsequently revoke an enrollment freeze, as the State budget allows. A freeze on enrollment became effective on November 1, 2003, and will remain in place until either additional funds become available, or the number of enrolled children no longer obligates all appropriated funds.

Date Amendment #6 Submitted: **September 27, 2005**
Date Amendment #6 Approved: **December 23, 2005**
Date Amendment #6 Effective: **July 1, 2005**

On September 27, 2005, Colorado submitted its sixth amendment to raise the upper eligibility limit for children covered under the State plan from 185 percent of the Federal Poverty Level (FPL) up to 200 percent of the FPL.

Date Amendment # 7 Submitted: **May 30, 2007**
Date Amendment # 7 Withdrawn: **May 23, 2008**

On May 30, 2007, Colorado submitted its seventh amendment to require individuals to establish residency before applying for the SCHIP program. The amendment was withdrawn on May 23, 2008.

Date Amendment # 8 Submitted: **June 25, 2008**
Date Amendment # 8 Approved: **May 6, 2009**
Date Amendment # 8 Effective: **March 1, 2008**

On June 25, 2008, Colorado submitted its eighth amendment to add a new income disregard of 2.5 percent of FPL only for families above 200 percent of FPL after allowable deductions (e.g. child support payments) are applied. If the family is above 200 percent of the FPL, the child qualifies for CHIP. IF the family remains above 200 percent of the FPL after allowable deductions, and the 2.5 percent disregard, the child is denied coverage under CHIP. The State requested a retroactive date of March 1, 2008.

Date Amendment #9 Submitted: **April 30, 2010**
Date Amendment # 9 Approved: **July 28, 2010**
Date Amendment #9 Effective: **May 1, 2010**

On April 30, 2010, Colorado submitted its ninth amendment to increase the upper income level to 250 percent of the FPL. The SPA adds the following out-of-pocket cost changes. For all families above 151 percent of the FPL there will be a $25 enrollment fee for one child, a $35 enrollment fee for two or more children. In addition, while copayments of $5 per office visit will be charged to families with incomes that fall between 151 and 200 percent FPL, families with incomes from 201 to 250 percent of FPL will be asked to pay $10 per office visit. The State requested a retroactive effective date of May 1, 2010.

Date Amendment # 10 Submitted: **April 16, 2012**
Date Amendment # 10 Approved: **September 17, 2012**
Date Amendment # 10 Effective: **April 1, 2012**

SPA # 10 Description: This State Plan Amendment includes the following changes:

- Puts the State Plan into the revised CHIP State Plan template that was issued in 2011.
- Adds Express Lane Eligibility.
- Adds the Tribal Consultation policy and procedure.
- Clarifies the State's presumptive eligibility and 12-month continuous eligibility policies for CHIP.
- Adds the Income and Eligibility Verification System as a method for verifying income.
- Clarifies the State's CHIP Dental Services, as required in the revised State Plan template.
- Increases the annual enrollment fee for families with income greater than 205% and up to 250% of the FPL, to $75 for one child and $105 for two or more children.

Date Amendment # 11 Submitted: **August 30, 2012**
Date Amendment # 11 Approved: **December 10, 2012**
Date Amendment # 11 Effective: **July 1, 2012**

This State Plan Amendment increases the copayments for some services and adds copayments for services that previously had none.

SPA # 12
Date Amendment # 12 Submitted: **January 23, 2013**
Date Amendment # 12 Approved: **April 25, 2013**
Date Amendment # 12 Effective: **January 1, 2013**

SPA # 12 Description: This State Plan Amendment includes the following changes:

- Changes Colorado's CHIP program from a Separate Program to a Combination Program. Under or uninsured children 6 through 18 years of age with family income above 100% FPL and at or below 133% FPL are covered through a Medicaid Expansion. Under or uninsured pregnant women with family income above 133% FPL and at or below 185% FPL are also covered through a Medicaid Expansion. Uninsured pregnant women with family income at or below 250% FPL that are ineligible for Medicaid are moved from the Section 1115 Waiver to coverage through the CHIP State Plan. No changes are made to the income eligibility requirements of populations already covered though the CHIP SPA.
- Adds eligibility for children of State employees as long as they meet all other eligibility requirements.
- Revises language surrounding the ten day noticing procedure.
- Modifies Express Lane Eligibility to comply with instructions from the Centers for Medicare and Medicaid Services.
- Adds passive enrollment to the MCO assignment and selection process for children.
- Updates eligibility screening process and methods used to coordinate with other health coverage programs.

SPA # 13
Date Amendment # 13 Submitted: **February 15, 2013**
Date Amendment # 13 Approved: **December 9, 2013**
Date Amendment # 13 Effective: **January 1, 2013**

SPA # 13 Description: This State Plan Amendment adds the prospective payment system for reimbursing FQHCs and RHCs per Section 503 of CHIPRA.

SPA # 14

Date Amendment # 14 Submitted: **May 30, 2013**
Date Amendment # 14 Approved: **August 7, 2013**
Date Amendment # 14 Effective: **May 1, 2013**

SPA # 14 Description: This State Plan Amendment removes the three-month waiting period for children to be eligible for CHP+.

Date Amendment # 15 Submitted: **November 29, 2013**
Date Amendment # 15 Approved: **September 5, 2014**
Date Amendment # 15 Effective: **January 1, 2014**

Effective January 1, 2014, Colorado amended its Title XXI State Plan through MMDL to reflect coverage for children and pregnant women under the provisions of MAGI, including coverage of state employee dependents.

Date Amendment # 16 Submitted: **September 6, 2013**
Date Amendment # 16 Approved: **November 1, 2013**
Date Amendment # 16 Effective: **January 1, 2014**

Effective January 1, 2014, Colorado amended its Title XXI State Plan through MMDL to cover children ages 6 through 18 years of age with family income above 100% FPL and at or below 133% FPL through Medicaid Expansion. This provision was previously approved via CHIP SPA #12, effective January 1, 2013.

Date Amendment # 17 Submitted: **August 30, 2013**
Date Amendment # 17 Withdrawn: **November 20, 2013**

On August 30, 2013, Colorado submitted a Title XXI State Plan to implement the provision of 2102(f) to ensure that children losing Medicaid eligibility due to the required use of MAGI methodology will be eligible for and enrolled in CHP+. This state plan amendment was withdrawn on November 20, 2013.

Date Amendment # 18 Submitted: **August 30, 2013**
Date Amendment # 18 Approved: **November 26, 2013**
Date Amendment # 18 Effective: **January 1, 2014**

Effective January 1, 2014, Colorado amended its Title XXI State Plan through MMDL to reflect the Affordable Care Act requirements concerning general eligibility processing under MAGI.

Date Amendment # 19 Submitted: **November 19, 2013**
Date Amendment # 19 Approved: **February 25, 2014**
Date Amendment # 19 Effective: **January 1, 2014**

Effective January 1, 2014, Colorado amended its Title XXI State Plan through MMDL to reflect non-financial eligibility processing options under the Affordable Care Act.

SPA # 20
Date Amendment # 20 Submitted: **December 23, 2013**
Date Amendment # 20 Approved: **May 9, 2014**
Date Amendment # 20 Effective: **October 1, 2013**

Effective October 1, 2013, Colorado amended its Title XXI State Plan to change the effective begin date when the person becomes eligible for CHP+ to the first day of the month of application.

SPA # 21
Date Amendment # 21 Submitted: **January 16, 2014**
Date Amendment # 21 Approved: **February 4, 2014**
Date Amendment # 21 Effective: **January 1, 2014**

Effective January 1, 2014, Colorado amended its Title XXI State Plan through MMDL to implement the provision of 2102(f) to ensure that children losing Medicaid eligibility due to the required use of MAGI methodology will be eligible for and enrolled in CHP+.

SPA # 22
Date Amendment # 22 Submitted: **August 28, 2014**
Date Amendment # 22 Approved: **September 30, 2015**
Date Amendment # 22 Effective: **August 1, 2014**

Effective August 1, 2014, Colorado amended its Title XXI State Plan to implement its compliance with the Children's Health Insurance Program Reauthorization Act (CHIPRA), including a dental benefit package expansion under Section 6.2, identifying its quality improvement strategies under Section 7.1.14, and describing its grievance process under Section 12.2.

SPA # 23

Date Amendment # 23 Submitted: **March 20, 2015**
Date Amendment # 23 Approved: **June 11, 2015**
Date Amendment # 23 Effective: **July 1, 2014**

Effective July 1, 2014, Colorado plans to amend its Title XXI State Plan to update the Premiums for the Federal Poverty Level (FPL) Percentage Bands.

SPA # 24

Date Amendment # 24 Submitted: **April 8, 2016**
Date Amendment # 24 Approved: **May 4, 2016**
Date Amendment # 24 Effective: **July 1, 2015**

Effective July 1, 2015, Colorado amended its Title XXI State Plan through MMDL to extend eligibility to children and pregnant women who are lawfully residing in the US and who have not met the 5-year waiting period, and who are otherwise eligible.

SPA #25

Date Amendment # 25 Submitted: **June 21, 2016**
Date Amendment # 25 Approved: **September 6, 2017**
Date Amendment # 25 Effective: **January 1, 2016**

Effective January 1, 2016, Colorado amended its eligibility application materials to improve readability of materials, streamline application questions to pertain only to eligibility determinations, and ensure that members of federally recognized tribes have the opportunity to obtain all benefits to which they are entitled.

SPA #26

Date Amendment # 26 Submitted: **August 28, 2017**
Date Amendment # 26 Approved: **October 5, 2017**
Date Amendment # 26 Effective: **July 1, 2017**

Effective July 1, 2017, Colorado implemented a reasonable methodology when an applicant/beneficiary is found ineligible based upon their current monthly income, the applicant/beneficiary has income that the Department has identified as most likely to fluctuate, and the applicant/beneficiary has attested that for the upcoming year the annual amount from the income most likely to fluctuate is equal to or less than the annual amount from that income for the current year.

SPA #27

Date Amendment # 27 Submitted: **June 29, 2018**
Date Amendment # 27 Approved:
Date Amendment # 27 Effective: **October 2, 2017** (Requested)

Effective October 2, 2017, Colorado amended its State Plan to document its compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) under Sections 6.2 and 8.4.

SPA #28

Date Amendment # 28 Submitted:	**June 29, 2018**
Date Amendment # 28 Approved:	**Aug 23, 2018**
Date Amendment # 28 Effective:	**July 1, 2017**

Effective July 1, 2017, Colorado added the authority for direct certification through Supplemental Nutritional Assistance Program (SNAP) and the Temporary Assistance for Needy Families Program (TANF) to the Express Lane Eligibility option. Moreover, Colorado added the authority to waive an enrollment fee when a child is eligible for the Child Health Plan Plus program, when there is a pregnant mother in the household, enrolled in either the Medicaid or Child Health Plan *Plus* program.

SPA #29

Date Amendment #29 Submitted:	**June 25, 2019**
Date Amendment #29 Approved:	**August 8, 2019**
Date Amendment #29 Effective:	**July 1, 2018**

Effective July 1, 2018, Colorado revised Section 3 of the plan to incorporate updates pursuant to the Medicaid Managed Care final rule as it relates to the Children's Health Insurance Program.

SPA #30

Date Amendment #30 Submitted:	**November 20, 2019**
Date Amendment #30 Approved:	**January 23, 2020**
Date Amendment #30 Effective:	**October 1, 2019**

Effective October 1, 2019, Colorado revised Section 6.2 of the plan to add pregnant women to the dental coverage pursuant to C.R.S. § 25.5-8-107(1)(a)(II). The amendment also updated the well-baby codes in Section 8.4.2 to reflect the most current codes.

SPA #31

Date Amendment # 31 Submitted:	**05/05/2020**
Date Amendment # 31 Approved:	**06/10/2020**
Date Amendment # 31 Effective:	**03/01/2020**
Date Amendment # 31 Implemented:	**03/01/2020**

Effective 03/01/2020, Colorado added provisions to implement temporary adjustments to policies related to tribal consultation, timely processing of applications, changes in

circumstances, enrollment fees, and cost-sharing during the Federal COVID-19 public health emergency.

SPA #32

Date Amendment # 32 Submitted: **06/23/2020**
Date Amendment # 32 Approved:
Date Amendment # 32 Effective: **10/24/2019**

Effective October 24, 2019, Colorado amended its State Plan to document Colorado's compliance with Section 5022 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act).

