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

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

State/Territory: Pennsylvania

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

September 2, 2026

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

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Titles 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: Valerie Arkoosh	Position/Title: Secretary, Human Services
Name: Sally Kozak	Position/Title: State Medicaid Director/Deputy Secretary, Human Service
Name: Nicole Harris	Position/Title: Executive Director, CHIP

Disclosure Statement This information is being collected pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26- 05, Baltimore, Maryland 21244-1850.

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):

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

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

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. (42 CFR 457.130)

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

Original Plan
Effective Date: May 28, 1998

Implementation Date: June 1, 1998

SPA number PA-26-0003-CHIP

Purpose of SPA: To implement a CHIP Health Services Initiative (HSI) that serves children in Pennsylvania who have complex medical needs through the use of Pediatric Complex Care Resource Center services (PCCRCs).

Proposed Effective date: July 1, 2025
Proposed Implementation date: July 1, 2025

SPA number PA-26-0002-CHIP:
Purpose of SPA: To demonstrate compliance with section 5121 of the Consolidated Appropriations Act 2023 (CAA, 2023), ensuring that children who are incarcerated do not lose coverage as an inmate of a public institution.

Effective date: July 1, 2026.
Implementation date: July 1, 2026.

SPA number PA-26-0001-CHIP

Purpose of SPA: To add language that assures there are no limitations imposed on dental services in the CHIP State Plan.

Proposed Effective date: July 1, 2025
Proposed Implementation date: July 1, 2025

SPA number PA-24-0002-CHIP

Purpose of SPA: The state demonstrates compliance with new section 5112 of the Consolidated Appropriations Act (CAA, 2023), which amended titles 1902(e)(12) and 2107(e)(1) of the Social Security Act to ensure that the state does not impose CE restrictions that are no longer permissible effective January 1, 2024.

Effective date: July 1, 2024
Implementation date: July 1, 2024

SPA number PA-24-0001-CHIP

Purpose of SPA: The state is assuring that it covers age-appropriate vaccines and their administration, without cost sharing. Autism Services is updated to Behavioral Health at section 6.3.10 from Physical Health at 6.2.23

Effective date: October 1, 2023
Implementation date: October 1, 2023

SPA number PA-22-0004-CHIP

Purpose of SPA: To implement a provision whereby the State will waive premium payments for applicants and existing beneficiaries who reside and/or work in a State or Federally declared disaster area and who have not made their premium payments. 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 takes effect in a prior state fiscal year. The amendment also corrects a formatting error under section 2.1.

Effective date: March 1, 2020
Implementation date: March 1, 2020.

SPA number PA-22-0003-CHIP

Purpose of SPA: Allows the State of Pennsylvania to use administrative funds available under Section 2105(a)(1)(D)(ii) of the Social Security Act and 42 CFR 457.10 to improve the health of low-income children by increasing their access to needed vision services and glasses through a targeted, school-based initiative.

Effective date: August 1, 2022
Implementation date: August 1, 2022.

SPA number: PA-22-0002-CHIP

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

Effective date: March 11, 2021
Implementation date: March 11, 2021

SPA number PA-20-0002-CHIP:

Purpose of SPA: To demonstrate compliance with section 5022 of Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. The provisions provided within this SPA describe the methods DHS are utilizing to ensure enrollees within CHIP are receiving the appropriate treatment, screenings, assessments and services for behavioral health conditions. The behavioral health benefits are not new benefits with the exception of adding tobacco cessation.
Medication Assisted Therapy (MAT) are also part of CHIP's existing pharmacy benefit. Tobacco cessation services are now a mandatory benefit effective as of October 24, 2019.

Effective date: October 24, 2019.
Implementation date: October 24, 2019.

SPA Number: PA-20-0001-CHIP

Purpose of SPA: To implement provisions for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in state or federally declared disaster areas. Due to COVID-19, the state is notifying CMS that it intends to provide temporary

adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable state and federally declared disaster area.

Effective date: March 1, 2020
Implementation date: March 1, 2020.

On March 6, 2020, Governor Wolf issued a disaster declaration in response to the presence of COVID-19 in Pennsylvania. Because CHIP is designed to provide benefits for whole months, CHIP is requesting an implementation date of March 1, 2020. In this SPA, the state requests the following flexibilities with an effective date of March 1, 2020 and an extension of them throughout the duration of the disaster:

- Temporarily waive requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests;
- Temporarily delay acting on certain changes in circumstances;
- Temporarily extend the processing of renewals;
- Temporarily suspend application of co-payments related to COVID-19 testing, screening and treatment services; and,
- Temporarily delay payment of premiums (and/or delay payment of premium balance). Pennsylvania will be temporarily suspending the commonwealth's premium lock out policy.

Transmittal Number	SPA Group	PDF	Description	Superseded Plan Section(s)
A-14-0001 Effective/Implementation Date: July 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Sections 4.1.1, 4.1.2, 4.1.3: Supersede all
		CS10	Children Who Have Access to Public Employee Coverage	Section 4.4.1: Supersede information on dependents of employees of a public agency
		CS10	Hardship Exemption	Appendix: Supersede current documentation
		CS13	Deemed Newborns	Section 4.3: Add new subsection; supersedes information in section 4.1.9 on CHIP deeming
		CS15	MAGI-Based Income Methodologies	Section 4.3: Add new subsection; supersedes information in section 4.1.3 on income counting
PA-14-0002 Effective/Implementation Date: July 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
PA-14-0003 Effective/Implementation Date: July 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
PA-14-0005 Effective/Implementation Date: July 1, 2014	Non-Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes the current section 4.1.5
		CS18	Non-Financial – Citizenship	Supersedes the current sections 4.1.0; 4.1.1-LR;

				4.1.1-LR
		CS19	Non-Financial – Social Security Number	Supersedes the current section 4.1.9.1
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
		CS21	Non-Payment of Premiums	Supersedes the current section 8.7
		CS27	Continuous Eligibility	Supersedes the current section 4.1.8
PA-22-0001-CHIP Effective/Implementation Date: April 1, 2022	Continuous Eligibility	CS27	Continuous Eligibility	Supersedes the current section 4.1.8
PA-24-0003-CHIP Effective/Implementation Date: July 1, 2024	Continuous Eligibility	CS27 CS21	Continuous Eligibility Non-Payment of Premiums	Supersedes the current section 4.1.8 Supersedes the current section 8.7
PA-26-0002-CHIP Effective/Implementation Date: July 1, 2026	CHIP Eligibility	CS31	Incarcerated CHIP Beneficiaries	Supersedes the current section 3.4.2.4

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.

TN No: Approval Date Effective Date

Currently there are no recognized tribes, Indian Health Programs or Urban Indian Organizations in Pennsylvania.

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

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))

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Act, 62 P.S. §§ 5001.101 et seq., as amended by Act 68 of 1998, 40 P.S. §§ 991.2301 et seq. (the Children's Health Care Act), Act 136 of 2006, and Act 84 of 2015, was originally enacted in December 1992 and implemented in May of 1993 (see Appendix A for a copy of the Children's Health Care Act as amended [the "Act"]). The program provides free or subsidized insurance for children in low-income families who are not eligible for Medicaid or not otherwise insured through private or employer-based insurance. The program also allows those that do not meet the income guidelines to purchase the coverage at the state's negotiated rate. CHIP is administered by the Pennsylvania Department of Human Services through individual contracts with eight health insurance companies (hereinafter referred to as Managed Care Organizations (MCOs)). Under terms of the contract, Pennsylvania requires the Contractors to:

- Conduct outreach
- Enter application/renewal data into the Commonwealth of Pennsylvania's Access to Social Services (COMPASS) portal from mail in applications and over the phone on behalf of applicants and enrollees
- Utilize CAPS to determine eligibility
- Enroll and renew enrollment for eligible children
- Provide required in-plan services
- Contract with qualified providers to provide primary and preventative health care
- Provide parent health education
- Perform quality assurance tasks (including but not limited to monitoring of quality of care and health outcomes)

CHIP provides free coverage to children from birth through age 18 whose family income exceeds the Medicaid limit, but is no greater than 208% of the Federal Poverty Level (FPL). Subsidized coverage is provided to children from birth through age 18 in families whose income is greater than 208% but no greater than 314% of the FPL. The free and subsidized programs are funded by state and federal funds. Families whose income is greater than 314% FPL may purchase the CHIP benefit package at the rate negotiated by the commonwealth. The buy-in program is not supported through state or federal funds. Additionally, utilization experience of the buy-in program is not included in rate setting for the free and subsidized programs.

The program is administered by the Pennsylvania Department of Human Services (see Appendix A). In addition, the Act provides for a Children's Health Advisory Council. The Council consists of sixteen voting members, nine (9) of whom are appointed by the Human Services Secretary. The Council also includes the Secretary of Health, the Insurance Commissioner, the Human Services Secretary, or their respective designees (see Appendix A, the Act, Section 2311 (I)). Its primary functions are to review outreach activities; and to review and evaluate the accessibility and availability of services to children enrolled in the program.

Public Insurance Program

Pennsylvania has operated a categorically and medically needy Medicaid program for many years. However, major program expansions have occurred, including the expansion of Medicaid for individuals age 19 – 64 with income below 138% of FPL provisions.

In 1988, the state implemented federally-mandated coverage for pregnant women and qualified children. This coverage was designated as Healthy Beginnings. Healthy Beginnings provides medical coverage to pregnant women and infants up to age one (Income Standard: 215% FPL); children ages one to five (Income Standard: 157% FPL); and children ages six to under the age of 19. (Income Standard: 133% FPL). Early periodic screening, diagnosis and treatment provide comprehensive health services to all persons under age 19 who are receiving Medicaid. These services include check-ups and follow-up care. Pennsylvania has also elected to provide presumptive eligibility to pregnant women thereby encouraging early prenatal care and providing payment for outpatient primary care expenses incurred during pregnancy.

Private Health Insurance Programs for Low-Income Families

Special Care Program

Description: Special Care is a low-cost insurance plan offered statewide to low-income residents by Pennsylvania Blue Cross plans and Pennsylvania Blue Shield. Special Care provides basic preventive care services to children and adults ineligible for CHIP and Medicaid who cannot afford private health insurance. Special Care provides protection for families by covering the high cost of hospitalization, surgery, emergency medical care in addition to routine primary care.