SPA #33

Date Amendment # 33 Submitted: **04/01/2021**
Date Amendment # 33 Approved: **04/14/2021**
Date Amendment # 33 Effective: **03/01/2020**

Effective 03/01/2020, Colorado added provisions to implement temporary adjustments to policies related to the state plan amendment effective date and enrollment fees during the Federal COVID-19 public health emergency.

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 priorstate fiscal year.

SPA#34

Date Amendment # 34 Submitted: **06/23/2021**
Date Amendment # 34 Approved: **08/30/2021**
Date Amendment # 34 Effective: **07/01/2020**

Effective July 1, 2020, Colorado amended its State Plan to clarify the reimbursement methodology for Federally Qualified Health Centers and Rural Health Centers, modifying section 3.1.

SPA #35

Date Amendment #35 Submitted: **March 28, 2022**
Date Amendment #35 Approved: **November 15, 2022**
Date Amendment #35 Effective: **07/01/2021**

Effective July 1, 2021, Colorado amended its State Plan to report amendments in the healthcare delivery system for CHIP eligible beneficiaries. Beginning July 1, 2021, Colorado eliminated the statewide managed care network, and enrolls all CHIP eligible beneficiaries into a contracted managed care organization. Additionally, Colorado

amended Section 9 of the State Plan to update and align Strategic Objectives and Performance Goals with the state's annual CARTS report.

SPA #36

Date Amendment #36 Submitted: **July 14, 2022**
Date Amendment #36 Approved: **September 1, 2022**
Date Amendment #36 Effective: **03/11/2021**

Effective 03/11/2021, Colorado added provisions to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

SPA #37

Date Amendment #37 Submitted: **June 28, 2022**
Date Amendment #37 Approved: **September 2, 2022**
Date Amendment #37 Effective: **07/01/2021**
Date Amendment #37 Implemented: **07/01/2022**

Effective July 1, 2021, Colorado updated the State Plan to reflect state changes to outreach methods. The Healthy Communities initiative has ended and references to the program regarding outreach activities have been removed. Additional outreach activities have been updated.

SPA #38

Date Amendment #38 Submitted: **April 28, 2023**
Date Amendment #38 Approved: **December 1, 2023**
Date Amendment #38 Effective: **07/01/2022**
Date Amendment #38 Implemented: **07/01/2022**

Effective July 1, 2022, Colorado updated the State Plan to reflect the state's new authority to make the following temporary policy adjustments for its CHIP program during any future state or federally-declared emergency upon notification to CMS:

- Delay the timely processing of applications and renewals, and
- Waive copayments for CHIP beneficiaries who reside and/or work in state or federally-declared disaster or emergency areas.

SPA #39

Date Amendment #39 Submitted:	**August 2, 2023**
Date Amendment #39 Approved:	**October 30, 2023**
Date Amendment #39 Effective:	**07/01/2023**
Date Amendment #39 Implemented:	**07/01/2023**

Effective July 1, 2023, Colorado clarifies that the state does not collect enrollment fees or premiums in its CHIP program.

Superseding Pages of MAGI CHIP State Plan Material

State: Colorado

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
CO-13-0015	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections 4.1.1, 4.1.2, and 4.1.3: Supersede information on children
Approval Date: 09/05/14 Effective/Implementation Date: January 1, 2014		CS8	Eligibility – Targeted Low Income Pregnant Women	Supersedes the current sections 4.1.1, 4.1.2, 4.1.3 and 4.1-PW: Supersede and add information on pregnant women
		CS8	Supporting Document	Section: Add new documentation
		CS10	Eligibility – Children Who Have Access to Public Employee Coverage	Supersedes the current sections 4.1.7 and 4.4.1: Supersede information on dependents of employees of a state agency
		CS10	Maintenance of Agency Contribution	Appendix: Supersede current documentation
		CS11	Eligibility – Pregnant Women Who Have Access to Public Employee Coverage	Section 4.4.1: Add new information to section
		CS11	Maintenance of Agency Contribution	Appendix: Add new documentation

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
		CS13 CS15	Eligibility – Deemed Newborns MAGI-Based Income Methodologies	Section 4.3: Add new subsection on deeming Section 4.3: Add new subsection and supersede information on income eligibility and methods
CO-13-0016 Approval Date: 11/01/13 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
CO-13-0021 Approval Date: 02/04/14 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
CO-13-0018 Approval Date: 11/26/13 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
CO-13-0019	Non-Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5 Supersedes the current sections 4.1.0;

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
Approval Date: 02/25/14 Effective/Implementation Date: January 1, 2014		CS18	Non-Financial – Citizenship	4.1.-LR; 4.1.1-LR
		CS19	Non-Financial – Social Security Number	Supersedes the current section 4.1.9.1
		CS20	Non-Financial Eligibility - Substitution of Coverage	Supersedes the current section 4.4.4
		CS21	Non-Financial Eligibility – Non-Payment of Premiums	Supersedes the current section 8.7
		CS27	General Eligibility – Continuous Eligibility	Supersedes the current section 4.1.8
		CS28	General Eligibility – Presumptive Eligibility for Children	Supersedes the current section 2.2.1 (Please note that this information will need to be reflected in the appropriate section in the future, section 4.3.2)
		CS29	General Eligibility – Presumptive Eligibility for Pregnant Women	Supersedes the current section 2.2.1 (Please note that this information will need to be reflected in the appropriate section in the future, section 4.3.2)
CO-15-0024 Approval Date: 05/04/16 Effective Date:	Non-Financial Eligibility	CS18	Non-Financial – Citizenship	Supersedes the current sections 4.1.0; 4.1.-LR; 4.1.1-LR

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
July 1, 2015				
CO-16-0025 Approval Date: 09/06/17 Effective Date: January 1, 2016	Eligibility Processing	CS24	Eligibility Process	Supersedes the current section 4.3 and 4.4
CO-17-0026 Approval Date: 10/05/17 Effective Date: July 1, 2017	Non-Financial Eligibility	CS15	MAGI-Based Income Methodologies	Section 4.3: Supersede information on income eligibility and methods in CO-13-0015.

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.

The State included consultation on this SPA in the tribal consultation log dated 08/19/2022. A copy of the relevant page of the consultation log is attached.

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))

See Attachment 1 for a description of children's insurance status by income and race and ethnicity.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.1005.

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

2.3-TC Tribal Consultation Requirements- (Sections 1902(a)(73) and 2107(e)(1)(C)) ; (ARRA #2, CHIPRA #3, issued May 28, 2009)

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

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

The Colorado CHP+ program meets the requirements described above through execution of a formal consultation agreement with American Indian health programs in Colorado. Together with the Department of Health Care Policy and Financing (the Department), the parties to the consultation agreement include the Southern Ute Indian Tribe, the Ute Mountain Ute Tribe, Denver Indian Health and Family Services, the Colorado Department of Public Health and Environment, and the Office of the Lieutenant Governor of Colorado.

The Department intends to use the following process, as described in the consultation agreement, to seek advice on a regular ongoing basis from the parties:

Programmatic Action Log Update

On a bi-monthly basis (approximately every sixty days) each state agency (the Department of Public Health and Environment and the Department of Health Care Policy and Financing) shall distribute to the Tribes and the UIHO Urban Indian Health Organization a Programmatic Action Log Update. The Update shall contain a continuous list of Programmatic Actions that each state agency is developing or initiating. The Update has a short description of each Programmatic

Action, any clearly foreseeable Tribal implications, important dates, or implementation timeframes, and if the Programmatic Action is considered an Actionable Item. The Update shall indicate a date by which additional consultation must be requested by a Tribe or the UIHO (thirty days from receipt of the Update). The Update shall also contain an area to track whether additional consultation was requested, and by whom, and to update current status or resolution of Programmatic Actions.

Additional Consultation
A Tribe or UIHO may request additional consultation on any Actionable Item on the Update or on any question, concern, policy, practice, or issue within the scope of the state agencies' responsibilities relating to the health of American Indians or Alaska Natives living in Colorado. Actionable Items on the Update shall indicate a date by which a Tribe or the UIHO must request additional consultation thirty days from receipt of the Update Additional consultation shall be initiated by written notice may be in the form of an email from a designated Tribal or UIHO Liaison(s) and directed to a designated Indian Health Liaison(s). Consultation may include but shall not be limited to meetings (face-to-face or via teleconference), written correspondence, including emails, presentations, and discussions at the Colorado Commission of Indian Affairs Health and Wellness Committee meetings. When consultation is completed, a written response from one or both state agencies to the party that requested the consultation shall be sent describing the final determination or outcome regarding the topic of consultation. This information shall also be included on the Programmatic Action Log Update.

Meetings:
Face-to-Face and Remotely
The state agencies, Tribes, and UIHO all together or individually, shall meet face-to-face no less than once per fiscal year and as resources allow. As necessary, the state agencies, Tribes, and UIHO, all together or individually, shall meet remotely via teleconference or videoconference to discuss outstanding issues or hold consultations as described above.

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.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.
Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

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

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

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

3.1. Delivery Standards Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and 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) (42CFR 457.490(a))

☒ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS' Regional Office for review and approval.

(Section 2103(f)(3))

Managed Care Organizations

State legislation (House Bill 97-1304) requires that only plans willing to contract with Medicaid are eligible to serve CHP+ clients. This will ensure that clients are not forced to change providers each time their financial situation changes the program for which they are eligible (Medicaid or CHP+). The CHP+ program contracts with managed care organizations serving a significant number of commercial and Medicaid clients statewide. These plans vary in structure, service area and membership.

Contract standards are based on a review of standards from the following sources: National Association of Insurance Commissioners (NAIC) Model Acts, National Committee for Quality Assurance (NCQA) Accreditation Standards, and Quality Improvement System for Managed Care (QISMC) standards.

CHP+ MCO contractors have to pass the examination of three entities: the Colorado Division of Insurance (DOI), the Department of Public Health and Environment (CDPHE) and the Colorado Department of Health Care Policy and Financing (HCPF). The DOI grants MCO licenses based on a review of financial stability, adequate provider subcontracts, access to care and quality of care. The DOI subcontracts the quality and access review to the CDPHE. When a licensed plan applies for a Medicaid contract, HCPF reviews several aspects of the plans operation including provider network, utilization, management, access to care, quality improvement and grievance procedures. HCPF reviews the Medicaid plans that apply to serve CHP+ clients. Where CHP+ contract standards vary from those of DOI and HCPF, the Department conducts additional reviews in coordination with the Medicaid, DOI, CDPHE, or other purchaser reviews.

Essential Community Providers: As required by state legislation (House Bill 97-1304), CHP+ only contracts with MCOs that are willing to contract with the Colorado Medicaid program. To retain their Medicaid contracts, these MCOs must fulfill the statutory requirements of SB 97-75 with regard to use of ECPs. Therefore, the CHP+ managed care network includes these providers. ECPs include community health centers, community mental health centers, public health agencies, school-based clinics, family planning clinics, and other indigent care providers.

Federally Qualified Health Centers and Rural Health Clinics

CHP+ MCOs subcontract with providers, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to furnish covered services to CHP+ managed care enrollees. Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) amends section 2107(e) (l) of the Social Security Act (Act) to make section 1902(bb) of the Act applicable to CHIP in the same manner as it applies to Medicaid. Section 1902(bb) was created in Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1902(bb) governs payment for FQHCs and RHCs, which is referred to as a prospective payment system (PPS), and allows states to choose one of three methodologies with which to implement this provision. The encounter rate for FQHCs and RHCs shall be the higher of the PPS rate or the alternative payment methodology (APM) rate. The APM rate for FQHCs is calculated in accordance with 10 CCR 2505, Section 8.700.6.D (2021). The APM rate for RHCs is the Medicare rate. In accordance with 10 CCR 2505, Section 8.740.7.B.2 (2021), the Medicare rate for hospital-based RHCs is their audited, finalized rate from their Medicare cost report and the Medicare rate for freestanding RHCs is the Medicare upper payment limit rate for RHCs set by the Centers for Medicare and Medicaid Services (CMS).

Guidance: In Section 3.2., note that 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. (42CFR, 457.490(b))

3.1.1 Choice of Delivery System

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

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

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

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

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

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

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

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

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

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

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

☐ No
☒ Yes

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

Children ages 0 – 3, that are determined eligible, may participate in the Early Intervention Program, which is a program administered by the Colorado Department of Human Services (CDHS). MCOs have financial responsibility, but services are provided by CDHS.