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

Pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act, Pennsylvania will use administrative funds to offer a Health Services Initiative (HSI) under this Plan with the goal of improving the health of children. Pennsylvania assures that it will use no more than 10 percent of the total expenditures under this Plan, as specified in 42 CFR § 457.618, to fund the State's HSI and other administrative costs. The HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

Pennsylvania assures that reporting metrics designed to evaluate and monitor the effectiveness and outcomes of this HSI initiative will be included in the CHIP Annual Report Template System (CARTS). At a minimum, these metrics will include the percentage of children receiving a vision exam that require glasses under the HSI.

Pediatric Complex Care Resource Centers HSI:
I. Background

Why is this population important
Children with medical complexity are a high-risk population who often have multiple life-limiting conditions with no unifying diagnosis or an unclear prognosis[1] that potentially comes with functional limitations that require substantial daily intervention within the home, or similar community-based settings (i.e., not in the hospital). While they represent a small proportion of children and youth within Medicaid and CHIP, they account for a large proportion of health care costs.[2] In a nation-wide study, children with medical complexity represented 5.8% of Medicaid-covered children yet accounted for 34.0% of pediatric Medicaid spending.[3]

The challenges are generally similar across states, such as lack of necessary in-home workforce[4] to account for the demand, inability to successfully coordinate the required range of providers and specialists involved in care of children with medical complexity, and difficulty in ensuring equity in access to services.[5] Even when Medicaid managed care organizations (MCOs) approve home nursing hours, families often cannot find home nurses, which leads to prolonged hospitalizations or exhausted family caregivers, resulting in worse health outcomes for the child.[6]

Why does the population need assistance

Workforce gaps in pediatric home health care have often shifted the burden of in-home care onto families and caregivers.[7] Coverage in the home from a nurse or home health aide can sometimes be needed twenty-four hours a day, seven-days-a-week. When there are workforce gaps, this burden falls on families and caregivers to provide additional support.

Research has demonstrated that caregivers of children with medical complexities spend an average of 2 hours a week on care coordination and 11 hours per week on direct home care. More than half (56.8%) report financial problems, 54.1% report that a family member stopped working because of the child's health, and 33.1% report difficulty in accessing nonmedical services.[8] Because children with medical complexities rely heavily on cross-system services such as early intervention and special education services,[9] it is important to provide streamlined, easily accessible services to these families and caregivers to

improve health care outcomes.

Why do the services the PCCRC provide fill a service gap for the population

Recent studies show that innovative interventions for children with medical complexities can improve the health of families by addressing the underlying social and financial conditions that worsen medical burden.[10] Targeted wrap-around supports are associated with improved child health and improved caregiver mental health, demonstrating the importance of Medicaid programs providing holistic support in a meaningful way.[11]

In response to the challenges in delivering care to children with medical complexities, the Pennsylvania Office of Medical Assistance Programs (OMAP) launched a special initiative[12] to re-envision the delivery of pediatric home health care in Medicaid managed care. As part of this initiative, OMAP and the Office of Development Programs (ODP) developed the Pediatric Complex Care Resource Centers (PCCRCs), a new program designed to provide non-clinical support through interconnected resources. The PCCRC model is intended to better support families and caregivers, therefore, providing unique, innovative solutions for children with medical complexity. Such an approach has received support from CMS, demonstrating how a Children's Resource Center is the best practice within delivering Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and allows families to better navigate the resources available within specific contexts. [13]

The PCCRC provides the following services

PCCRCs offer both in-person and virtual opportunities for individualized support and education for both families and professional caregivers, such as home health aides and in-home nurses. PCCRCs provide access to non-medical information and create referrals to community-based support services; provide a formal feedback channel for families and caregivers to the Medicaid service delivery system; and provide support to the caregiver team through transitioning from hospital or congregate care to community-based home care.

PCCRCs provide resources through a team-based approach at regional PCCRCs. The PCCRC team includes a PCCRC Director, a Pediatric Coach, and a Family Facilitator. The different team roles offer a personalized experience for the family. The team members communicate and share notes when serving caregivers to create holistic service delivery.

The members of the team provide the following:

- PCCRC Director: The Director of each PCCRC supports the team by handling the intake process and assigning cases to staff members; providing oversight of all service delivery; assisting staff members with connections to state and community resources; and serving as a central communication line from Pennsylvania Department of Human Services (DHS) program offices (such as OMAP and ODP) to PCCRCs.
- Pediatric Coach: The Pediatric Coaches have three core functions:
    - Caregiver Support and Intervention: The Pediatric Coach provides personalized support and intervention for caregiver teams as they work together and collaborate around the needs of the child or youth. This includes providing problem solving and conflict resolution, and creating

a bridge between familial, social, and medical goals. Additionally, the pediatric coach is able to make referrals to programs across systems to support the caregivers access to resources needed to meet their child's needs and support them remaining in the home/community.
    - They also work individually with family members to empower them to successfully advocate and communicate needs and concerns to the larger caregiver team.
    - Learning Customization and Facilitation: The Pediatric Coach provides education and training support to the caregiver team based in online curricula developed by the University of Pittsburgh and accessible through the DHS myODP online training resource center.[14] This curricula is targeted to meet non-clinical needs of children with medical complexity to empower caregiver teams to best support the child or youth.
    - Family Advisory Workgroup Facilitation: The Pediatric Coach develops, schedules, and hosts ongoing regional family advisory workgroups aimed at supporting families caring for children with medical complexity. The purpose of the workgroups is to give families an opportunity to provide insight and feedback on services being utilized as well as serving as a peer support community.
- Family Facilitator Coordinator: Coordinates with all Family Facilitators across the Commonwealth. The Family Facilitator Coordinator serves as a liaison between departments, providing information to families, and assisting with coordination and planning for in-home services and options for family based alternatives to institutions.
- Family Facilitator: The Family Facilitator has the following core functions:
    - Supporting children and youth transitioning from congregate facilities and hospitals to community settings and supports the ability for the child to remain at home.
    - Supports diverting children currently living in the community to placement in congregate care settings.
    - Conducts outreach to families, and various organizations that may include community health/health promotion organizations, hospital/facility social workers, and discharge planners to coordinate in-home services and family-based alternatives.

In addition to the services provided by the PCCRC team members, the PCCRC offers self-paced virtual training for caregiver teams (e.g., family members, medical personnel, home health agency staff, managed care organizations). OMAP and ODP collaborated with the University of Pittsburgh Implementation and Research Center for Healthy Communities (Pitt IRC) to develop new curricula for the existing myODP online training resource center. Courses were developed and deployed following recognized principles of effectively addressing health disparities and creating opportunities for belonging. Courses focus on fundamentals of supporting children with medical complexity receiving in-home care, including education focused on supporting behavioral health needs; using durable medical equipment (DME) in individual home environments; improving advocacy efforts through inclusion in family/community systems; ensuring safe and efficient life transitions; and improving collaboration through relationship building amongst caregiver teams.

Pennsylvania uses the HSI option defined at 42 CFR 457.10 and authorized under Section 2105(a)(1)(D)(ii) of the Social Security Act to provide

community-based support services to low-income children/youth 19 years of age and younger who are enrolled in Pennsylvania Medicaid and CHIP programs and have serious physical health complexities. These children/youth may be living in a hospital, other in-patient or congregate care facilities, or in the community. The Commonwealth will leverage the HSI program's access to children to help enroll eligible, yet currently uninsured or underinsured children in Medicaid and CHIP where feasible and appropriate.

The Commonwealth assures that funding under the HSI will not supplant or match CHIP federal funds with other federal funds, nor will it allow other federal funds to supplant or match CHIP federal funds.

II. Operational Details

The PCCRC team is organized as follows:

1. There are four Pediatric Complex Care Resource Center Organizations who oversee seven regions.
2. Each PCCRC organization has Director who oversees 2-4 Pediatric Coaches and 1 Family Facilitator.
3. There are five Family Facilitators across PCCRC regions, focused on serving areas with the highest need. In addition, there is one Family Facilitator Coordinator who oversees and supports all cases.

The number of Pediatric Coaches and Family Facilitators are determined based on the number of children with medical complexities in that region.

The CHIP HSI will support the continuation and expansion of PCCRC services as follows:

Referral Pathways and Intake

PCCRCs support children with medical complexities by coordinating with a network of direct care providers, county administrative entities, and DHS offices. DHS offices include but are not limited to OMAP, ODP, Office of Children and Youth Services (OCYF), Office of Mental Health Substance Abuse Services(OMHSAS), and Office of Child Development and Early Learning(OCDEL). In order to streamline the connection of individuals to community organizations and services within the PCCRC network, partners are able to utilize intake and referral pathways that link multiple resources.

Referrals

Referrals may be initiated by caregivers or providers through the DHS PCCRC website[15], where families can use a map locator to identify their appropriate PCCRC and submit a referral through the PCCRC Director or the PCCRC's referral form.

- PCCRCs receive referrals from multiple sources, particularly home health agencies and MCOs. MCOs, Hospitals, Patient-Centered Medical Homes, County Administrative Entities (AEs), Home Health Agencies, other DHS offices also identify and refer children who need additional support that PCCRCs provide.
- After receiving the referral, PCCRCs identify a Pediatric Coach or Family

Facilitator who can support the family and/or caregiver and complete an intake process within 3-7 days of receiving the referral.

Intake

After the referral process is completed, PCCRC staff reaches out to the family and/or caregiver to understand their needs, talk about a care action plan, understand family's goals and set up additional time as needed for that family's specific situation.

- Once children are identified, Coaches and Facilitators ask the caregiver/family to complete consent forms. Consent forms allow the Coach and Facilitator to assist the caregiver with administrative activities and attend meetings with and on behalf of the caregiver.
- PCCRC staff help families find nursing and home health aide coverage.
- Family Facilitators will provide discharge guidance during intake.
- Intake will be used to match families to community resources.

Role	**Qualifications**	**Summarized Services**
PCCRC Director	Each PCCRC Director is also the Director of the Health Care Quality Unit, an existing DHS ODP program, and assumed the role of PCCRC Director in addition to their prior responsibilities.	Provide support with intake, oversight, monitoring, and connecting the PCCRC team with DHS resources and other PCCRC organizations.
Pediatric Coach	A master's degree in social work or a related field OR master's degree in learning and instruction OR master's degree in the human services field. At least five (5) years experience in the human services field.	Variety of support including resource navigation and connection, advocacy, collaboration meetings, and assisting with home modifications. Pediatric Coaches also facilitate the Family Advisory Workgroup and guide families in using the Caregiver Journey Maps.
Family Facilitator	A master's degree in social work or a related field OR master's degree in learning and instruction OR	Provide a range of support including coordination with the hospital/facility, preparing the home to support the child, working with the caregiver team, helping with the discharge, and guide families in using the Caregiver Journey Maps.

	master's degree in the human services field. At least five (5) years experience in the human services field.	

Monitoring and Oversight for the Pediatric Coaches and Family Facilitators

Each PCCRC Director provides supervisory oversight of each Pediatric Coach and Family Facilitator's case load and assists with staffing and coordination between the caregiver/family and the Pediatric Coaches and Family Facilitators.

- Coaches and Facilitators collect data related to every interaction with caregivers including how time is spent, duties conducted during the interaction, and any referral information provided. This data is then provided to DHS on a quarterly basis.

Service Delivery
Each PCCRC team member has certain qualifications and services they provide:

Additional Details on Services:
While a family is working with the PCCRC Team, they have an option to join a regional PCCRC-run Family Advisory Workgroup where they can provide input to PCCRC services, highlight gaps of services, connect with other families in similar situations, and learn of new resources to support them. The Family Advisory Workgroups serve as a conduit for families to shape PCCRC programs and services to ensure PCCRC services remain relevant and timely to local community needs, thus meeting the specific needs of families in specific regions of the Commonwealth. Pediatric Coaches collaborate with select family caregivers to plan the Family Advisory Workgroup meetings to emphasize the importance of the family caregiver's perspective when planning such advisory-type meetings.

The Pediatric Coach and Family Facilitator also guide families in using the Caregiver Journey Maps provided on the PCCRC website to help families understand how to connect to DHS offices and direct care providers. The Journey Maps are organized by life events such as starting school or aging out so a family can easily see how the PCCRC can support them at their specific life stage. Journey Maps are a free tool that empowers and educates families to better be able to advocate for their needs and find the wrap-around services for their child or youth. The Journey maps come with an AI-infused, closed loop chat bot to better support families navigate the resource. Funding for the closed-loop, chat-bot is allocated within the total budget.

PCCRC services become inactive when a family's unique needs are met and they do not request additional support from the Pediatric Coach or when the child is fully transitioned home after working with the Family Facilitator. Families continue to have the opportunity to reengage with the PCCRCs for services if needed.

Funding
PCCRCs were established through CMS-approved expanded funding for Home and Community Based Services through American Rescue Plan Act of 2021, Section 9817 (ARPA).[16] ARPA funds sustained the PCCRCs through 2026 through allocations based on regional calculations of annual operating costs for each PCCRC region. The HSI will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

Vision to Learn HSI
I. Background

To ensure optimal classroom learning, approximately one in four children needs corrective lenses to see the board, read a book, or participate in class.1 Access to vision exams and glasses is critical to promoting positive educational achievements and health outcomes, as 80 percent of all learning during a child's first 12 years is visual.2 Students with vision problems tend to have lower academic performance, as measured by test scores and grades, and students' performance in school affects future employment earnings, health behaviors, and life expectancy.3

Given the importance of ensuring access to vision health services for children, Pennsylvania seeks to use the HSI option to deliver needed vision services and glasses to low-income children through a targeted, school-based initiative. This initiative is available to eligible schools in all school districts in the Commonwealth, contingent on the capacity and operations of the vision provider to expand services over time.

Pennsylvania intends to have a provider agreement with qualified vision services providers to offer vision services and glasses onsite at certain Pennsylvania schools. Pennsylvania currently partners with Vision To Learn (VTL), a non-profit, philanthropically funded entity that provides free vision screenings, eye exams, and glasses to students at schools in low-income communities. VTL4 is a Medicaid (Medical Assistance (MA)) and CHIP participating provider that currently serves schools in 13 Pennsylvania counties and is seeking to continue

1 American Optometric Association. (2018) School performance bridled by poor vision, visual disorders. Accessed online October 14, 2021. https://www.aoa.org/news/clinical-eye-care/health-and-wellness/reading-proficiency-and-eye-exams?sso=y
2 American Optometric Association. "School-aged Vision: 6 to 18 Years of Age." http://www.aoa.org/patients-and-public/good-vision- throughout-life/childrens-vision/school-aged-vision-6-to-18-years-of-age?sso=y
3 Slusser, Wendelin and Dudovitz, Rebecca. Impact Analysis of Vision To Learn. UCLA. http://visiontolearn.org/wp-content/uploads/UCLA-Study-Quantitative-Analysis.pdf
4 Vision To Learn. https://visiontolearn.org/

expanding services throughout the state, particularly in Western and Central Pennsylvania. Since launching services in Pennsylvania in May 2018, VTL provided exams to over 20,000 children who had failed a vision screening, 80% of whom needed but did not have glasses. As made clear by VTL's experience, Pennsylvania children in low-income families and communities experience real barriers to accessing essential, basic services. Particularly for school-aged children, not receiving needed vision care has serious educational consequences, as described above. This SPA helps to address low-income children's inequitable access to essential vision care services with an evidence-based intervention shown to lead to significant gains in learning among children.5

II. Operational Details

The vision services CHIP HSI will operate as follows.

Process for Identifying and Providing Services to Children in Need of Glasses

- The qualified vision services provider serves Pennsylvania's low-income children in Title I schools in which at least 51 percent of the student body is eligible for free or subsidized meals ("target schools"). In Pennsylvania, these schools represent approximately 41 percent of public schools.6
- In these schools:
  - Upon consent of each school district, the qualified vision services provider receives information from the school regarding student vision screenings, or the school's designated vision screening provider, to identify which children failed the screening and therefore require an eye exam and potentially, glasses.
  - Each child receives information about services from the qualified vision service provider's onsite mobile eye clinic at the school. Depending on each school district's preference, the parent either opts in or opts out of the qualified vision service provider's mobile service offering. See more about consent options below.
  - For children who fail the vision screening and whose parent/guardian consents, the qualified vision services provider performs one vision exam (onsite in a mobile eye clinic) and, if needed, provides corrective lenses and frames (onsite at the school campus).
  - For children who receive corrective lenses and frames, the qualified vision services provider completes a glasses' fitting and also provides replacements, as needed.
- Consent Option: In Pennsylvania, each school district determines whether school-based vision services are provided via an opt-in or opt-out consent model.
  - In school districts that require opt-in consent, the qualified vision services provider gives children who failed the vision screening a parent/guardian

5 Neitzel AJ, Wolf B, Guo X, et al. Effect of a Randomized Interventional School-Based Vision Program on Academic Performance of Students in Grades 3 to 7: A Cluster Randomized Clinical Trial. *JAMA Ophthalmol.* Published online September 09, 2021

6 According to data from the National Center for Education Statistics, there are 2,873 public schools in PA, with 1,182 having 51% or higher FRPL population. https://nces.ed.gov/

consent form that provides information about the services. The parent/guardian fills out the consent form to opt-in or authorize the services. The form provides space for the child's name, birthdate, and insurance information. The completed forms are returned to the qualified vision services provider, which maintains a copy, and the school, which maintains a list of children whose parents have consented to the services.

- In school districts that require opt-out consent, the qualified vision services provider gives children who failed the vision screening a parent/guardian consent form that provides information about the services. The parent/guardian fills out the consent form to opts-out or decline the services. The qualified vision services provider provides children with mobile vision services unless the parent/guardian opts out of the program via the consent form. The school maintains a list of children whose parents/guardians have declined the services.

Process for Billing and Reimbursement for Services Covered by the CHIP HSI

The qualified vision services provider conducts a "matching process" that allows the provider to bill Medicaid (MA) and CHIP managed care plans for the services provided to children enrolled in Medicaid (MA) or CHIP. The qualified vision services provider uses a centralized state portal for the Medicaid (MA) matching process and, until CHIP information is incorporated into the centralized state portal, the qualified vision services provider uses the state's CHIP eligibility system for the CHIP matching process.7 To prevent HSI funds from being used to furnish services to children in Title I schools who may have private insurance, the qualified vision service provider will deduct a pre-determined percentage of services from the total fee billed to the CHIP HSI to account for estimated private insurance coverage within Title I schools in opt-out school districts. A description of the process follows:

1. Data Collection
   - The qualified vision services provider collects identifying information on all children it serves (including first name, last name and date of birth).

2. CHIP and Medicaid (MA) Matching Process and Billing Medicaid (MA) or CHIP MCOs
   - The qualified vision services provider enters the collected data into the Pennsylvania Department of Human Services online state Medicaid (MA) portal (MMIS) to identify children with an active Medicaid (MA) plan. For these children, the portal provides a Medicaid (MA) identification number and the plan in which they are enrolled.
   - The qualified vision services provider uses the Medicaid (MA) identification number and plan information it receives from the state portal to verify MCO enrollment by entering this information into the corresponding MCO's system. The qualified vision services provider then submits bills directly to the identified MCOs with which it is credentialed for children for whom active enrollment can be verified. The MCOs pay the qualified vision services provider for the services delivered based on negotiated, standard fees. To

7 Pennsylvania anticipates the centralized portal will include CHIP information beginning in April 2023.

the extent the qualified vision services provider is not credentialed with a Medicaid (MA) MCO, it will not seek HSI reimbursement for children identified as enrolled in that Medicaid (MA) MCO.