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 Each MCO has their own actuarially sound rate
  Describe population served:

☐ 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: PAHP is only for Dental services. All CHIP eligible populations, except the CHIP presumptive eligible population.
- ☐ 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))

The PAHP is only for dental services and does not have physician services.

3.1.3 Nonemergency Medical Transportation PAHPs

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

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

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

3.2. General Managed Care Contract Provisions

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

In the state of Colorado, there is no procurement process for an MCOs to join the program.

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. NA

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

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

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

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

3.4 Enrollment

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

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

3.4.1 Enrollment Process

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

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

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

☒ Yes
☐ No

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

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

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

MCO, PIHP, PAHP, PCCM or PCCM entity from being considered. (42 CFR 457.1210(a)(1)(ii), 42 CFR 457.1210(a)(1)(iii))

3.4.2 Disenrollment

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

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

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

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

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

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

3.4.2.5 Enrollee Requests for Disenrollment.

Guidance: The State may also choose to limit disenrollment from the MCO, PIHP, PAHP, PCCM, or PCCM entity, except for either: 1) for cause, at any time; or 2) without cause during the latter of the 90 days after the beneficiary's initial enrollment or the State sends the beneficiary notice of that enrollment, at least once every 12 months, upon reenrollment if the temporary loss of CHIP eligibility caused the

beneficiary to miss the annual disenrollment opportunity, or when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c))

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

☒ 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

3.6 Benefits and Services

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

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

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

3.6.3 ☒ The State assures that it:

- Publishes the State's network adequacy standards developed in accordance with 42 CFR 457.1218, cross-referencing 42 CFR 438.68(b)(1) on the Web

site required by 42 CFR 438.10;

- Makes available, upon request, the State's network adequacy standards at no cost to enrollees with disabilities in alternate formats or through the provision of auxiliary aids and services. (42 CFR 457.1218, cross-referencing 42 CFR 438.68(e))

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

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

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

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

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

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

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

- Requiring the contract to adequately and timely cover out-of-network services if the provider network is unable to provide necessary services covered under the contract to a particular enrollee and at a cost to the enrollee that is no greater than if the services were furnished within the network;
- Requiring the MCO, PIHP and PAHP meet and its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services;
- Ensuring that the hours of operation for a network provider are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid or CHIP Fee-For-Service, if the provider serves only Medicaid or CHIP

enrollees;

- Ensuring that the MCO, PIHP and PAHP makes available services include in the contract on a 24 hours a day, 7 days a week basis when medically necessary;
- Establishing mechanisms to ensure compliance by network providers;
- Monitoring network providers regularly to determine compliance;
- Taking corrective action if there is a failure to comply by a network provider. (42 CFR 457.1230(a), cross-referencing to 42 CFR 438.206(b)(4) and (5) and (c))

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

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

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

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

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

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

- The MCO, PIHP, or PAHP and its subcontractors have in place and follow written policies and procedures;
- The MCO, PIHP, or PAHP have in place mechanisms to ensure consistent application of review criteria and consult with the requesting provider when appropriate; and
- Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an

individual with appropriate expertise in addressing the enrollee's medical, or behavioral health needs. (42 CFR 457.1230(d), cross referencing to 42 CFR 438.210(b), except that 438.210(b)(2)(iii) does not apply to CHIP contracts)

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

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

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

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

- Ensure that each enrollee has an ongoing source of care appropriate to his or her needs;
- Ensure that each enrollee has a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee;
- Provide the enrollee with information on how to contract their designated person or entity responsible for the enrollee's coordination of services;
- Coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee between settings of care; with services from any other MCO, PIHP, or PAHP; with fee-for-service services; and with the services the enrollee receives from community and social support providers;
- Make a best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees;
- Share with the State or other MCOs, PIHPs, or PAHPs serving the enrollee the results of any identification and assessment of the enrollee's needs;
- Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and
- Ensure that each enrollee's privacy is protected in the process of coordinating care is protected with the requirements of 45 CFR parts 160 and 164 subparts A and E. (42 CFR 457.1230(c), cross-referencing to 42 CFR 438.208(b))

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

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

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

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

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

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

457.1260)

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 sub contractual relationships and delegation requirements in 42 CFR 457.1233(b), cross-referencing 42 CFR 438.230, including that:

- ☒ The MCO, PIHP, or PAHP maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State;
- ☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor specify that all delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement, the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, or PAHP's contract obligations, and the contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, or PAHP determine that the subcontractor has not performed satisfactorily;
- ☒ All contracts or written arrangements between the MCO, PIHP, or PAHP and any subcontractor must specify that the subcontractor agrees to comply with all applicable CHIP laws, regulations, including applicable sub regulatory guidance and contract provisions; and
- ☒ The subcontractor agrees to the audit provisions in 438.230(c)(3).

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

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

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

3.7.7 ☒ The State assures that it reviews and validates the encounter data collected, maintained, and submitted to the State by the MCO, PIHP, or PAHP to ensure it is a complete and accurate representation of the services provided to the enrollees under the contract between the State and the MCO, PIHP, or PAHP and meets the requirements 42 CFR 438.242 of this section. (42 CFR 457.1233(d), cross referencing 42 CFR 438.242)

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

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

3.8 Beneficiary Protections

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

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

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

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

3.9 Grievances and Appeals

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

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

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

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

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

☐ Yes
☒ No

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

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

- At the enrollee's option and not required before or used as a deterrent to proceed 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 it has established a method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR 438.10. (42 CFR 457.1260, cross referencing to 42 CFR 457.408(d)(1))

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

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

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

3.9.23☒ The State assures that if it offers an external medical review:

- The review is at the enrollee's option and is not required before or used as a deterrent to proceed 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).

3.11.5 ☒ 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).

3.12.2.2 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).

3.12.5.3 External Quality Review Report

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

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

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

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

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

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

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR 438.310(c)(2));
- For each EQR-related activity (mandatory or optional) conducted in accordance with 42 CFR 438.358:
  - Objectives;
  - Technical methods of data collection and analysis;
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR 438.358(b)(1)(i) and (ii); and
  - Conclusions drawn from the data;
- An assessment of each MCO's, PIHP's, PAHP's, or PCCM entity's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Recommendations for improving the quality of health care services furnished by each MCO, PIHP, PAHP, or PCCM entity, including how the State can target goals and objectives in the quality strategy, under 42 CFR 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to CHIP beneficiaries;
- Methodologically appropriate, comparative information about all

MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with 42 CFR 438.352(e); and

- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.350(f) and 438.364(a))

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

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

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

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

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

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

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the 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) (42CFR 457.490(b))

CHIP MCOs use managed care utilization standards to assure that enrollees only receive appropriate and medically necessary care.

Section 4. Eligibility Standards and Methodology

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

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

4.0. ☒ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group: The Medicaid expansion will increase eligibility to under or uninsured children 6 through 18 years of age with family income above 100% FPL and at or below 133% FPL and to under or uninsured pregnant women with family income above 133% FPL and at or below 185% FPL.

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

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option. SSA verification is used to verify citizenship and identity. An automated response from SSA confirms that the self-reported data is consistent with SSA data and meets citizenship and identity verification requirements. No further action is required for the applicant.

Please see approved CS18 template for citizenship verification requirements.

4.1.1 ☑ Geographic area served by the Plan if less than Statewide: The plan is available statewide, in all 64 Colorado counties.

4.1.2 ☑ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group: CHP+ is available to children 0 through 18 years of age with family income at or below 250% FPL.

4.1.2.1-PC ☐ Age:_____through birth (SHO #02-004, issued November 12, 2002)

4.1.3 ☑ Income of each separate eligibility group (if applicable): To be eligible, a child must be from a family whose annual income is at or below 250% of the federal poverty level. Family size and income criteria are described in Attachment 2.

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

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

4.1.5 ☑ Residency (so long as residency requirement is not based on length of time in state): A resident is anyone who is: 1) a U.S. citizen; or 2) a documented legal immigrant who has had an Alien Registration Card for 5 years or more and 3) a resident of Colorado. The state accepts self-declaration of residency.

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child will be denied coverage because the child is eligible for Medicaid, not for reasons of disability status.

4.1.7 ☑ Access to or coverage under other health coverage: Both the application and the separate "Insurance Form" ask families questions about other insurance coverage. The plan administration seeks information about all other access to health care coverage, both public and private, on the application form before the child is enrolled in the plan and from providers once the child is determined eligible for the plan. A child will be found ineligible if the child: 1) is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; or 2) is eligible for Medicaid; or 3) is a member of a family that is eligible for health benefits coverage under a State health benefits plan based on a family members employment with a public agency in the State; or 4) has had coverage under an employer plan with at least a 50% employer contribution during the three months prior to application. The Health Care Program for Children with Special Needs is not considered a private health plan and children covered under this plan may still be covered by CHP+.

If the State finds that a child enrolled in CHP+ is retroactively eligible for Medicaid, the State will notify the family that the child will be disenrolled from CHP+ and enrolled into Medicaid in 10 days. The State may choose to enroll the child into Medicaid sooner than 10 days if the Medicaid benefit package offers necessary services that the CHP+ plan does not cover.

4.1.8 ☑ Duration of eligibility, not to exceed 12 months: Once a child has been accepted, he or she is continuously eligible for one year from the first day of the month of application unless the child moves from the state, turns 19 years old, or becomes eligible for or enrolled in Medicaid, or other private insurance.

4.1.9 ☐ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

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. Social Security Numbers are not required.

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

4.1.9.2 ☒ Continuous eligibility. Children ages 0-18 may be continuously eligible. Once a child has been determined eligible, the child is continuously eligible for one year from the first day of the month of application unless the child moves from the state, turns 19 years old, or becomes eligible for or enrolled in Medicaid, or private health insurance.

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

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1)"lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In other words, a State that chooses to cover pregnant women under this option must otherwise cover pregnant women under their State plan as described in 4.1.11. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

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

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

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

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

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

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

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

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

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

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

Please see approved CS18 template for citizenship verification requirements.

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

Please see approved CS18 template for citizenship verification requirements.

4.1-DS ☐ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards

and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

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

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

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

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

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

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

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

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

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

Please see approved CS24 template for eligibility processing requirements and approved CS15 template for MAGI-Based Income Methodologies.

During the Federal COVID-19 public health emergency, requirements related to timely processing of applications may be temporarily waived for CHIP applicants.

During the Federal COVID-19 public health emergency, the State will temporarily delay acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by COVID-19 such that processing the change in a timely manner is not feasible. The state will continue to act on the changes in circumstances

described in 42 CFR 457.342(a) cross-referencing 435.926(d).

Both initial eligibility and annual renewal eligibility for CHP+ are determined either at the main office or at a decentralized eligibility site.

Applications may be received by mail or by Fax at the central office or during face-to-face interviews at the decentralized sites. Applicants may also complete applications online, or drop off paper applications in person during central office business hours.

The State has developed and implemented an eligibility, enrollment and application tracking system for CHP+. The system uses a sophisticated business rules engine and state-of-the-art secure Internet technologies to reduce the overall cost of administration and increase the speed and accuracy of screening for Medicaid eligibility, determining eligibility for CHP+ and enrolling children into the program.

Current employment income, self-employment income and cash income from other sources reported are used to qualify families with employment or retirement income. Verification of earned income is verified through the Income and Eligibility Verification System (IEVS), which extracts wage information reported by employers to the Colorado Department of Labor and Employment.

ELIGIBILITY DETERMINATION AND RENEWAL

Redetermination of Eligibility

Persons enrolled in CHP+ are enrolled for a period of twelve months. Renewal letters and packets are mailed to families at least 45 days before the day their CHP+ coverage terminates. Reminder letters are mailed to the family 30 days before the end-of-coverage date. Families are encouraged to return their completed renewal application at least 30 days prior to termination to allow continuity of care through their HMO. If the family does not resubmit a complete application by the ending date of coverage, the person's eligibility may still be renewed. The only penalty is interrupted coverage.

At redetermination, renewal requires the same financial documentation as was required at the time of the family's original application. A family will be fully processed for eligibility at each renewal period.

Once the State has re-determined eligibility, a letter is sent to households that are above 150% and up to and including 250% of the FPL to notify them that they owe an enrollment fee and have 30 days from the date of re-determination to submit an enrollment fee. Coverage begins when the State receives the enrollment fee. If the enrollment fee is not submitted by the end of the 30-day period, the client's coverage will end at the end of the redetermination period. Once the client pays the enrollment fee, coverage will resume.