3. CHIP Matching Process and Billing CHIP MCOs
   - Until Pennsylvania's centralized portal can identify children with an active CHIP plan, the qualified vision services provider enters collected data for children not identified through the state Medicaid (MA) portal into the Pennsylvania Department of Human Services CHIP Application Processing System (CAPS) to identify children with an active CHIP plan. For these children, the system provides a CHIP identification number and the plan in which they are enrolled.
   - The qualified vision services provider uses the CHIP identification number and plan information it receives from the state portal to verify MCO enrollment by entering this information into the corresponding MCO's system. The qualified vision services provider then submits bills directly to the identified MCOs with which it is credentialed for children for whom active enrollment can be verified. The MCOs pay the qualified vision services provider for the services delivered based on negotiated, standard fees. To the extent the qualified vision services provider is not credentialed with a CHIP MCO, it will not seek HSI reimbursement for children identified as enrolled in that CHIP MCO.

4. ESI Enrollment Deduction
   - The majority of children who receive vision services at Title I schools are likely to be covered by Medicaid (MA) or CHIP or be uninsured. However, to prevent HSI funds from being used to furnish services to children who have private insurance, the qualified vision services provider will deduct a pre-determined percentage of service costs—28%—from the total amount of expenditures for children served in opt-out districts in which consent forms with insurance information are not actively returned to the qualified vision services provider. This percentage deduction was developed as follows:
     - The state used data from the National Center for Education Statistics (NCES) Elementary/Secondary Information System (ElSi; based on data collected through the U.S. Department of Education's Common Core of Data and Private School Survey)8 to estimate the income distribution in target schools in Pennsylvania9 and integrated that with 2020 American Community Survey data10 to estimate insurance status based on various characteristics.
     - Specifically, to estimate the prevalence of employer sponsored insurance (ESI) among the children that will receive the vision services, using the

8 National Center for Education Statistics, Elementary/Secondary Information System (ElSi), https://nces.ed.gov/ccd/elsi/default.aspx?agree=0
9 I.e., schools where at least 60% of students receive FRPL.
10 State Health Access Data Assistance Center (SHADAC) Analysis of 2020 American Community Survey Data. http://statehealthcompare.shadac.org/

2020 American Community Survey data, the State identified the ESI rate among children in Pennsylvania
    - Who are between ages 5-18
    - Who do not attend private school, and
    - Whose family income is below 200% FPL
- The State chose 200% FPL as its income cut-off based on data from the NCES ElSi. NCES data indicates that 94% of students in Pennsylvania public schools receive free or reduced-price lunch (FRPL).
    - Students must have income at or below 185% of FPL to qualify for FRPL. When 2020 ACS data is limited to individuals with incomes up to 200% FPL, approximately 94% of individuals in the sample have incomes of 185% FPL or lower (i.e., aligning with the NCES estimate of the share of students receiving FRPL).
- When the 2020 ACS data is analyzed under the parameters described above (children in Pennsylvania ages 5-18, who do not attend private school, and whose family income is below 200% FPL), 27.5% of individuals are estimated to have ESI.

5. HSI Reimbursement
    - The qualified vision services provider submits an invoice to the Department of Human Services describing services provided for which it seeks HSI reimbursement.[11]
    - The invoice will:
        - Only include children under age 19 who were not identified through the matching process described above as being actively enrolled in Medicaid (MA) or CHIP.
        - Separately list children served in school districts that require opt-in and opt-out consent to allow the qualified vision service provider to apply the ESI enrollment deduction only to children served in opt-out school districts.
        - Aggregate the two sub-totals (for children in opt-in school districts plus children in opt-out school districts) to identify the full payment to the qualified vision services provider.
    - The Department of Human Services reimburses the qualified vision services provider for the total invoice amount using CHIP HSI funding.
    - Annually, Pennsylvania expects that the HSI will serve approximately 8,000 children who will need and receive vision exams, and approximately 80% of those children (or 6,400 children) will need and receive corrective lenses and frames.

11 Services that will be reimbursed through this HSI include vision exams, inclusive of associated program overhead costs, and glasses dispensing. Frames and lenses are not included at this time because the qualified vision service provider receives the majority of frames/lenses it provides to children in Pennsylvania as in-kind donations.

- Given that this is a school-based program, the number of children served during the COVID-19 public health emergency may be affected by school closures and other pandemic-related factors. A budget is included in Section 9.10.

The commonwealth is committed to providing access to quality health care coverage and to improving the health status of its children. Of particular concern are children of low-income families; families with limited access to care; and families having children with special needs due to chronic or disabling conditions. (Special needs programs include spina bifida, diabetes, asthma, hepatitis B, etc.)

To achieve the goal of providing access to health care the office of CHIP meets regularly with the statewide advocacy community dedicated to increasing awareness and enrollment in both CHIP and Medicaid. Senior and management staffs of the Department of Human Services, Health and Education are consulted to complete strategic planning, to monitor progress, collaborate, share resources and to problem solve. The efforts of these meetings and relationships has increased awareness and enrollment with the following efforts which include but are not limited to:

- Establishing a single statewide toll-free number (1-800-986-KIDS) to provide access to helpline staff who inform, refer, and assist in applying for CHIP and Medicaid.
- Jointly funding a multi-year contract with a media consultant.
- Developing complementary media messages about the availability of healthcare coverage and the importance of preventative care.
- Improving access to enrollment by streamlining eligibility and application practices.
- Conducting studies regarding hard-to-reach populations to increase knowledge on how to achieve better results in-outreach to them.
- Measuring the effectiveness of our efforts by gathering and analyzing available data.

The Department's particular efforts to identify and enroll all uncovered children who may be eligible for CHIP include but are not limited to the following:

- Conducting a statewide outreach campaign for CHIP. The campaign includes but is not limited to: paid television, Internet and radio advertisements, posters, brochures, banners and the like.
- Monitoring, measuring and evaluating the effectiveness of the statewide outreach campaign as well as other outreach strategies initiated and implemented by the Department.
- Engaging in collaborative interagency outreach for the purpose of developing and implementing strategies to enroll children in both CHIP and Medicaid. Agencies include but are not limited to: the Department of Education (school- and library-based enrollment) and, the Department of Health

- Developing a strategic plan to maximize awareness of CHIP with organizations and associations with existing statewide networks.
    - Implementing school-based outreach and/or enrollment.
- Approving and monitoring the outreach and enrollment strategies of CHIP MCOs.
- Participating in outreach activities initiated by local community organizations.
- Conducting studies which improve the Department's understanding of issues relating to hard to reach populations and developing outreach strategies recommended by such studies.

As stated above, the commonwealth is committed to assuring that children receive the health care coverage for which they are eligible (either CHIP or Medicaid). If a parent or guardian applies for healthcare coverage, application is first reviewed for Medicaid and then CHIP. This practice streamlines the application process and facilitates timely enrollment of the child into the program they are eligible for. In 2023, CHIP eligibility determinations were moved into the Medicaid electronic Client Information System (eCIS) system to improve timeliness and efficiency in determining eligibility for both programs. Additionally, the Department is making a concerted effort to have the CHIP MCOs identify children who are potentially eligible for Medicaid due to a serious illness or disabling condition.

The Department has worked to expand access and simplify the application and renewal process for the CHIP and Medicaid programs through the development of an online application and renewal system called COMPASS (Commonwealth of Pennsylvania Access to Social Services). This web portal allows citizens to screen and apply for CHIP or Medicaid as well as many other social service programs across several Commonwealth agencies with one application. The Department provides administrative funding for toll-free helplines that can answer citizens' questions about CHIP, Medicaid, and various other social service programs, as well as assist callers with completing applications over the phone, utilizing COMPASS.

In 2003, shortly after being sworn into office, Governor Edward G. Rendell created the Governor's Office of Health Care Reform (GOHCR) aimed at improving access, affordability and quality by rejuvenating the state government's approach to health care. In January 2004, Pennsylvania launched a statewide data collection effort to more accurately define the characteristics of the state's uninsured. This effort was repeated in 2008. In July 2004, the GOHCR was given

the lead responsibility to apply for a State Planning Grant through the Health Resources and Services Administration (HRSA). The purpose of the grant was to develop a comprehensive plan to provide access to affordable, quality health care coverage for every Pennsylvanian.

In keeping with that goal, in early 2006, the Governor introduced the Cover All Kids expansion that makes CHIP benefits available to all eligible children in the commonwealth. Later that year, eligibility was expanded to cover all children in Pennsylvania through either Medicaid or CHIP. Following federal approval in February 2007, enrollment began in the expanded program in March 2007.

Pennsylvania has added a post application screening process to COMPASS. If a family applies for any of the social services accessed by COMPASS other than Medicaid or CHIP, at the end of the application, the family is made aware of the fact that it appears they are eligible for Medicaid or CHIP and asks if they wish to apply. The information is then pulled from the current application into the application for access to health care. COMPASS then requests any additional information from the family, screens for eligibility and routes the application to the appropriate agency for an eligibility determination.

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.

Currently there are no recognized tribes, Indian Health Programs or Urban Indian Organizations in Pennsylvania.

Section 3. Methods of Delivery and Utilization Controls

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

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

CHIP benefits are provided on a statewide basis using a managed care model with covered benefits delivered through insurers. The insurers are Blue Cross and/or Blue Shield entities, subsidiaries or affiliates of Blue Cross and/or Blue Shield entities, Health Maintenance Organizations (HMO), or risk-assuming gatekeeper Preferred Provider Organizations (PPO). All enrollees are provided the same Act 68 consumer protections. (Act 68 of 1998 is the state law that outlines requirements for managed care plans in Pennsylvania, many of those mirroring the requirements of Section 403 of CHIPRA.) Enrollees do have the option to terminate enrollment or voluntarily transfer from one contractor to another as required by Section 2103(f)(3) (incorporating section 1932(a)(4) (42 U.S.C. §1396u-2(a)(4)).

Effective with dates of service on or after October 1, 2009, Pennsylvania will ensure the Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) will receive a reimbursement equivalent in aggregate by federal fiscal year to the amounts of reimbursement each FQHC/RHC would have received under the Medicaid Prospective Payment System (PPS). This is the result of Section 503 of the CHIP Reauthorization Act of 2009 (CHIPRA) which amended section 2107(e)(1) of the Social Security Act to make section 1902(bb) of the Social Security Act applicable to CHIP in the same manner as it applies to Medicaid.