During a state or federally-declared disaster and at the state's discretion, the state may implement the following changes to its enrollment and redetermination policies for beneficiaries living and/or working in state or federally-declared disaster areas:

- The state may temporarily use the regulatory timeliness exception for timely processing of CHIP applications under 42 CFR 457.340(d)(1).
- The state may temporarily use the regulatory timeliness exception for timely processing of CHIP renewals under 42 CFR 457.340(d)(1).

Enrollment in Health Plans

All CHIP eligible children and prenatal individuals are enrolled into managed care organizations. At the time of eligibility determination and annually at the time of redetermination, members are notified which MCO they have been passively enrolled into. If the member wants to change MCO enrollment, members who live in service areas with multiple MCOs participating will have 90 days from the effective date of MCO enrollment at the time of eligibility determination and redetermination to contact the Department or its designee in order to select a different MCO. Once a member has selected an MCO or upon expiration of the 90-day period, the enrollee shall remain enrolled in that MCO until the time of redetermination.

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

4.3.1 Limitation on Enrollment. Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(4)) (42CFR, 457.305(b))

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

The applicant must pay the annual enrollment fee in order for the child(ren) to enroll in CHP+. Once the State has determined eligibility (or automatic redetermination has occurred), a letter is sent to households that are above 150% and up to and including 250% of the FPL to notify them that they owe an enrollment fee and have 30 days from the date of determination (or redetermination) to submit an enrollment fee. Coverage begins when the State receives the enrollment fee. If the enrollment fee is not submitted by the end of the 30-day period, the client will be denied for non-payment and will have to re-apply.

In the event the Department makes a determination to limit enrollment to ensure that the program maintains sufficient funds, enrollment in CHP+ shall be halted.

The Department accepts applications for enrollment at times when sufficient funding is available to justify enrolling more individuals. The Department may limit the number of children to be enrolled according to the funds available for the program. When the Department has established that all of the funds appropriated for this program are obligated, the Department, in accordance with 457.65(b), will notify CMS in writing that a freeze in enrollment has taken place, or will take place.

During an enrollment cap, applications will be screened for Medicaid in the same manner as currently described in the approved State Plan Amendment. If the applicant appears to be Medicaid eligible, the application will be referred to Medicaid. If the applicant does not appear to be Medicaid eligible, the application will be returned to the applicant with a letter explaining the cap. The letter will also encourage the applicant to apply again when the enrollment cap is lifted.

An enrollment cap will not affect current enrollees. Reenrollment applications will be screened for Medicaid and the CHP+ and enrolled in exactly the same way as prior to the cap. Siblings and newborns to existing enrollees will continue to be enrolled using currently approved procedures. Applicants will be enrolled in CHP+ if they are determined eligible after being screened for Medicaid.

As funds become available through the budget process, the cap will be lifted. Public notice will occur using the methods used as described for the implementation of the cap. Applicants will be screened and enrolled in the order of receipt. CMS will be notified any time the cap will be lifted based on the criteria listed above.

No waiting list will be maintained for CHP+.

The administration of an enrollment cap will be communicated prior to implementation by providing in writing; a posting on the Internet, a letter to the legislature, and policymakers throughout the state. It will also be presented to the Medical Services Board, members of which are appointed according to political affiliation, geographic representation, and provider or recipient status. A news release will be provided to the media on how the new applications will be responded to. No waiting list will be maintained for interested CHP+ applicants. A notice of the removal of a cap will be provided to media, interested parties, and policy makers at the appropriate time.

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). The State provides presumptive eligibility for children, and meets the requirement in 42 CFR 457.355. The State does not require verification of citizenship status for purposes of presumptive eligibility.

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. The Express Lane option is applied to both initial eligibility determination and redetermination.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies. Supplemental Nutritional Assistance Program (SNAP) and the Temporary Assistance for Needy Families Program (TANF)

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.

Income declared to other agencies will be used to determine CHIP eligibility, clients will not be required to provide additional income verification under the Express Lane option.

The eligibility findings from SNAP and TANF will be used to determine state residency, household size, and gross household income. All other eligibility requirements such as citizenship and identity will be verified through the standard verification process (SSA data match). Children up to 142% FPL are eligible for Medicaid, and children up to 260% FPL are eligible for CHIP.

SNAP and TANF ELE Process:

When an application for SNAP and/or TANF (cash assistance) is approved for a child, the state uses SNAP and/or TANF findings for income and eligibility household size for Medicaid and CHIP eligibility determinations for children who apply via these methods. With this process, no additional eligibility determinations are required. The only requirement is for the family to provide affirmative consent for the child to receive Medical Assistance. The state also uses SNAP and/or TANF findings for verification of SSN and state residency. The state then verifies citizenship and obtains any supplemental health insurance information.

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. Citizenship and identity are verified through the SSA interface.

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

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

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

4.4.1. ☑ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a

State health benefits plan) are furnished child health assistance under the plan. (Sections 2102)(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

Please see approved CS24 template for eligibility processing requirements.

The State has developed and implemented an eligibility, enrollment and application tracking system for CHP+. The system utilizes a sophisticated business rules engine and state-of-the-art secure Internet technologies to reduce the overall cost of administration and increase the speed and accuracy of screening for Medicaid eligibility, determining eligibility for CHP+ and enrolling children into the program.

Using the rules set, a precise determination of income for the Medicaid Budget Unit, including applicable income disregards, has been included to screen for Medicaid eligibility. Screening for Medicaid eligibility occurs at the time of application. For each child listed on the application, the system displays whether or not the child is eligible for Medicaid. The family of a child found to be eligible for Medicaid receives a letter indicating that the child cannot be insured by the plan because the child appears to be eligible for Medicaid. If the application originated at the CHP+ central office, the application is then forwarded to Medicaid Eligibility Technicians located at the central CHP+ administrative office; if the application originated at a satellite eligibility determination site, it is forwarded to the county department of social services and the family is given a 1-800-phone number to call with further questions. The family will be notified that the application will be reconsidered if Medicaid Technicians determine that the person is ineligible for Medicaid. CHP+ requests that the family provide the Medicaid denial letter.

Families who apply for Medicaid are informed about CHP+ and families applying for CHP+ are informed about Medicaid. The joint Medicaid/ CHP+ application notifies the applicant that information will be shared with both Medicaid and CHP+ to determine eligibility for both programs.

County departments of social services provide support to low-income families in communities ranging from food stamps and Women, Infants, and Children programs to child care and Colorado Works. Many CHP+ referrals come from these programs. In addition, because federal law mandates linkage between CHP+ and Medicaid (for example, through a common application) about 20% of CHP+ applications are submitted through the Medicaid application process managed directly by county departments of social services.

<u>Other Credible Coverage Screening</u>

The joint Medicaid/CHP+ application, asks the applicant to report any health insurance

coverage. If the family reports creditable coverage (most group health plans and health insurance coverage), the child or pregnant woman will be found ineligible. Providers contracting with the CHP+ are required contractually to notify the plan whenever they have reason to believe a member has coverage other than CHP+. CHP+ then verifies coverage with the insurance carrier and notifies the family that they will be disenrolled.

There is no waiting period for pregnant women. To be eligible, a child must not be insured by a comparable group health plan.

The Department will conduct the biennial Colorado Health Access Survey (CHAS) which determines *inter alia,* the percent of enrollees who dropped group health insurance without good cause in order to gain eligibility for CHP+. If substitution exceeds ten (10) percent, the department will collaborate with CMS to identify a strategy to reduce substitution.

Children of state employees will be enrolled into CHP+ if they meet all other technical eligibility requirements including income limits and lack of health insurance. Per section 10203(b)(2)(D) of the Affordable Care Act, States are permitted to extend CHIP eligibility to children of State employees who are otherwise eligible under the Title XXI (CHIP) State Plan to the extent that one of two conditions is met. These conditions are described in a new section 2110(b)(6) of the Social Security Act (added by the Affordable Care Act and amended by Public Law 111-309) and are referred to as the hardship and the maintenance of agency contribution conditions.

Colorado is electing to cover children of state employees under the maintenance of agency contribution condition authorized in Section 2110(b)(6)(B) of the Social Security Act. Specifically, this section grants an exception to the exclusion of children of state employees if the State determines that public agency expenditures for health coverage for employees that have dependent coverage is not less than the amount of such expenditures in the 1997 State fiscal year, increased by the percentage increase of the medical care expenditure category of the Consumer Price Index for All-Urban Consumers (all items: U.S. City Average).

Colorado will monitor whether it meets the maintenance of agency contribution criteria on an annual basis. The methodology outlined above will be used each year to ensure that Colorado's contribution towards the cost of employee dependent coverage remains no less than its contribution in 1997, adjusted for inflation.

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

CHP+ applicants are screened for Medicaid eligibility at the central site and decentralized sites. The Medicaid-eligible person's application is referred to both the county social

service offices and the Medicaid technicians housed in the CHP+ administrative offices. CHP+ eligibility staff follow up on these referrals with clients and notify eligibility staff that they have made a referral. Children who appear to be Medicaid eligible are only enrolled in CHP+ after they have received a denial letter from the State Medicaid staff. State Medicaid staff have access to important information concerning cases referred to Medicaid from CHP+ through the eligibility system. A 1-800 number is used to facilitate client questions concerning the disposition of their application that has been referred to Medicaid but originated with CHP+.

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))

Families who apply for Medicaid are informed about CHP+ and families applying for CHP+ are informed about Medicaid. The joint Medicaid/ CHP+ application notifies the applicant that information will be shared with both Medicaid and CHP+ to determine eligibility for both programs.

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

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

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

CHP+ has contracts with Indian Health Services in all areas of the state to allow tribal clinics to deliver health care to Native Americans. Because the federal legislation governing the Indian Health Services has regulations against the use of managed care, CHP+ pays these facilities fee-for-service. These primary care contracts, continue to allow Native Americans full access to specialty providers through a managed care environment (though still paid fee-for-service.)

CHP+ works directly with the Denver Indian Health & Family Services to reach out to Native

Americans living in the Denver metro area, home to nearly half of Colorado's American Indian/Alaskan Native population. CHP+ conducts outreach to American Indian/Alaskan Natives living in the remainder of the state, much of which is rural, through local public health nurses, caseworkers, and Tribal consultations. In Southwestern Colorado, case workers at the San Juan Basin Public Health department in Durango provide outreach at two Indian Health Centers at the Ute Mountain Ute Indian Reservation near Towaoc and Southern Ute Indian Reservation in Ignacio.

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

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

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

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

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

Section 5. Outreach and Coordination

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

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

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

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

Colorado identifies and enrolls children eligible to participate in public health insurance programs through a broad outreach strategy using public and private partners and direct appeals to families in the media and in their communities. One of the most successful efforts has been and continues to be word of mouth generated by the positive experiences of members and local partners.

One important method of enrollment that has simplified the process for families is the development of a simplified, joint application process that the agency can use to enroll children and families in Medicaid or CHP+. This simplified application can be obtained through the standard Medicaid outreach and enrollment process, as well as through the standard CHP+ outreach and enrollment processes.

1. Medicaid, administered by the Colorado Department of Health Care Policy and Financing, provides health coverage to low-income children and families, elderly and disabled Coloradans. Colorado takes the following steps to enroll children in Medicaid:

    - County human/social services departments determine a person's eligibility for Medicaid. Presumptive eligibility sites (Federally Qualified Health Centers and Planned Parenthood clinics), county nurses offices, doctor's offices and Indian Health Centers determine presumptive Medicaid eligibility and enroll pregnant women. Infants up to twelve months old born to Medicaid-enrolled women are guaranteed Medicaid eligibility for twelve months.

    - Outstationed eligibility sites (FQHCs, Disproportionate Share Hospitals, and local county health departments) help people apply for Medicaid by collecting and sending their applications and paperwork to the county department of social services office for eligibility determination.

    - Posters, brochures, and a 1-800 number provide Medicaid information to potentially eligible families at several locations, including public assistance offices**.**

    - CHP+ screens applicants for Medicaid eligibility. When an applicant appears to be Medicaid eligible: the CHP+ central office refers applications to Medicaid technicians located at the CHP+ office who process the application for the family.

This process accelerates enrollment. Satellite eligibility determination sites refer directly to county department of social services for application processing.

2. CHP+ is a public/private partnership providing subsidized health insurance for children in low-income families statewide who are not eligible for Medicaid. The CBHP Policy Board provided oversight and policy development. CHP+ is administered by the Department of Health Care Policy and Financing through private contractors who provide various services. These organizations manage the routine administrative matters associated with CHP+.

   National data and years of experience have shown that reaching out on a local level is the most effective way to reach eligible families. CHP+ has continued its efforts to partner with many community-based organizations throughout the year. CHP+ created partnerships with approximately 2000 community-based organizations including: schools; Head Start programs; the Family Resource Center; community health centers; United Way agencies; public health departments; county departments of human/social services; Women, Infants, and Children programs; and many others. These extensive partnerships represent an extraordinary commitment statewide to enroll uninsured children as part of the CHP+ comprehensive marketing and outreach strategy. In addition, the CHP+ program initiated a targeted television advertising campaign and began testing employer-based outreach activities. All of these activities represent Colorado's interest in reaching families in every way possible.

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:

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

CHP+ has created an extensive marketing and outreach program encompassing strategies that range from grass roots networking to mass market advertising campaigns. These

efforts have been implemented to reach families in myriad ways with different messages.

To better evaluate the effectiveness of these strategies, CHP+ has implemented a large-scale, application-source tracking system. The system allows an application to be traced back to the initial source without relying on self-reported referral data. This tracking system will continue to be used to monitor trends and results from marketing and outreach campaigns.

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

1. The Health Care Program for Children with Special Needs (HCP) is a joint state/federal program administered by the Colorado Department of Public Health and Environment for children age 20 and under who have a physical disability that interferes with normal growth and development. HCP helps pay medical bills and provides follow-up for children diagnosed with a clinically qualifying handicapping condition. Children with conditions eligible for the program are identified through county nursing services, health care providers, Child Find coordinators in public schools, and local Early Childhood Connections staff.

2. Colorado Indigent Care Program (CICP), administered by the Colorado Department of Health Care Policy and Financing, is a state and federally funded provider reimbursement program that discounts the cost of medical care at its participating health facilities for adults as well as children. If a person is eligible for Medicaid or CHP+, he or she is ineligible for CICP. Covered services vary by participating hospitals or clinics, but generally include hospital costs such as inpatient stays, surgery, and prescription drugs. All children deemed eligible for the above mentioned programs are directed toward them at CICP-participating providers. Colorado takes the following steps to enroll children in CICP:

    - CICP-contracted providers (primarily FQHCs, DSH hospitals, and participating clinics) screen children for CICP eligibility during their visit, assist with completing the application, and determine eligibility for the program.

    - The non-CICP community health centers and other safety net providers who determine Medicaid eligibility refer clients to a CICP provider if they determine that a client is not eligible for Medicaid but may be eligible for CICP. Children are referred to CHP+ first if the safety net providers determine that a client is not eligible for Medicaid.

3. Community Health Centers offer a wide range of health care to people who may need some financial assistance with their medical bills. Colorado has 20 community health centers with more than 50 clinic sites in medically under-served areas of the state. Community health centers provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, emergency care, diagnostic services and prescriptions.

   Community Health Centers, many of who are Federally Qualified Health Centers, take the following steps to enroll children in Medicaid, CHP+, the Colorado Indigent Care Program (CICP), or the health center's sliding fee scale plan:

   - Provide a financial screen for each new patient or family.
   - Provide information on and explanation of the program(s) that the family members are eligible for.
   - Assist with completing applications and collecting necessary documentation for eligibility determination.
   - Determine eligibility on-site or forward applications to the determining agency and communicate with family about eligibility status.
   - Assist families when their financial situation and eligibility changes to transition to the appropriate program.

   If a patient/family is not eligible for any program, the health center uses its sliding fee scale to determine the fee according to family size and income.

4. County public health departments identify low income, uninsured children through referrals from a variety of sources including: Women, Infant and Children (WIC), child health and immunization clinics, other community health providers (including private physicians), community health and human/social services agencies and schools, Headstart centers, Early Childhood Connections (Part C), homeless shelters, and self-referrals. Public health staff refer families to any available health care insurance source for which they appear to be eligible, including Medicaid and CHP+ and work with local physicians to try and secure services on a reduced-fee basis. Many public health agency staff members assist families in completing application forms for Medicaid and the CHP+, as well as family resource and healthcare referrals. In Colorado, Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) outreach workers and administrative case managers are a part of local public health agency staff who facilitate access to Medicaid and to CHP+ services for eligible children.

5. Maternal and Child Health Block Grant (Title V of the Social Security Act) funds in

Colorado are "passed through" to local public health agencies and other qualified non-profit agencies where they are used to support a number of activities on behalf of women and children, particularly those of low income. State Title V staff provides oversight, consultation and standards to assure appropriate utilization of these funds. When families are ineligible for any insurance plan, or when there is not another provider of free or reduced price health care (i.e. community or rural health centers) available or accessible, these public health agencies provide direct services to low- income children. Services provided in local public health agencies are almost always provided by public health nurses. Services include comprehensive well child clinic services, including developmental and physical assessments, immunizations, and parent education. Families under 100% FPL pay nothing for these services. Others pay on a sliding fee scale.

6. School-based health centers (SBHC) provide comprehensive primary care services including care for acute and chronic illness, injuries, family planning and prenatal care, some diagnostics services and prescriptions. SBHCs provide services at no charge. However, patients are asked whether they have health care coverage. The amount of reimbursement for which SBHCs bill depends on the administrative capabilities of the center and whether a CHP+ participating managed care organization contracts with them. SBHCs facilitate application to Medicaid, CHP+ or CICP when documentation of family income and assets is obtainable without jeopardizing students' confidentiality.

7. The Special Nutritional Program for Women, Infants and Children (WIC) provides nutritious food to supplement the regular diet of pregnant women, breast-feeding women, infants, and children under age five who meet state income standards. Women and children under five years old qualify if the combined family income is at or below 185% of the federal poverty level. WIC staff encourage pregnant women and parents and guardians of infants under 12 months of age to apply for Medicaid and CHP+.

8. The Commodity Supplemental Food Program (CSFP) provides infant formula and nutritious foods to supplement the diet of pregnant and postpartum women and children under age 6. Women who live in Conejos, Costillo, Denver, Mesa, Rio Grande or Weld counties and who have a family income at or below 185% of the federal poverty level qualify for the program. Staff encourage pregnant women and parents and guardians of infants under 12 months of age to apply for Medicaid and CHP+.

5.2-ELThe 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. Express lane eligibility streamlines the eligibility process and reduces administrative burden to eligibility sites and clients. If the school determines the child is eligible for Free or Reduced Lunch using the Free/Reduced Lunch application, the school will provide the application information to an eligibility site, and a Family Medicaid/ CHP+ application will be initiated. Currently, on the Free/Reduced Lunch application, families may opt out of sharing their information with Medicaid/CHP+.

5.3 Strategies (formerly Section 5 "Outreach")

Guidance: Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90) The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

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

The State uses the following strategies to reach people who may be eligible for the program:

1. Community Partnerships: A cornerstone of the CHP+ outreach strategy is to maintain and build on community partnerships. To reach all eligible families through as many avenues as possible, CHP+ works with more than 2000 partners. These include: schools; Head Start programs; the Family Resource Center; community health centers; United Way agencies; public health departments; county departments of human/social services; Women, Infants, and Children nutrition programs; faith-based organizations and myriad others. So far, the most effective efforts in actually enrolling families are through schools, doctors' offices, health departments, community health centers, and departments of human/social services.

2. Managed Care Organizations: Managed care organizations have increased their CHP+ outreach. One method of partnering has been the implementation of joint media campaigns in which a majority of managed care partners have participated. These purchased advertisements were structured so that each partner received airtime when marketing would be most effective.

   All of CHP+'s managed care partners have participated in various community events throughout the state.

3. Advertising and Earned Media: Television ranks as the highest source of referral for individual applications. CHP+ and managed care organizations have partnered to purchase targeted television advertisements. Further, the state utilizes advertising and awareness campaigns through Connect for Health Colorado, Colorado's official health insurance marketplace, to increase awareness of CHP+ and explain the enrollment process.

4. County Departments of Human/Social Services: County departments of social services provide support to low-income families in communities ranging from food stamps and Women, Infants, and Children programs to child-care and Colorado Works. Many CHP+ referrals come from these programs. About 20% of CHP+ applications are submitted through the Medicaid application process managed by county departments of human/social services. CHP+ continues to focus on ways to minimize delays in referrals so that eligible children can be enrolled in an expeditious manner.

5. Certified Application Assistance Sites: CHP+ has a network of 305 Certified Application Assistance Sites (CAAS) statewide, including Presumptive Eligibility and Medicaid Assistance sites, with multiple locations for some sites. These sites are composed of community health centers, county nursing services, school-based health centers, Indian Health Centers and other community providers, and have been an essential component of the programs outreach and enrollment activities. As part of their contract with CHP+, they are required to provide outreach to their community for CHP+ and have access to an on-line eligibility program to accelerate program enrollment. CAAS account for more than 30% of submitted applications.

6. Schools: Schools are consistently one of the most frequently cited sources of referral by applicants. Increasing numbers of school districts are partnering with CHP+ to assure the children they serve know about CHP+. More than 60% of all school districts in the state participated in CHP+ outreach activities including coordination with National School Lunch Program information, disseminating materials about CHP+ to families or allowing CHP+ partners and staff to present to family-related functions.

7. Community Health Centers: The Colorado Community Health Network has made involving its members in Medicaid and CHP+ outreach a priority. Community health centers are the largest group of primary care providers throughout the state serving low-income children. Some serve as CAAS. Others participate in community coalitions that enroll children in Medicaid and CHP+.

8. Colorado Covering Kids and Families: A significant partner in developing community-based outreach has been Colorado Covering Kids and Families, which is a Robert Wood Johnson Foundation funded grant program administered by the Department of Public Health and Environment. Colorado received a Covering Kids and Families Grant from the Robert Wood Johnson Foundation in 2002. This grant is administered by a coalition of community groups

including the Colorado Community Health Network, the Colorado Children's Campaign and Catholic Charities. The program is active across the state.

9. Community Voices: This is a joint Kellogg Foundation and Colorado Trust funded

program, which has among its goals to improve the health of Denver's medically underserved through innovations in community outreach, enrollment in publicly funded health insurance programs like CHP+, as well as small employment health plans, and clinical case management. Community Voices efforts are designed to demonstrate that culturally sensitive community outreach to underserved populations improves enrollment of eligible individuals into plans, while engaging and empowering communities to assume greater responsibility for health. Staff at the Department met regularly with the Denver Health and Hospital Corporations Community Voices team to explore program successes, as well as, identify and resolve issues that might impede enrollment and access to care.

10. Toll Free Number and Website: CHP+ maintains a toll-free telephone number so that community partners, members and potential members can obtain information about the program. In addition, CHP+ maintains a website (www.cchp.org) that can be used as a reference tool for community partners, members and potential members. CHP+ has observed a steady increase in web-based traffic regarding the program over the years. Both the toll-free telephone number and website have Spanish options. For other languages, CHP+ relies on AT&T's language line. This is publicized on program materials.

Section 6. Coverage Requirements for Children's Health Insurance

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

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

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

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

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

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

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

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

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

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

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

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

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The

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

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

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

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

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

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

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

6.1.4.1. ☐ Coverage the same as Medicaid State plan

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

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

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

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

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

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

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

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

including any benefit limitations or exclusions.

6.1.4.7. ☐ Other (Describe)

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

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

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

6.2.1. ☑ Inpatient services (Section 2110(a)(1))
6.2.2. ☑ Outpatient services (Section 2110(a)(2))
6.2.3. ☑ Physician services (Section 2110(a)(3))
6.2.4. ☑ Surgical services (Section 2110(a)(4))
6.2.5. ☑ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
6.2.6. ☑ Prescription drugs (Section 2110(a)(6))
6.2.7. ☐ Over-the-counter medications (Section 2110(a)(7))
6.2.8. ☑ Laboratory and radiological services (Section 2110(a)(8))
6.2.9. ☑ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
6.2.10. ☑ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
6.2.11. ☑ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)
6.2.12. ☑ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
6.2.13. ☐ Disposable medical supplies (Section 2110(a)(13))

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

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

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

6.2.15. ☐ Nursing care services (Section 2110(a)(15))
6.2.16. ☑ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)
6.2.17. ☑ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
6.2.18. ☐ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
6.2.19. ☑ Outpatient substance abuse treatment services (Section 2110(a)(19))
6.2.20. ☑ Case management services (Section 2110(a)(20))
6.2.21. ☐ Care coordination services (Section 2110(a)(21))
6.2.22. ☑ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
6.2.23. ☑ Hospice care (Section 2110(a)(23))

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

6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
6.2.25. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))
6.2.26. ☑ Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may

be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

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

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

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

COVID-19 Vaccine:

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

COVID-19 Testing:

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

COVID-19 Treatment:

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

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

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

6.2-BH Behavioral Health Coverage Section 2103(c)(6) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner.