Under this provision of CHIPRA, PA CHIP will ensure that payments to each FQHC and RHC for services provided on and after October 1, 2009 to PA CHIP covered children are at least equal in aggregate by federal fiscal year by date of service to the amount that would have been paid to that FQHC/RHC if PA CHIP reimbursement had been consistent with Medicaid prospective payment principles. Beginning December 1, 2013 CHIP Contractors assumed the responsibility of reimbursing FQHCs and RHCs at the Medicaid prospective payment rate. All internal claims systems have the ability to process reimbursements.

On an annual basis, PPS rates are developed by PA DHS, and PA CHIP disseminates these rates to all PA CHIP contractors. Changes in rates during the

year, are sent by DHS to the FQHCs via hard copy letter and the CHIP contractors are notified via email on the change in rates. For other policy changes, FQHCs are notified via MA Bulletin or the Public Notice process. PA CHIP has taken several steps to ensure that the FQHC/RHC's receive at least the full Medicaid PPS reimbursement rate. The first of which is a CHIP PPS Quarterly Report. Within this report, contractors must list a total count of all paid encounters within the reporting quarter. These encounters are broken down by category- medical, dental, and vaccine. Within this report providers are required to summarize reportable FQHC/RHC encounters. CHIP Contractors provide reimbursement for the difference between the established Prospective Payment System (PPS) Rate and the amounts paid to FQHC/RHC's for encounters provided to CHIP recipients. In order to receive reimbursement, this Report of Managed Care encounters and receipts must be completed by the Provider for the end of each quarter and submitted to DHS. Data from the Quarterly CHIP Report, from our CHIP contractors, is used in comparison with the Quarterly DHS Report, from the FQHC's, to ensure correct payment is made to participating FQHC/RHC's. FQHC/RHC's have been instructed to contact the appropriate CHIP contractor to resolve any discrepancies. FQHC's and or PACHC (Pennsylvania Association of Community Health Centers) will notify PA CHIP of any discrepancies between PA CHIP contractors and FQHC's. PA CHIP will facilitate communications concerning discrepancies between PA CHIP contractors and FQHC's. Dialogue between CHIP contractor and FQHC/RHC is monitored to ensure amicable and timely resolution of discrepancies.

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

3.1.1 Choice of Delivery System

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

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

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

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

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP.

States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

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.

3.1.2 Use of a Managed Care Delivery System for All or Some of the State's CHIP Populations

3.1.2.1 Check each of the types of entities below that the State will contract with under its managed care delivery system, and select and/or explain the method(s) of payment that the State will use:

☒ Managed care organization (MCO) (42 CFR 457.10)
- ☒ Capitation payment
  Describe population served: Entire CHIP population.

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

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

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

☐ Primary care case manager (PCCM) (individual practitioners) (42 CFR 457.10)
- ☐ Case management fee
- ☐ Other (please explain)

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

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

☐ Provision of intensive telephonic case management
☐ Provision of face-to-face case management
☐ Operation of a nurse triage advice line

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

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

The current CHIP contract stipulates CHIP MCOs must comply with the Physician Incentive requirements under 42 CFR 438.3(i) incorporating 42 CFR 422.208 and 422.210.

3.1.3 Nonemergency Medical Transportation PAHPs

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

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

- All contract provisions in 42 CFR 457.1201 except those set forth in 42 CFR 457.1201(h) (related to physician incentive plans) and 42 CFR 457.1201(l) (related to mental health parity).
- The information requirements in 42 CFR 457.1207 (see Section 3.5 below for more details).
- The provision against provider discrimination in 42 CFR 457.1208.
- The State responsibility provisions in 42 CFR 457.1212 (about disenrollment), 42 CFR 457.1214 (about conflict of interest safeguards),

and 42 CFR 438.62(a), as cross-referenced in 42 CFR 457.1216 (about continued services to enrollees).

- The provisions on enrollee rights and protections in 42 CFR 457.1220, 457.1222, 457.1224, and 457.1226.
- The PAHP standards in 42 CFR 438.206(b)(1), as cross-referenced by 42 CFR 457.1230(a) (about availability of services), 42 CFR 457.1230(d) (about coverage and authorization of services), and 42 CFR 457.1233(a), (b) and (d) (about structure and operation standards).
- An enrollee's right to a State review under subpart K of 42 CFR 457.
- Prohibitions against affiliations with individuals debarred or excluded by Federal agencies in 42 CFR 438.610, as cross referenced by 42 CFR 457.1285.
- Requirements relating to contracts involving Indians, Indian Health Care Providers, and Indian managed care entities in 42 CFR 457.1209.

3.2. General Managed Care Contract Provisions

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

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

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

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

3.3 Rate Development Standards and Medical Loss Ratio

3.3.1 The State assures that its payment rates are:

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

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

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

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

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

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

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

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1203. The CHIP Procedures Handbook, incorporated by reference in the current contract, provides specific reporting requirements, timeframes and templates pertaining to medical loss ratio.

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.

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1203. The CHIP Procedures Handbook, incorporated by reference in the current contract, states that the MCO will owe a remittance to the Department if an MLR of at least 85 percent is not achieved for the MLR Reporting Year. The Department

uses the MLR reporting template, published with the CHIP Procedures Handbook, to track MLR for each MCO.

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

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

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

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

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

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1203. The CHIP Procedures Handbook, incorporated by reference in the current contract, provides specific reporting requirements, timeframes and templates pertaining to medical loss ratio.

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)).

The Department publishes informational notices on its website that includes the available managed care entities, explains how to select and entity, the implications of making or not making an active choice of an entity, the length of the enrollment period as well as the disenrollment policies on its website at which complies with the information requirements in 42 CFR 457.1207. The website is at www.chipcoverspakids.com. Furthermore, the CHIP standardized paper application includes the available managed care entities, explains how to select an entity, and explains the implications of making or not making an active choice of an entity. Both the website and paper application meet the accessibility standards established under 42 CFR 457.430.

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)).

The Department has a default enrollment process if an applicant does not choose a CHIP MCO at application, or an application is submitted by referral from a County Assistance Office. The Department's electronic application processing system, COMPASS, automatically assigns an application without a designated provider using a "round robin" assignment system to ensure equitable distribution of applications to all eligible MCOs within a county. If a household is adding a new member, and already has existing coverage with CHIP, system rules are designed so that the application will be routed to the CHIP MCO with the existing provider-beneficiary relationship.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f)(2)) regarding and enrollee's right to disenroll. The Department does not restrict an enrollee's right to disenroll at any time. This right to disenroll is included in the CHIP Procedures Handbook. To ensure enrollees are receiving annual notice of this established policy, CHIP is updating its application and renewal notices to include the information. CHIP anticipates release of the revised application in July 2019 and revised renewal notices in September 2019.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1212. Furthermore, CHIP provides templated notices which MCOs use to systematically populate the disenrollment date in accordance with 42 CFR 457.1212.

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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1212. Furthermore, CHIP provides templated notices which MCOs utilize to inform disenrolled individuals of the option to receive benefits in another plan or alternate delivery system such as Medical Assistance. CHIP enrollees are offered Medical Assistance enrollment if they are disenrolled due to income. The Healthcare Handshake sends the enrollee's information and income directly to Medical Assistance for consideration. Income and citizenship are considered verified.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1212. Furthermore, the CHIP Procedures Handbook lists the reasons for disenrollment.

Disenrollment reasons include the following:

1. The child moves out of state;
2. The child becomes 19 years of age (At age 19, the child is screened for potential MA eligibility) (This does not apply to CHIP enrollees age 19 who are either pregnant or in their 12 month postpartum period) and if potential MA eligibility exists, then the child is electronically referred to the appropriate CAO for final eligibility determination;
3. Private health insurance is obtained, or the child becomes eligible for or is enrolled in MA; present during the application and renewal. If private health insurance is obtained after the child is enrolled, coverage will be maintained until renewal;
4. The child becomes eligible for or is enrolled in MA;
5. The child becomes an inmate of a juvenile delinquency facility or related public facility; When a child becomes incarcerated, their eligibility is redetermined based on a household size of one (1) and are moved to MA if found eligible.
6. The child is a resident in a public hospital or similar facility for treating behavioral or mental health issues;

7. Notification is received that the child is deceased;
8. A voluntary request for termination is received;
9. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative;
10. At renewal, if a family does not pay the premium for the first month of the new enrollment period for the child.

resulted in a different eligibility determination had the correct information been provided;

11. A special needs child is referred to MA, but the family or physician does not provide required information for an eligibility determination;
12. The child is eligible for coverage through a state health benefit plan based on a family member's employment with a state/public agency; or
13. Nonpayment of the required monthly premium payment for Low-Cost and Full-Cost CHIP.

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

3.4.2.5 Enrollee Requests for Disenrollment.

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

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

☐ Yes
☒ No

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

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

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

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

- During the 90 days following the date of the beneficiary's initial enrollment into the MCO, PIHP, PAHP, PCCM, or PCCM entity, or during the 90 days following the date the State sends the beneficiary notice of that enrollment, whichever is later;
- At least once every 12 months thereafter;
- If the State plan provides for automatic reenrollment for an individual who loses CHIP eligibility for a period of 2 months or less and the temporary loss of CHIP eligibility has caused the beneficiary to miss the annual disenrollment opportunity; and
- When the State imposes the intermediate sanction on the MCO, PIHP, PAHP, PCCM or PCCM entity specified in 42 CFR 438.702(a)(4). (42 CFR 457.1212, cross-referencing to 42 CFR 438.56(c)(2))

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

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1212.

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.

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1207. The CHIP Procedures Handbook includes templated letters which comply with 42 CFR 457.1207. The CHIP Procedures Handbook is incorporated into the MCO contract by reference.

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

understoodand is readily accessible by such enrollees and potential enrollees. (42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(1)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1207. Furthermore, The Department reviews information sent to enrollees and potential enrollees through its programmatic change process and by providing templated notices. Both the programmatic change process and templated notices are part of the CHIP Procedures Handbook. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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.

The CHIP Procedures Handbook and the CHIP Eligibility and Benefits Handbook are on-line at www.chipcoverspakids.com/Pages/default.aspx. Each CHIP MCO posts its provider directories and enrollee handbooks on their individual websites.

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)).