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

Attached to this document is the State's periodicity scheduled.

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

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

All Developmental and Behavioral Health recommendations outlined in the United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B.

☐ Other (please describe:)

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

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral benefit.

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

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

In addition to the Behavioral Health benefits covered within the CHIP benefit as outlined by the AAP Bright Futures periodicity schedule and the USPFTF recommendations graded A or B, the State allows for flexibility among CHIP MCO's to go beyond services defined in the CHIP state plan to address the specific needs of individual patients and populations.

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

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

This is a contractual requirement for the Contractor to provide access to all required components of periodic health screens, as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule. American Society of Addiction Medicine (ASAM) and InterQual provide guidelines for determination of the appropriate levels of care. CHP plans in Colorado utilizes these tools for acute and intermediate-level services which require a prior authorization.

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

The State requires that CHIP MCO's use age-appropriate, validated behavioral health screening tool(s) in primary care as well as behavioral health care settings. MCO's are required to provide an individual needs assessment after enrollment, and at any other necessary time, that includes, but not limited to, the screening for behavioral health needs. Within these requirements, the State provides flexibility in the use of behavioral health screening tools to ensure practices are given the freedom to select screening tools that fit with their practice workflow and patient population, and the screening is appropriate for the needs of the individual patient.

In accordance with Colorado Revised Statute 10-16-139(5), and as specified in Colorado's managed care contracts, MCO's "shall include coverage and reimbursement for behavioral health screenings using a validated screening tool for behavioral health; coverage and reimbursement may be no less extensive than the coverage and reimbursement for the annual physical examination." Managed care contracts also specify the requirement that MCO's must implement mechanisms to provide an individual needs assessment after enrollment, and at any other time necessary, which includes a screening for special healthcare needs, to identify any ongoing special conditions of the member that requires a course of treatment or regular care monitoring and develop a treatment plan as necessary.

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

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

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

Benefit includes, but not limited to psychotherapy, individual therapy, group therapy, family therapy, and case and medication management. Routine outpatient psychosocial treatment services are covered with no limitations if medically necessary.

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

Benefit includes services for the medical management of withdrawal symptoms, inclusive of access to classes, FDA-approved medications, nicotine patches, and the Colorado QuitLine. Services have no limitations if medically necessary, however, some medications may have limitations. FDA-approved tobacco cessation medications are covered per age requirements for prescriptions. Nicotine Replacement Therapy is not currently approved for youth under 18 years old.

As the CHIP program in Colorado utilizes a managed care delivery model, MCOs have the latitude to select quantity limitations based on literature reviews and recommendations from their internal pharmacy and therapeutics committees. Colorado's CHIP MCOs are not currently implementing any quantity limitations on tobacco cessation medications or are limiting to 180 days of treatment per 365 days.

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

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

Colorado passed legislation HB19-1289, amending COLO. REV. STAT. § 10-16-148 requiring that health plans not impose any prior authorization requirements on any prescription medications approved by the Food and Drug Administration (FDA) for the treatment of substance use disorders.
Quantity limitations for Opioid Use Disorder MAT medications offered on the CHIP benefit include the following:

- Butorphanol Tartrate Nasal Spray (Quantity Limit = 1 bottle/30 days)
- Naloxone injection (Quantity Limit= 2 injections/fill)

Currently, there are no quantity limitations for Alcohol Use Disorder MAT medications on the CHIP benefit. Once in a 12-month period, health benefit plans must cover a 5-day supply of at least one FDA-approved substance use disorder treatment medication, without prior authorization per COLO. REV. STAT. § 10-16-104(5.5)(III)(B) (2018)).

6.3.2.3.1- BH ☒ Opioid Use Disorder

MAT medications for Opioid Use Disorder are included on the CO CHIP formulary, and any other MAT medications may be obtained through a prior authorization process. Some MAT drugs may have quantity limitations in place.

6.3.2.3.2- BH ☒ Alcohol Use Disorder

MAT medications for alcohol use disorder are included on the CO CHIP formulary, and any other MAT medications may be obtained through a prior authorization process. Some MAT drugs may have quantity limitations in place.

6.3.2.3.3- BH ☒ Other

MAT medications for tobacco cessation are included on the CO CHIP formulary, and any other MAT medications may be obtained through a prior authorization process. Some MAT drugs may have quantity limitations in place.

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

Peer and caregiver support services are not required covered benefits within the CHP+ benefit. However, while it is not a required benefit, CHIP MCO's have the option to cover caregiver support services. MCO's differentiate between peer and caregiver support. One of our plans covers peer support but not caregiver.

Another covers caregiver support when the caregiver is a MCO member. One MCO contracts peer, caregiver, and rehabilitation services to community mental health centers. One of our plans does not offer peer or caregiver support.

6.3.2.5- BH ☒ Respite Care
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Respite Care services are not required covered benefits within the CHP+ benefit. However, while it is not a required benefit, CHIP MCO's have the option to cover Respite Care services. When covered by CHP MCO's, Respite Care is based on medical necessity. Prior authorization may be required.

6.3.2.6- BH ☒ Intensive in-home services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Treatment for mental health or substance use disorder in a home-setting allows for a strong focus on community and home-based care. Services may be like intensive outpatient, for example, but not limited to, individual counseling/therapy, family therapy, case and medication management, crisis intervention, diagnostic evaluation. In-home treatment is provided when medically necessary. Prior authorization may be required.

In-home mental health and SUD benefits are only covered when determined medically necessary, and require prior authorization. MCOs cover these services in-home when mental health and SUD services traditionally covered in an outpatient setting have been determined to have not been effective.

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

Benefit includes, but not limited to individual therapy, group therapy, family therapy, crisis intervention, diagnostic evaluation, case and medication management. Intensive outpatient services covered without limitation if medically necessary.

In-home mental health and SUD benefits are only covered when determined medically necessary, and require prior authorization. MCOs cover these services in-home when mental health and SUD services traditionally covered in an outpatient setting have been determined to have not been effective.

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

CHIP MCO's cover a variety of psychosocial rehabilitation services, based on the individuals needs of the patient. These services are covered without limitation if medically necessary.

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

6.3.3- BH ☒ Day Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Day treatment services for mental health can include, but not limited to, evaluation, observation, monitoring, and individual, group, or family therapy. This benefit has no limitation if medically necessary. The state considers day treatment and partial hospitalization to be the same benefit.

Day treatment services for substance use disorder can include services that are provided for the purposes of completing a medically safe withdrawal from alcohol or substances, observation, evaluation, medical monitoring and addiction treatment for alcohol and substance abuse.

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

The state considers day treatment and partial hospitalization to be the same benefit. Currently, one of our health plans does not cover partial hospitalization for substance use disorder, as it is not part of our Medicaid benefit package. Network adequacy allows for intensive outpatient services rather than partial hospitalization, as one is required from ASAM level 2.

Day treatment services for substance use disorder can include services that are provided for the purposes of completing a medically safe withdrawal from alcohol or substances, observation, evaluation, medical monitoring and addiction treatment for alcohol and substance abuse.

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))
Provided for: ☒ Mental Health ☒ Substance Use Disorder

This benefit includes acute treatment provided in a psychiatric or general hospital, with covered services inclusive of, but not limited to, provider visits during a covered admission, room and board, ancillary services, group/individual therapy, medication management, medical supplies. Inpatient services require prior authorization to determine medical necessity. No limits apply if medically necessary.

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

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

This benefit covers a 24-hour structured treatment in a licensed residential facility in order to stabilize and provide a safe and supportive living environment, and/or to provide a supportive treatment environment to assist with the initiation or continuation of a patient's recovery process. These services require prior authorization to determine medical necessity. Benefit has no limitation if medical necessary.

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

The MCO plans cover detoxification for Alcoholism and Substance Abuse, this includes services that are provided for the purpose of completing a medically safe withdrawal from alcohol or substances. Limit: Must be medically necessary, and member must complete the recommended course of treatment. Benefit has no limitation if medical necessary.

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

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

This benefit includes emergency services provided in a hospital emergency department for treatment and stabilization of mental health or substance use disorder-related crisis. These services are covered without limitation.

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

This benefit covers unanticipated services rendered in the process of resolving a patient crisis, requiring immediate attention, that without intervention, which could result in the patient requiring a higher level of care. These services can be provided in a variety of settings, including, but not limited to, a via mobile crisis or a crisis stabilization unit. These services are covered without limitation.

6.3.6- BH ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Members new to the CHIP program can receive medically necessary covered services at the level of care received prior to enrollment for a transition period of up to 60 calendar days. Prenatal individuals who are in their second or third trimester of pregnancy, may continue to see their current provider until the completion of postpartum care.

Per state managed care contracts, MCO's are required to implement mechanisms to provide an individual needs assessment after enrollment, and at any other time necessary, which includes a screening for special healthcare needs, to identify any ongoing special conditions of the member that requires a course of treatment or regular care monitoring and develop a treatment plan as necessary. For children who are identified as having special healthcare needs, MCO's are required to establish and maintain procedures and policies to coordinate healthcare services with other agencies or entities such as those dealing with mental health and substance use disorders, public health, home and community-based care, Early Interventions and Supports, local school districts, child welfare, IDEA programs, Title V, and families, guardians, caregivers, and advocates.

Additionally, in accordance with Colorado Revised Statute 25.5-5-406(1)(g), members with special healthcare

needs may continue to receive services from ancillary, or non-network providers at a level of care received prior to enrollment into an MCO's plan, for a period of seventy-five calendar days.

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

Care coordination services are offered at no cost to CHIP members. Care coordinators is designed to support members navigating and understanding their benefits. CHIP MCO's are required to provide comprehensive needs assessment and periodic reassessment, and care coordination services to help coordinate with various systems, community organizations, providers, family members advocates, and other necessary individuals and entities to address the complex, multi-factorial needs of each patient. These services are provided without limitation.

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

This benefit is based on an assessment of individual needs, this benefit offers comprehensive wraparound supports and resources to promote, maintain, and/or restore successful community living. These services are provided without limitation.

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

Care transition services are provided to members throughout transitions from institutional and inpatient settings to the community. Transition services can include but are not limited to, assisting members with chronic disease self-management, medication reconciliation, barrier mitigation, and navigation of the healthcare system.

CHIP MCO's are required to establish policies and procedures to ensure coordination and continuity of care for members transitioning between healthcare setting or different levels of care. Care coordinators and care transition services and are provided to members throughout transitions from inpatient and institutional settings to the community. MCOs are required to implement transition of care procedures in a manner that promotes person and family centered care, assures service accessibility, attention to individual needs, continuity of care, maintenance of health, and independent living. The policies and procedures established by MCO's are required to be comprehensive to ensure coordination of care between services a member receives from all providers, community-based organizations, and social supports. These services are provided without limitation and without prior authorization.

6.3.8- BH ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Benefit includes case managers, available to CHIP members to provide services designed to assist and support a patient to gain access to needed medical, social, education, and other services as well as provide care coordination and care transition services, continuing care, and complex case management. These services are covered without limitation. Case management includes Transitions of Care, Continuing Care, Care Coordination and Complex Case Management. These services are considered routine services and are covered without prior authorization or benefit limits.

6.3.9- BH ☐ Other
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe the tool(s) used by the state or each managed care entity:

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

☒ InterQual
☒ Mental Health ☒ Substance Use Disorders

☒ MCG Care Guidelines
☒ Mental Health ☒ Substance Use Disorders

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

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

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

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

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

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

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

The State requires the use of validated, age-appropriate behavioral health assessment tool(s) by CHIP MCO's. However, the State does not require the use of specific criteria or tools for mental health and substance use disorders, to allow for appropriate assessment, treatment, and intervention, as necessary.

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

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

The State requires that CHIP MCO's provide an individual needs assessment at the time of enrollment, and at any other necessary time, inclusive of, but not limited to, assessment for behavioral health needs. MCO's are required to develop an individual treatment plan, as necessary, based on the needs assessment and to avoid duplication of treatment, and are required to establish treatment objectives, treatment follow-up, the monitoring of outcomes and a process to ensure that treatment plans are revised as necessary. MCO contracts also require needs assessment

findings to inform member outreach and care coordination. The State allows for flexibility in use of behavioral health assessment tools to allow for appropriate assessment, treatment, and intervention, as necessary. The MCO's are responsible for conducting trainings and communications to providers to utilize the required assessment tools and follow-up for compliance.

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

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

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

6.2-DC Dental Coverage The State will provide dental coverage to children, and, beginning October 1, 2019, to enrolled pregnant women of any age, through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children and enrolled pregnant women eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5); see also CHIPRA #7, SHO #09-012 issued October 7, 2009):

6.2.1-DC ☒State Specific Dental Benefit Package. The State assures that the following categories of dental services, represented by the American Dental Association's Current Dental Terminology (CDT) Code of Dental Procedures and Nomenclature, are covered in the dental benefit package:

1. Diagnostic (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (CDT codes: D2000-D2999)
4. Endodontic (CDT codes: D3000-D3999)
5. Periodontic (CDT codes: D4000-D4999)
6. Prosthodontic (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (CDT codes: D7000-D7999)
8. Orthodontics (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 – Contractor-developed periodicity schedule (description attached).

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

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

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. Ifthe

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Current Dental Terminology, © 2015 American Dental Association. All rights reserved.

State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)Page - 11 – State Health Official

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.4.1.3. The coverage must be provided through the use of a community based

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

Guidance: Check 6.6.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR, 457.1010)

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

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

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

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

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

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

☐ Yes
☒ No. This option is offered through a waiver, not the State Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Yes
☒ No

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

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

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

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

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

Section 7. Quality and Appropriateness of Care

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

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

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

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

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

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

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

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

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

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

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

7.1.1. ☑ Quality standards
7.1.2. ☑ Performance measurement
7.1.2 (a) ☒ CHIPRA Quality Core Set
7.1.2 (b) ☐ Other

7.1.3. ☑ Information strategies
7.1.4. ☑ Quality improvement strategies

CHP+ will use quality standards, performance measures, information strategies, and quality improvement studies to assure high-quality care for CHP+ enrollees. The CHP+ program will use quality assurance methods and tools such as NCQA accreditation standards, National Association of Insurance Commissioners (NAIC) standards, Quality Improvement System for Managed Care (QISMC), Healthplan Employer Data and Information Set (HEDIS), Consumer Assessment of Health Plans Survey (CAHPS) data, standard Division of Insurance reports and quality improvement study data. CHP+ will use standards, performance measures, consumer information, and quality improvement methods for MCOs.

The Department Contractors are required to perform Quality Assurance activities. The Contractors provide consulting services that incorporate Federal and State requirements that address ongoing quality assessment and improvement strategy for the CHP+ Program contracting program. The strategy, among other things, will include:

- Performance based contracting standards
-
- HEDIS analysis for all plans

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the

care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

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

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

The Department contracts with a quality assurance vendor to measure HEDIS indicators such as the following:

- Childhood Immunizations
- Adolescent Immunizations
- Children's access to primary care practitioners
- Appropriate medications for children with asthma
- Well child visits

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))

Adequate access to emergency services is assured for all Colorado managed care enrollees by a Division of Insurance regulation that took effect on July 1, 1997. This regulation (4-2-17) specifies that a managed care organization cannot deny an emergency claim if a "prudent lay person would have believed that an emergency medical condition or life or limb threatening emergency existed." The regulation also restricts the use of prior authorizations for emergency care and the denial of emergency care provided by non-network providers.

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

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

The following are the benefits for persons with chronic conditions:

- Any combination of 30 treatment days for inpatient physical, occupational, and/or speech therapy per injury or illness. The services must be received within six months from the date on which the illness or injury occurred.

- Any combination of 30 treatments for outpatient physical, occupational, and/or speech therapy per illness or injury or diagnosed neurological, muscular, or structural abnormality per year.

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 CHP+ prior authorizations are consistent with commercial packages. The contracted managed care organizations are required to comply with the State regulations set forth by the Division of Insurance.

Section 8. Cost-Sharing and Payment

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

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

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

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

Guidance: It is important to note that for families below 150% of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50-.59). For families with incomes of 150% of poverty and above, cost sharing for all children in the family cannot exceed 5% of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

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

8.2.1. Premiums: Colorado does not impose premiums or enrollment fees as of July 1, 2022.

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments:

American Indian/Alaska Natives are exempt from co-payment and annual enrollment fees.

The following copayments shall be due for enrollees at the time of service:

A. For families with income, at the time of eligibility determination, less than 101% of the federal poverty level, all copayments shall be waived, except for emergency and urgent/after hours care, which shall be three dollars per use (co-pay is waived if client is admitted to the hospital).

B. For families with income, at the time of eligibility determination, between 101% and 155% of the federal poverty level, the copayment is:
   1. Two dollars per office visit;
   2. Two dollars per outpatient mental health or substance abuse visit;
   3. One dollar per prescription;
   4. Two dollars per physical therapy, occupational therapy or speech therapy visit;
   5. Two dollars per vision visit;
   6. Three dollars per use of emergency care and urgent/after hours care. (Co-pay is waived if client is admitted to the hospital.)
   7. Two dollars per trip for emergency transport/ambulance.
   8. Two dollars per inpatient hospital visit.
   9. Two dollars per inpatient hospital stay, for physician services in the hospital.

10. Two dollars per outpatient hospital or ambulatory surgery center visit.

C. For families with income, at the time of eligibility determination, between 156% and 212% of federal poverty level, the copayment is:
   1. Five dollars per office visit;
   2. Five dollars per outpatient mental health or substance abuse visit;
   3. Three dollars per generic prescription;
   4. Ten dollars per brand name prescription;
   5. Five dollars per physical therapy, occupational therapy or speech therapy visit;
   6. Five dollars per vision visit;
   7. Twenty dollars per use of urgent/after hours care.
   8. Thirty dollars per use of emergency care (co-pay is waived if client is admitted to the hospital.)
   9. Fifteen dollars per trip for emergency transport/ambulance.
   10. Twenty dollars per inpatient hospital visit.
   11. Five dollars per inpatient hospital stay for physician services in the hospital.
   12. Five dollars per outpatient hospital or ambulatory surgery center visit.
   13. Five dollars per date of service for laboratory and imaging services.

D. For families with income, at the time of eligibility determination, between 213% and 259% of federal poverty level, the copayment is:
   1. Ten dollars per office visit;
   2. Ten dollars per outpatient mental health or substance abuse visit;
   3. Five dollars per generic prescription;
   4. Fifteen dollars per brand name prescription;
   5. Ten dollars per physical therapy, occupational therapy or speech therapy visit;
   6. Ten dollars per vision visit;
   7. Thirty dollars per use of urgent/after hours care.
   8. Fifty dollars per use of emergency care (co-pay is waived if client is admitted to the hospital.)
   9. Twenty-five dollars per trip for emergency transport/ambulance.
   10. Fifty dollars per inpatient hospital visit.
   11. Ten dollars per inpatient hospital stay for physician services in the hospital.
   12. Ten dollars per outpatient hospital or ambulatory surgery center visit.
   13. Ten dollars per date of service for laboratory and imaging services.

During a state or federally-declared disaster and at the state's discretion, the state may waive copayments for CHIP beneficiaries who reside and/or work in state or federally-declared disaster areas.

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

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration without cost sharing, in accordance with the requirements of section 2103(c)(11)(A) and 2013(e)(2) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

COVID-19 Treatment:

- The state provides coverage of COVID-19-related treatments without cost sharing, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act.

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

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without cost sharing, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) and 2103(e)(2) of the Act. This coverage includes items and services, including drugs, that were covered by the state as of March 11, 2021.

8.2.4. Other:

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

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

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

The Department worked closely with CHP+ stakeholders before putting forth this proposal to increase copayments. This change has been adopted into rule and was subject to the public rulemaking process. Stakeholders testified in favor of this change because it was a more acceptable alternative to the one put forth by the State Legislature, which would have increased cost sharing over 1000%. After rule adoption, the rules are published in the Colorado Register and posted to the Secretary of State website.

The Department gives CHP+ members and applicants a chart that describes plan options, annual enrollment fees, and copayments based on income and family size.

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

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

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

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

The following procedures will be considered well-baby and well-child care: CPT-4 codes: Preventive medicine codes: 99381-New patient under one year; 99382-New Patient age 1-4 years; 99383-New patient ages 5-11 years; 99384-

New patient ages 12 through 17 years; 99385- New patient aged 18 years; 99391-Established patient under one year; 99392-Established patient ages 1-4 years; 99393-Established patient ages 5 through 11 years; 99394 – Established patient aged 12-17; 99395- Established patient aged 18 years; 99431- Newborn care (history and examination); 99432-Normal newborn care.

Evaluation and Management Codes: 99201-99205-New patient; 99211-99215-Established patient.

The following diagnoses will be considered well-baby and well-child care: ICD-10 codes: Z00.1- Z00.129—Encounter for routine child health and/or Health examination for newborn; Z00.2-Z00.6— Encounter for examination; Z00.70-Z00.71— Encounter for examination for a period of delayed growth; Z02.82 - Z02.89— Encounter for adoption services or other general examination.

All infants and children should be seen by a Primary Care Provider regularly for immunizations (shots) and check-ups. The CHP+ follows the well-child visits schedule recommended by the American Academy of Pediatrics (AAP) accepted Bright Future Schedule. The American Academy of Pediatrics recommends that children receive well-child visits at the following ages: 1 week, 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months 18 months, 2 years, 3 years, 4 years, 5 years 6 years, 8 years, 10 years, 11 years, 12 years, and 13 years.

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

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

The 5% maximum allowable cost-sharing limit is calculated for each individual family. The annual amount is then recorded on the family's enrollment card with instructions in the member packet of the "shoe box" method and the process to be followed when the limit is reached.

State planners estimate that few families will reach their 5% limit. An analysis of the State's fee schedule suggests that cumulative cost sharing will rarely exceed 1% of the family's adjusted gross income. However, CHP+ administrative personnel make families aware of the aggregate limit on cost sharing through a number of information and educational sources.

Through direct communication with families, the CHP+ marketing and outreach efforts often discuss the aggregate limit on cost sharing. The first direct written communication with CHP+

families instructs parents that the expenditures on their child(ren)s health care through CHP+ should not exceed 5% of family income. Through contracts with Managed Care Organizations, the CHP+ administration ensure that the plans make their enrollees aware of the aggregate limit on cost sharing by including information regarding the cost-sharing limit in their member handbooks.

The State has adopted the "shoe box" approach to reimburse families who exceed the 5% limit. Families are required to track expenditures based on the calculation of family income provided by the state and to submit receipts for all expenditures in excess of the 5% limit. Since the eligibility process will determine an “eligibility income” for each family, that family will receive notification of the exact dollar figure that will represent 5% of the family’s adjusted gross income.

Once they submit evidence that they have exceeded the 5% cap, the state will issue them a "co-pay exempt" sticker to be placed on their membership card. Providers and plans will be informed that enrollees with this sticker are not being charged co-payment for any service. The 5% limit is calculated on the family’s income at the time of eligibility determination. This cap is cited on the enrollment card. The cap will be recalculated if a family applies for a redetermination before the year is complete.

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 joint application includes a question asking the applicant to indicate their ethnicity. Alaskan Native and American Indian are two of the choices. When this information is entered into the computerized eligibility and tracking system, the rules engine recognizes ethnicity and determines a $0 co-payment. This $0 is printed out on the enrollees’ card. The provider uses this card to determine the co-payment to be charged to the patient.

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

If an enrollee does not pay the annual enrollment fee within the 30 days after the notice, they are denied for the program.

Guidance: Section 8.8.1is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

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

Guidance: Provide a description below of the State’s premium grace period process and how

the State notifies families of their rights and responsibilities with respect to payment of premiums. (42CFR 457.570(a))

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

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

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

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

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

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

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

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

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

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

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

Section 9. Strategic Objectives and Performance Goals and Plan Administration

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

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

Strategic objectives are to:

1. Increase the use of preventive care.
2. Increase access to care.

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

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

1. Increase the use of preventive care.
   Performance Goals:
   - Increase the percentage of children and adolescent well care visits (W30, WCV) above the NCQA Mean until the 90th percentile has been reached.
     - DATA SOURCE: HEDIS Measure W30 "Well-Child Visits in the First 30 Months of Life" assesses children who turned 15 months old during the measurement year and had at least six well-child visits and assesses children who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician.
   - Increase the percentage of children combo 10 vaccines (CIS) to above the NCQA Mean.
     - DATA SOURCE: HEDIS Measure CIS, "Childhood Immunization Status" is the percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
   - Increase the percentage of adolescent combo 2 vaccines (IMA) to the NCQA Mean
     - DATA SOURCE: HEDIS Measure IMA, "Immunization for Adolescents" assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday.