Pennsylvania is working towards a Department-wide model enrollee handbook and uniform definitions for all MCOs to utilize which meets 42 CFR 438.10(c)(4)(i), and 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(c)(4)). The intent is to provide all MCOs with a single product that allows for a one-time, seamless transition rather than each program issuing separate model enrollee handbooks or definitions at separate times. The MCO CHIP enrollee handbooks currently utilized by the CHIP MCOs are reviewed and approved by PA CHIP through its programmatic change process to ensure information is accurate and consistent throughout the program. Any changes to an enrollee handbook including its definitions must be approved by the Department through PA CHIP prior to the CHIP MCO implementing the change. The programmatic change process is incorporated by reference to the Procedures Handbook in the CHIP MCOs current contract. The Department intends to release its model enrollee handbook and uniform definitions in January 2020.

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.

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1207. Furthermore, any changes to MCO communications to enrollees must be approved by the Department through PA CHIP prior to the CHIP MCO implementing the change. The changes are reviewed through the programmatic change process. The programmatic change process is part of the CHIP Procedures Handbook. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1207. The Department's online COMPASS application has a choice of 67 languages, or an "other" option. If the applicant chooses a language which eCIS automatically captures, the language populates into the applicant's record. If eCISdoes not automatically capture the language, then eCIS lists the language as "other" and a case comment is noted as to the preferred

language of the applicant.For a paper application, there is a question asking for the applicant's primary language. When an applicant chooses a language other than English, the language is entered into the applicant's record in eCIS when the paper application information is data entered.

Additionally, the Department contracts with Propio Language Services. When an applicant is in need of materials in a language other than English, or calls into PA CHIP's toll-free consumer helpline, and requires an interpreter, the Department utilizes Propio for interpretation and translation services. These translation and interpretation services are free of charge to applicants and enrollees. Furthermore, the Department reviews and approves MCO materials to ensure compliance through its programmatic change request process. When a material is translated into a foreign language, the Department requires the MCO to provide a certification of accurate translation for the material. The programmatic change process is outlined in the CHIP Procedures Handbook. The CHIP Procedures Handbook is incorporated into the MCO contract by reference. Also, as stated previously, the current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1207, therefore, CHIP MCOs are required to provide interpretation and translation services as required by federal regulation.

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.

Enrollment and disenrollment information, network adequacy standards, cost-sharing information, coordination of care standards and benefit information are found in both the CHIP Eligibility and Benefits Handbook as well as the CHIP Procedures Handbook located on-line at https://www.chipcoverspakids.com/Pages/default.aspx.

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.

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1207, cross-referencing to 42 CFR 438.10(f) regarding an enrollee's right to disenroll and appropriate timeframes. The Department does not restrict an enrollee's right to disenroll at any time. Current disenrollment templates do specify and comply with the notice timeframes within the regulation. This right to disenroll is included in the CHIP Procedures Handbook. The CHIP Procedures Handbook is incorporated in the CHIP MCOs current contract by reference. Furthermore, to ensure enrollees are receiving annual notice of this established policy, CHIP is updating its application and renewal notices to include the information.

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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 1207. Furthermore, PA CHIP provides templated notices for provider termination. The CHIP Procedures Handbook includes templated letters in compliance with 42 CFR 1207. The CHIP Procedures Handbook is incorporated into the MCO contract by reference.

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.

Each CHIP MCO provides an enrollment packet and access to the CHIP MCO's enrollee handbook to all new enrollees as required by 42 CFR 457.1207 cross-referencing 438.10(g). Each CHIP MCO enrollee handbook is reviewed and approved by CHIP Quality Assurance staff to ensure all required information as outlined in the bulleted list above is included. CHIP MCOs provide paper copies of the enrollee handbook upon request to an enrollee. Any changes to the enrollee handbook are sent to the Department for review and approval through the programmatic change request process. Furthermore, the current contract between CHIP MCOs and the Department stipulates that CHIP MCOs must meet the requirements of 42 CFR 1207. All requirements listed under this assurance are also outlined within the CHIP Procedures Handbook as well as the programmatic change process. The CHIP Procedures Handbook is incorporated into the CHIP MCO contract by reference.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1207. Furthermore, any significant changes to an enrollee handbook must be approved by PA CHIP prior to the CHIP MCO implementing the change. The programmatic review process ensures that CHIP MCOs provide at least 30 days-notice to enrollees regarding significant changes to the enrollee handbook. The programmatic change process is incorporated by reference to the CHIP Procedures Handbook in the CHIP MCOs current contract.

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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1207. This includes the provision of a provider directory.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1207. This includes timely updates of paper and electronic provider directories.

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.

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1207. This includes making the formulary available, and that the formulary meets the requirements of 42 CFR 438.10(i).

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1224. Furthermore, marketing activities must be approved by the Department prior to the CHIP

MCO implementing the activity. The CHIP Procedures Handbook outlines acceptable marketing activities which comply with 42 CFR 457.1224 and provides reporting templates that CHIP MCOs must use. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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.

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1222.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1280. Furthermore, the Department reviews and approves potential and existing enrollee communications through its programmatic change process to ensure no prohibited unsolicited contact occurs. The programmatic change process is incorporated by reference to the Procedures Handbook in the CHIP MCOs current contract.

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

3.5.18 ☒ The State assures that each contracted MCO, PIHP, and PAHP comply with the notice requirements specified for grievances and appeals in accordance with the terms of 42 CFR 438, Subpart F, except that the terms of 42 CFR 438.420 do not apply and that references to reviews should be read to refer to reviews as described in 42 CFR 457, Subpart K. (42 CFR 457.1260).

The current contract between CHIP MCOs and the Department stipulates

that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides specific instructions managing grievances and appeals as well as letter templates. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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).

Currently there are no recognized tribes, Indian health providers, or Indian managed care entities in Programs in Pennsylvania. However, the current contract between CHIP MCOs and the Department does stipulate that CHIP MCOs meet the requirements of 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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230. Furthermore, The Department provides a standardized PA CHIP enrollee eligibility and benefits handbook that outlines all services available and accessible to enrollees.

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)).

Pennsylvania has codified its network adequacy standards in 28 Pa. Code § 9.679 regarding access requirements in service areas. The network adequacy standards are available on-line at www.pacode.com/secure/data/028/chapter9/s9.679.html. The Department provides copies to enrollees upon request at no cost and in alternate formats or through auxiliary aids and services.

Pennsylvania has codified its network adequacy standards in 28 Pa. Code § 9.679 regarding access requirements in service areas. Before the Department contracts with a CHIP MCO, the CHIP MCO must provide certification from the Pennsylvania Department of Health (PA DOH) that it

meets network adequacy standards. The PA DOH is responsible for certifying that Pennsylvania MCOs comply with Title 28 of the Pa Code. Furthermore, PA CHIP requires that each CHIP MCO has National Committee for Quality Assurance (NCQA) accreditation. NCQA accreditation provides for further certification of network adequacy standards. CHIP MCOs are required to provide the Department with verification of NCQA certification at initial contract and every three years after (recredential).

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).

Pennsylvania has codified its network adequacy standards in 28 Pa. Code § 9.679 regarding access requirements in service areas. The standards include the composition requirements of a network. Before the Department contracts with a CHIP MCO, the CHIP MCO must provide certification from the Pennsylvania Department of Health (PA DOH) that it meets network adequacy standards. The PA DOH is responsible for certifying that Pennsylvania MCOs comply with Title 28 of the Pa Code. Furthermore, the Department requires that each CHIP MCO has National Committee for Quality Assurance (NCQA) accreditation. NCQA accreditation provides for further certification of network adequacy standards including network composition. CHIP MCOs are required to provide the Department with verification of NCQA certification at initial contract and every three years after (recredential).

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1201(j).

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230. Furthermore, the PA CHIP Eligibility and Benefits handbook specifically states that each CHIP MCO must provide for a second opinion from a network provider or arrange for the enrollee to obtain a second opinion from outside the network, at no cost. During the MCO on-site review, PA CHIP Quality Assurance staff verify that MCOs meet the requirements of both federal regulations and the PA CHIP Eligibility and Benefits handbook.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230. Furthermore, the CHIP Procedures Handbook stipulates CHIP MCOS must provide timely access to care and services which includes all of the bulleted items in this assurance. PA CHIP also reviews provider agreements between the CHIP MCO and network providers to ensure network providers meet their obligations as stipulated in this assurance. The requirement for CHIP MCOs to provide provider agreements to PA CHIP is a process within the CHIP Procedures Handbook. The CHIP Procedures handbook is incorporated into the current CHIP MCO contract by reference. Additionally, PA CHIP Quality Assurance staff review network provider and service provision during its annual on-site review with CHIP MCOs starting in 2019.

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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230. Also, Pennsylvania has codified its network adequacy standards in 28 Pa. Code § 9.679 regarding access requirements in service areas. Before the Department contracts with a CHIP MCO, the CHIP MCO must provide certification from the Pennsylvania Department of Health (PA DOH) that it meets network adequacy standards which includes the state's standards for access to care. The PA DOH is responsible for certifying that Pennsylvania MCOs comply with Title 28 of the Pa Code. Furthermore, the Department requires that each CHIP MCO has National Committee for Quality Assurance (NCQA) accreditation. NCQA accreditation provides for further certification of network adequacy standards which includes access to care standards. CHIP MCOs are required to provide the Department with verification of NCQA certification at initial contract and every three years after (recredential).

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230.

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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230.

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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230.

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).

The current contract between CHIP MCOs and the Department stipulates

that CHIP MCOs meet the requirements of 42 CFR 457.1216. The CHIP Procedures Handbook outlines a transition of care policy that meets the requirements of 42 CFR 438.62(b). CHIP MCOs are required to implement the CHIP Procedures Handbook because the CHIP Procedures Handbook is incorporated by reference into the CHIP MCO contract with the Department.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230(c). PA CHIP also reviews information on coordination of care, screening requirements, service delivery, privacy protections, and designation of a primary care coordinator during quality on-site reviews. During the Quarterly Quality Review Meetings with each CHIP MCO, the Department discusses issues of coordination of care, service delivery, and privacy protections. Furthermore, PA CHIP reviews the CHIP MCO enrollee handbooks to ensure compliance with regulatory requirements and policies such as those required in the PA CHIP Procedures Handbook. Any changes to an enrollee

handbook must be approved by PA CHIP prior to the CHIP MCO implementing the change. The CHIP Procedures Handbook outlines the above bulleted requirements and the CHIP MCO's obligation to meet those requirements. The CHIP Procedures handbook is incorporated into the current CHIP MCO contract by reference.