2. Increase access to care
   Performance Goals:

- Increase the percentage of enrolled children under age 21 who had one or more preventive oral evaluation as a dental service during the past 12 months to the NCQA Mean (OEV-CH)
    - DATA SOURCE: Child Core Set Annual Report
- Increase the percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment (PPC-CH) in the organization to the NCQA Mean.
    - DATA SOURCE: HEDIS Measure PPC-CH
- Increase the percentage of women with a recent live birth who reported receiving a postpartum visit on or between 7 and 84 days after delivery (PPC-AD) and the NCQA Mean.
    DATA SOURCE: HEDIS Measure PPC-AD
- Increase the number of CHP+ children and pregnant women that receive any dental service by 10% over the 5-year life of the contract.
    - DATA SOURCE: dental claims data from HCPF.

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))

Each of the program goals have specific, measurable, and objective methods to evaluate and compare. In addition to the above data sources for SMART goal calculations, we will use the below performance measurements checked off. In preparation of full core sets reporting by 2024, our annual HEDIS report will include those adult and child core set measures in fiscal year 2021-2022. We use individual MCO data for comparison and to drive performance improvement. In

addition, the state is starting to collect performance measure indicator data such as contraceptive care not only for the post-partum person. Other measures, such as well child visit data may indicate performance improvement in other areas such as immunization and developmental screening, where those claims numbers may not match state data.

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.

☒ **9.3.6.1.** If not utilizing the entire HEDIS Measurement Set, specify which measures will

be collected, such as:

9.3.6.2. ☒ Immunizations
9.3.6.3. ☒ Well childcare
9.3.6.4. ☐ Adolescent well visits
9.3.6.5. ☐ Satisfaction with care
9.3.6.6. ☐ Mental health
9.3.6.7. ☒ Dental care
9.3.6.8. ☐ Other, list:

9.3.7. ☐ Performance measures for special targeted populations.

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

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

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

The State works with a vendor to analyze survey results from the American Community Survey to estimate the percentage of children who are eligible for CHP+ but not enrolled.

The State uses HEDIS to measure changes in health outcomes and health care related goals. In order to comply with upcoming requirements to collect all child and adult core set data, the CHP+ program is using the 2022 fiscal year to implement performance measures reporting systems among all managed care organizations. Utilizing updated HEDIS specifications and input from internal and external subject matter experts, the Colorado CHP+ program is striving to proactively improve performance and ensure compliance with all federal requirements.

The state uses US Census, American Community Survey data to calculate the eligible but not enrolled rate of children in Colorado. This rate is compared to previous years and state and external social and economic factors are considered.

In addition to participating in the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the state CHP+ and Medicaid programs conduct an annual quality review of state-defined focus areas, and each managed care organization develops a quality improvement plan for the year. As performance measure data collection progresses, we will drive performance improvement by integrating existing assessments into the development of program goals and targets.

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

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by

CMS, the states, advocates, and other interested parties.

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

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

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

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

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

Six working teams were created to design the core elements of the CHP+ and to promote ongoing public input into the plan. The CHP+ teams recommended benefits and cost sharing were applied to the CHP+ proposed in this Title XXI State Plan. The six teams were: 1) benefits design and pricing; 2) eligibility, enrollment, and management information system design; 3) financing; 4) marketing and outreach; 5) employer advisory group; and 6) contracting and quality assurance. A Policy Board reviewed team recommendations and gave strategic direction to the Department of Health Care Policy and Financing. The individuals who were members of these working teams had the opportunity to provide input into the development of CHP+, from the early stages of the decision-making process up to and beyond implementation. These working teams were staffed and led by individuals representing the Department, the business community, the insurance industry, providers, children's advocates, schools, employers, and other public and private programs providing services to children.

Benefits Design and Pricing. This team was responsible for designing the benefit package and developing cost-sharing and subsidy structures. This team developed price estimates for the benefit package under different cost sharing and subsidy structures scenarios. Members of this team represented advocates for low-income families, the Colorado Division of Insurance, mental

health providers, EPSDT outreach workers, providers of care to handicapped children, pediatricians, community health centers, and managed care organizations.

Marketing and Outreach. This team was responsible for developing a marketing plan and outreach strategy for partnering with schools, doctors' offices, employers, social service providers, and public health entities throughout the state. This team recommended to the Department the most effective outreach plan, materials design, and marketing strategy to ensure that eligible families are notified that this product was available and how they could apply. The team developed a long term, phased plan for outreach and marketing CHP+. Not only school systems were tapped, but team members, through their varied work in the community were natural advocates and enlisted volunteers who could advocate for CHP+, throughout the state. Members of this team represented schools, day care centers, managed care organizations, providers, children's advocacy groups, and CHP+.

Eligibility, Enrollment, and Management Information Systems Design. This team was responsible for developing an eligibility and enrollment system that would be flexible, simple to administer, and meet the long-term needs of CHP+. This team was also responsible for developing recommendations for the rules by which a child would be deemed eligible for the program. Members of this team included representatives from managed care organizations, the Medicaid program in the Department of Health Care Policy and Financing, the Program for Children with Special Health Care Needs, Indian tribes, community health centers, CHP+ philanthropic provider clinics, and other providers.

Financing. This team was responsible for identifying funding streams available to finance the program, preparing budget projections, developing estimates of the number of children that would be enrolled, and creating mechanisms to ensure that CHP+ would be fiscally sound. Members of this team included representatives from community health centers, the Colorado Indigent Care Program, the Office of State Planning and Budgeting, the CHP+, and the Department of Health Care Policy and Financings budget and accounting offices.

Employer Advisory Group. This team presented recommendations to the Department regarding mechanisms to ensure that CHP+ did not become a substitute for employer-based coverage. This group established a means for the Department and employers to coordinate coverage for children eligible for the program, create incentives for employers to assist the Department with outreach and eligibility determination, and presented recommendations as to how the subsidy can be structured to ensure that employees did not drop employer-based coverage. Membership of this team represented a broad base of employers and business organizations such as US West, Kodak, and Mile Hi Child Care Centers.

Contracting and Quality Assurance. This team was responsible for developing purchasing strategies and contract standards for the CHP+ program. The team reviewed options for purchasing, pricing and quality assurance from Medicaid and commercial models.

Policy Board. The initial Department-appointed Policy Board reviewed key team

recommendations and gave strategic guidance to the Department of Health Care Policy and Financing in the design and implementation of CHP+. This group was comprised of high-level private sector business managers, hospitals, providers, children's advocates, the insurance industry, the General Assembly, the Colorado Department of Public Health and Environment, and the Colorado Division of Insurance.

The Department-appointed Policy Board disbanded after the passage of House Bill 98-1325, which became law on April 21, 1998. A provision of that legislation created an 11-member Policy Board charged with promulgating rules for the as CHP+.

Upon dissolution of the Policy Board in August 2001, public input is received through a variety of methods:

- Rule Making: At the time of any presentation of a rule to be approved by the Board, interested advocates are notified of the rule and public testimony is encouraged at the Board meeting;
- Department staff meet regularly with patient advocacy groups;
- Drafts of items requesting public input are placed on the CHP+ Website;
- Any member of the public has the right to correspond directly with Board members.

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

CHP+ contracts with Indian Health Services providers as SED sites and looks for ways to reach the tribal populations. In addition, CHP+ follows the tribal consultation process described in Section 2.3-TC Tribal Consultation Requirements.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR457.65(b) through (d).

a. Express Lane Eligibility: Public notice was published in the Colorado Register and the Department's website on October 10, 2011.

b. Income Eligibility Verification System: Public notice was published in the Colorado Register and the Department's website on November 10, 2011.

c. New Enrollment Fees: Public notice was published in the Colorado Register and the Department's website on October 10, 2011. .

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. Indian tribes and organizations were consulted about Express Lane eligibility using the approved consultation agreement process. This consultation was sent to the tribes and organizations on December 20, 2011.

9.10 Provide a 1-year projected budget (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

If the State's proposed disaster event provisions pose a significant budget impact, please include an updated budget. If the proposed changes do not make any notable impact to the budget, please include a statement with that assumption.

CHIP Budget Plan Template

State: Colorado SPA Number: CHIP CO-21-0033 Federal Fiscal Year (FFY): 2021-22	Federal Fiscal Year Costs	Net Change Due to Amendment
Enhanced FMAP rate:	**66.09%**	**66.09%**
Benefit Costs		
Managed care	$200,961,774	$0
Fee for Service	$172,620,947	$0
Premium Assistance Insurance Payments	$0	$0
Other	$0	$0
Total Benefit Costs	$373,582,721	$0
Offsetting beneficiary cost sharing payments	($1,297,376)	($185,085)
Net Benefit Costs	**$374,880,097**	**$185,085**
Administration Costs		
Personnel	$426,796	$0
General administration	$1,268,511	$0
Contractors/Brokers (e.g., enrollment contractors)	$2,242,605	$0
Claims Processing	$2,056,799	$0
Outreach/marketing costs	$2,047,637	$0
Health Services Initiative	$0	$0
Other	$293,892	$0
Total Administration Costs	$8,336,240	$0
10% Administrative Cost Ceiling (net benefit costs / 9)	$41,653,344	$20,565
Federal Share (multiplied by E-FMAP rate)	$253,267,677	$122,323
State Share	$129,948,660	$62,762
TOTAL PROGRAM COSTS	**$383,216,337**	**$185,085**

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

Budget Assumptions:

FFY:	# of eligibles	$ PMPM
Managed Care	68,049	$246.10
Fee for Service	71,606	$200.89
Total PMPM		$446.99

Source(s) of non-federal funding used for state match:

Other Assumptions:

Section 10. Annual Reports and Evaluations

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

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

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

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

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

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

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

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

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

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX:

(Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

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

11.2.2. ☑ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☑ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☑ Section 1128A (relating to civil monetary penalties)

11.2.5. ☑ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☑ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

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

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

If an applicant does not agree with the eligibility determination assessed by the contractor, the applicant may appeal the decision. This appeal must be in writing and within 30 days of the eligibility determination letter. If the appeal cannot be favorably resolved with the contractor, the appeal is taken to the Grievance Committee. The Grievance Committee consists of the appeal staff person from the contractor, an eligibility technician, and three staff persons from the Department of Health Care Policy and Financing. The three staff persons have never seen the case before and are well versed in the rules of the program. Applicants may attend the committee meeting by telephone, in person, or may send a representative and may have access to all documents that were used to determine their eligibility. All communication needs are taken care of for the applicant during a committee meeting; i.e. translation. A final decision is made during the Grievance Committee meeting and the applicant is notified of the decision within 10 days. All decisions made in the Grievance Committee are final.

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

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

The MCO contracts contain provisions regarding health services matters. The Contractors are required to adequately staff and maintain a Member services and Complaint response function to

explain operations, assist in the selection of a PCP, assist in how to make appointments and recording and responding to member complaints, or oral expressions of dissatisfaction with the Contractors plan.

The Contractors are required to process prospective, concurrent and retrospective reviews, and have in place procedures for grievances and appeals of Adverse Determinations that comply with the requirements concerning these activities contained in Title 10, C.R.S., 42 CFR 438 Managed Care, Subpart F – Grievance System, Colorado Division of Insurance regulations, and 10 CCR 2505-10 §8.209. All determinations of Medical Necessity of Covered Services are subject to the Grievance and Appeals processes.

The Contractors are required to establish and maintain a Grievance Process through which Members, or a Provider acting on behalf of a Member, may file a complaint that is not the result of an action subject to an appeal and complies with 42 CFR §438.56(e)(1), 42 CFR §438.402(b)(2) and 10 CCR 2505-10 §8.209.5.A., and 42 CFR 457.1160(b), Health Services Matters.

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.

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CMS Regional Offices				
CMS Regional Offices	**States**		**Associate Regional Administrator**	**Regional Office Address**
Region 1-Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2-New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3-Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 S. Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4-Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5-Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6-Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7-Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8-Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9-San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103
Region 10-Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from SEC. 2110. DEFINITIONS.

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

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

24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
    a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
    b. performed under the general supervision or at the direction of a physician, or
    c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

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

COVID-19 Vaccine:

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

COVID-19 Testing:

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

COVID-19 Treatment:

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

Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

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

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

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.