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.

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230(c). Furthermore, The Department has a special needs process in place to ensure enrollees are getting appropriate care. CHIP MCOs identify special needs enrollee by conducting a claims review. A packet regarding special needs information is sent to the Department's Office of Income Maintenance for review and determination of eligibility for Medical Assistance. The special needs process is outlined in the CHIP Procedures Handbook. The CHIP Procedures handbook is incorporated into the current CHIP MCO contract by reference.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230(c). Furthermore, The Department has a special needs process in place to ensure enrollees are getting appropriate care. CHIP MCOs are required to review history from medical claims management information to identify children enrolled in CHIP who may potentially be eligible for MA based on the child's disability. The Department has a program for children under the age of 18 with special needs who meet the SSA definition of a disability. The SSA's definition of a disability for a child is:

1. A physical or mental condition or a combination of conditions, that results in "marked and severe functional limitations". This means that the condition(s) must very seriously limit the child's activities; and
2. The child's condition(s) must be permanent or have lasted or be expected to last at least 12 months; or must be expected to result in death.

A packet regarding special needs information is sent to the Department's Office of Income Maintenance for review and determination of eligibility for Medical Assistance. Quarterly Quality Review Meetings are held by the Department with each CHIP MCO to ensure that treatment and service plans are in place for enrollees identified as having special heath care needs. These assessments and service plans are also reviewed during on-site visits. The special needs process is outlined in the CHIP Procedures Handbook. The CHIP Procedures handbook is incorporated into the current CHIP MCO contract by reference.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230(c). Furthermore, The Department conducts Quarterly Quality Review Meetings with each CHIP MCO to ensure that treatment and service plans are in place for enrollees identified as having special heath care needs. These assessments and service plans are also reviewed during annual on-site visits. The special needs process is outlined in the CHIP Procedures Handbook. The CHIP Procedures handbook outlines the states quality assurance and utilization review standards and is incorporated into the current CHIP MCO contract by reference. Additionally, the CHIP MCOs are required to have NCQA accreditation every three years. NCQA accreditation includes quality assurances and utilization review standards. Once the CHIP MCOs obtain the accreditation certificate they are required to send a copy to the Department.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1230(c). Furthermore, the CHIP Procedures Handbook and the CHIP Eligibility and Benefits Handbook require CHIP MCOs to ensure that an enrollee has direct access to a specialist appropriate for the condition, so the enrollee receives appropriate course of treatment. The CHIP Procedures handbook is incorporated into the current CHIP MCO contract by reference. The CHIP Eligibility and Benefits Handbook outlines all services and benefits available to enrollees through CHIP regardless of their chosen MCO.

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)).

The Department requires that each MCO has National Committee for Quality Assurance (NCQA) accreditation. NCQA accreditation provides for a uniform credentialing and recredentialing policy that addresses acute and primary providers. The NCQA credentialing/ recredentialling assures that CHIP MCOs are following prescribed policies. Recredentialling occurs every three years. CHIP MCOs are required to provide a copy of their NCQA credentialing to the Department per the CHIP MCO contract. The CHIP MCOs are responsible for ensuring the credentialing for behavioral health and substance use disorder providers. The Department reviews the CHIP MCOs credentialing procedures during its on-site reviews to ensure CHIP MCOs are providing appropriate credentialing and recredentialing.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1208 and 457.1233. Furthermore, the Department through PA CHIP conducts on-site monitoring with each MCO. During the monitoring, PA CHIP assures that an MCO's documents, policies and procedures comply with provisions listed above including network adequacy, MCO certification and provider credentialing, provider enrollment validation, and provider communications.

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

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

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

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

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

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1233. Furthermore, PA CHIP may review contracts between CHIP MCOs and their subcontractors to ensure the subcontractor meets the provisions of 42 CFR 457.1233. This review requirement is outlined in the CHIP Procedures Handbook. The review is at PA CHIP's discretion. In 2019, all contracts

are reviewed. The Procedures Handbook is incorporated by reference in the MCOs current contract.

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)).

Each CHIP MCO has provider agreements that are reviewed during on-site visits by PA CHIP Quality Assurance (QA) staff. The review includes ensuring that covered services adhere to Bright Futures guidelines and case management are a based on valid and reliable clinical evidence. Bright Futures is a national health promotion and prevention initiative, led by the American Academy of Pediatrics and supported, in part, by the US Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). The Bright Futures Guidelines provide theory-based and evidence driven guidance for all preventative care screenings and well-child visits. The Department through PA CHIP ensures these guidelines are adopted in consultation with network providers. PA CHIP QA staff also ensure MCOs update and review their guidelines periodically as appropriate. Furthermore, all CHIP MCOs have National Committee for Quality Assurance (NCQA) accreditation. NCQA accreditation also monitors provider quality every three years.

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)).

The Department holds Quarterly Quality Review Meetings with each CHIP MCO. During each meeting, the CHIP MCO provides the Department information regarding utilization management, enrollee education, and coverage of services. The Department through PA CHIP also reviews information on utilization management, enrollee education and coverage of services contained within the CHIP MCO enrollee handbook. Any changes to an enrollee handbook must be approved by the Deparment through PA CHIP prior to the CHIP MCO implementing the change. The programmatic change process is incorporated by reference to the Procedures Handbook in the CHIP MCOs current contract.

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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1233. Each CHIP MCO maintains a health information system that collects, analyzes, integrates and reports data on utilization, claims, grievances and appeals as well as disenrollment. CHIP MCOs provide regular and ad hoc reports related to utilization, claims, grievances and appeals and disenrollment as directed by the Department.

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)).

The CHIP MCO contract has multiple provisions establishing privacy protections of enrollee health information which comply with 42 CFR 457.1110. Furthermore, the current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1233(e). The Department through PA CHIP issued a transmittal to MCOs that outlines how and when a provider must report a privacy breach to the HIPPA Privacy Coordinator. The transmittal was issued January 28, 2018. The Quality Assurance director receives non-compliance notifications and follows-up with the MCO to ensure remediation occurs.

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)).

The CHIP MCOs enrollee handbooks contain the enrollees' rights. All CHIP MCO enrollee handbooks are vetted by PA CHIP through its programmatic change process to ensure information is accurate and consistent throughout the program. Any changes to an enrollee handbook

including its enrollee rights must be approved by PA CHIP prior to the CHIP MCO implementing the change. The programmatic change process is incorporated by reference to the Procedures Handbook in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1226.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides specific instructions managing grievances and appeals as well as letter templates. The CHIP Procedures Handbook is incorporated by reference in the MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides specific instructions managing grievances and appeals including the MCO level of appeal. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides specific instructions regarding the state review. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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

☒ Yes
☐ No

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

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

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

CHIP Procedures Handbook outlines the external medical review process that is conducted by the Department of Health. The process is at the enrollee's option and does not impede upon an enrollee's right for further review. There is no cost to the enrollee for the review. The MCOs are required to follow the external medical review process requirement as the CHIP Procedures Handbook is incorporated by reference into the CHIP MCOs current contract. Furthermore, state statute (40 P.S. §§ 991.2301-A – 991.2309-A) requires CHIP to offer an external medical review and that review meets the requirements as outlined in 42 CFR 1260, cross referencing 438.408(f).

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides specific instructions on how and when and enrollee may file a grievance. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides specific instructions including timeframes regarding appeals. The Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides specific instructions including how an enrollee may request an appeal. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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.

The current contract between CHIP MCOs and the Department stipulates that MCOs meet the requirements of 42 CFR 457.1260 (referenced in Section 3.9.10 (below)). Furthermore, the CHIP Procedures Handbook provides specific instructions including timely and adequate notice. Templated notices are also provided through the CHIP Procedures Handbook. The CHIP Procedures Handbook outlines the external medical review process that is conducted by the Department of Health. There is no cost to the enrollee for the review. The CHIP MCOs are required to follow the external medical review process requirement as the CHIP Procedures Handbook is incorporated by reference into the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides specific instructions including adverse benefit explanations. Templated notices are also provided through the CHIP Procedures Handbook. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides specific instructions including adverse benefit explanation timeframes. Templated notices are also provided through the CHIP Procedures Handbook. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides specific instructions including providing assistance to enrollees in completing forms and procedural steps

related to grievances and appeals. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides MCOs with specific information regarding the handling of grievances and appeals, and includes each element listed in this assurance. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. Furthermore, PA CHIP Quality Assurance staff review MCOs' appeals and grievance procedures and files as part of on-site reviews, and through ad hoc reporting requests. The review and reports provide the state assurances that the MCOs meet the requirements of 42 CFR 457.1260.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides MCOs with specific information regarding the handling of grievances and appeals including the requirement standard grievances are resolved within 90 calendar days. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. Furthermore, PA CHIP Quality Assurance staff review MCOs' appeals and grievance procedures and files as part of on-site reviews, and through ad hoc reporting requests. The review and reports provide the state assurances that the MCOs meet the requirements of 42 CFR 457.1260.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides CHIP MCOs with specific information regarding the handling of grievances and appeals including the requirement standard appeals are resolved within 30 calendar days. The process outlined in the CHIP Procedures Handbook also allows for the 14-calendar day extension. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. Furthermore, PA CHIP Quality Assurance staff review CHIP MCOs' appeals and grievance procedures and files as part of on-site reviews, and through ad hoc reporting requests. The review and reports provide the state assurances that the CHIP MCOs meet the requirements of 42 CFR 457.1260.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides CHIP MCOs with specific information regarding the handling of grievances and appeals including expedited review process for appeals is no longer than 72 hours and when to apply the expedited review process as described in 42 CFR 457.1260. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. Furthermore, PA CHIP Quality Assurance staff review CHIP MCOs' appeals and grievance procedures and files as part of on-site reviews, and through ad hoc reporting requests. The review and reports provide the state assurances that the MCOs meet the requirements of 42 CFR 457.1260.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides CHIP MCOs with specific information regarding the handling of grievances and appeals which is in accordance with timeframes established. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. Furthermore, PA CHIP Quality Assurance staff review CHIP MCOs' appeals and grievance procedures and files as part of on-site reviews, and through ad hoc reporting requests. The review and reports provide the state assurances that the MCOs meet the requirements of 42 CFR 457.1260.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides CHIP MCOs with specific information regarding the handling of grievances and appeals including the

bullet items listed in this assurance. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. Furthermore, PA CHIP Quality Assurance staff reviews CHIP MCOs' appeals and grievance procedures and files as part of on-site reviews, and through ad hoc reporting requests. The review and reports provide the state assurances that the CHIP MCOs meet the requirements of 42 CFR 457.1260.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. The stipulation includes that if a CHIP MCO fails to adhere to the notice and timing requirements of 42 CFR 1260, that the enrollee is deemed to have exhausted the CHIP MCO's appeals process and the enrollee may initiate a state review.

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

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides templated notices for notification of an enrollee of the resolution of a grievance. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides templated notices for notification of an enrollee of the resolution of a grievance including all bulleted elements listed in this assurance. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. Additionally, PA CHIP Quality Assurance reviews MCOs' appeals and grievance procedures and files as part of on-site reviews, and through ad hoc reporting requests. The review and reports provide the state assurances that the MCOs meet the requirements of 42 CFR 457.1260.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides MCOs with specific information regarding the handling of grievances and appeals including the requirement to provide oral notice. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. Furthermore, PA CHIP Quality Assurance reviews CHIP MCOs' appeals and grievance procedures and files as part of on-site reviews, and through ad hoc reporting requests. The review and reports provide the state assurances that the CHIP MCOs meet the requirements of 42 CFR 457.1260.

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

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

CHIP Procedures Handbook outlines the external medical review process that is conducted by the Department of Health. The process is at the enrollee's option and does not impede upon an enrollee's right for further review. There is no cost to the enrollee for the review. The CHIP MCOs are required to follow the external medical review process requirement as the CHIP Procedures Handbook is incorporated by reference into the CHIP MCOs current contract. Furthermore, state statute (40 P.S. §§ 991.2301-A – 991.2309-A) requires CHIP to offer an external medical review and that review meets the requirements as outlined in 42 CFR 1260, cross referencing 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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides MCOs with specific information regarding the handling of grievances and appeals including the requirement not to take punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. Furthermore, PA CHIP Quality Assurance staff review MCOs' appeals and grievance procedures and files as part of on-site reviews, and through ad hoc reporting requests. The review and reports provide the state assurances that the MCOs meet the requirements of 42 CFR 457.1260.

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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides CHIP MCOs with specific information regarding the handling of grievances and appeals including each element listed in this assurance. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. Each CHIP MCO is required to provide grievance and appeals information to enrollees through the CHIP MCOs enrollee handbook, and to provide information on filing an appeal when adverse decisions are made. The Department provides templated notices regarding benefit decisions to CHIP MCOs to use which includes appeal and grievance information. Those notices are also part of the CHIP Procedures Handbook. The CHIP Procedures Handbook is also available on-line at https://www.chipcoverspakids.com.

Furthermore, PA CHIP Quality Assurance staff review CHIP MCOs' appeals and grievance procedures and files as part of on-site reviews, and through ad hoc reporting requests. The review and reports provide the state assurances that the CHIP MCOs meet the requirements of 42 CFR 457.1260.

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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, the CHIP Procedures Handbook provides requirements for maintain grievance and appeal records. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1260. Furthermore, PA CHIP conducts on-site reviews at MCOs. During the on-site reviews, the Department through PA CHIP Quality Assurance staff reviews MCO decisions and follow-up actions to ensure that services were provided appropriately after an appeal decision and within prescribed timeframes. Additionally, the requirement the MCOs provide disputed services promptly and expeditiously but no later than 72 hours from the date of notice of the decision reversal is included in the CHIP Procedures Handbook. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1280. Furthermore, the CHIP Procedures Handbook provides requirements and procedures designed to safeguard against fraud and abuse as stated in this assurance. PA CHIP also reviews and approves all enrollee communications are through the programmatic change process. The programmatic change process is part of the CHIP Procedures Handbook. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. Additionally, PA CHIP conducts on-site reviews to ensure compliance with the requirements of 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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1285. Furthermore, the CHIP Procedures Handbook provides requirements for compliance programs, reporting overpayments, providing notifications and referrals, and ability for the CHIP MCO to suspend payments to providers as outlined in the above section. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1285. Furthermore, the CHIP Procedures Handbook requires MCOs have a mechanism to

receive and return and overpayment within 60 calendar days of identification of the overpayment. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1285. Furthermore, the CHIP Procedures Handbook requires CHIP MCOs to have "prompt reporting" rather than annually so reporting may occur more frequently. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The Department screens and enrolls CHIP providers as part of the Department's provider enrollment process. Revalidation of providers occurs every 5 years.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1285. Furthermore, the Department through PA CHIP reviews the ownership and control disclosures submitted by the CHIP MCO and subcontractors. These disclosures are submitted to the Department using the programmatic change process. The programmatic change process is part of the CHIP Procedures Handbook. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1285. Furthermore, the Department through PA CHIP reviews changes regarding key staff positions within the MCO and subcontractors. These changes are submitted to the Department using the programmatic change process. Organization charts must be included to further document owner and control. The Department through PA CHIP reviews specific website for provider exclusions. The programmatic change process is part of the CHIP Procedures Handbook. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

When PA CHIP receives information from a whistleblower relating to the integrity of an MCO or network provider, the CHIP Quality Assurance staff conduct an investigation based on established fraud, waste and abuse policies and procedures set forth in the CHIP Procedures Handbook.

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).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1285. Specifically, the contract prohibits CHIP MCOs from making payments for claims to providers, sucontractors or financial institutions located outside of the United States. This requirement will be reviewed at the next annual MCO on-site monitoring. conducted by the Department. Furthermore, the eight MCOs contracting with the Department are all incorporated within the United States. Additionally, the Department is currently working with CHIP MCOs to provide certification that future claims data provided will not include claims paid from outside the United States.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1285. Furthermore, the CHIP Procedures Handbooks provides additional information regarding submission of data, documentation and information as stated above. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1285. Furthermore, the CHIP Procedures Handbooks outlines the certification requirements when submitting information. Each MCO submits certifications to the Department for review in accordance with the Procedures Handbook. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1285.

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)).

Each CHIP MCOs must have National Committee for Quality Assurance (NCQA) accreditation which verifies it complies with standards for availability and accessibility of services. NCQA certifications are found on-line at https://www.chipcoverspakids.com/chip-resources/Pages/AccreditationStatus.aspx. Ownership and control information is part of each contract. CHIP MCO contracts are found on-line at http://contracts.patreasury.gov/ and http://www.emarketplace.state.pa.us/. MCO audit information is posted by the Department at http://www.dhs.pa.gov/learnaboutdhs/dhsorganization/officeofadministration/bureauoffinancialoperations/index.htm and http://www.dhs.pa.gov/publications/finalperformanceauditreports/ .

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).

The current contract between CHIP MCOs and the Department stipulates intermediate sanctions including liquidated damages and corrective action plans as requirements of 42 CFR 457.1270.

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

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

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

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

☐ Yes
☐ No

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

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

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

This requirement will be included in the next CHIP contract amendment on 3/1/2020.

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)).

The CHIP Procedures Handbook requires MCOs to develop and implement a comprehensive quality improvement assessment and performance improvement program through its Quality Management/ Utilization Management (QM/UM) requirements. The MCOs must adhere to Pennsylvania Performance Measures and CMS performance measures as required. PA CHIP currently has Performance Improvement Projects (PIPs) that run from 2017-2021. IPRO provides performance measurement data annually to CHIP Quality Assurance staff for review. Further data is provided through the QM/UM reports including data on underutilization and overutilization. Furthermore. Quality Assurance staff reviews reports to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1240(b). Furthermore, the CHIP Procedures Handbook provides specific requirements regarding performance improvement projects. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. A member of the CHIP Quality Assurance Staff reviews performance improvement projects to ensure compliance with the requirements outlined in the Procedures Handbook. The performance improvement projects are reviewed at each Quarterly Quality Review Meeting (QQRMs). Quarterly Quality Review Meetings are held by the Department with each CHIP MCO on a quarterly calendar schedule.

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

3.12.2.1.3 ☐ The State assures that it requires that each PCCM entity establishes and implements an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its enrollees as provided in 42 CFR 438.330, except that the terms of 42 CFR 438.330(d)(4)

(related to dual eligibles) do not apply. The assessment and program must include:

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

3.12.2.2 Quality Assessment and Performance Improvement Program: Reporting and Effectiveness

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

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

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1240(b). Furthermore, the CHIP Procedures Handbook provides reporting requirements and timeframes regarding performance improvement projects. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract. The performance improvement projects are reviewed at each Quarterly Quality Review Meeting (QQRMs). Quarterly Quality Review Meetings are held by the Department with each CHIP MCO on a quarterly calendar schedule.

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)).

The current contract between CHIP MCOs and the Department stipulates that CHIP MCOs meet the requirements of 42 CFR 457.1240(b). Furthermore, the CHIP Procedures Handbook provides specific requirements to measure, report and submit data specified by the state. The CHIP Procedures Handbook is incorporated by reference in the CHIP MCOs current contract.

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)).

The CHIP Quality Assurance staff receive reports from IPRO, the EQR vendor, which analyze the impact and effectiveness of the quality assessment. The reports also document trends and outcomes. The CHIP Quality Assurance staff receive, review and analyze this information on an annual basis.

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)).

PA CHIP receives a copy of each CHIP MCO's National Committee for Quality Assurance (NCQA) certification.

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)).

PA CHIP and PA CHIP MCOs contract with Island Peer Review Organization (IPRO) which is a qualified EQR vendor. The CHIP Procedures Handbook requires a qualified EQRO perform an annual EQR with each contracting MCO.

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)).

PA CHIP contracts with Island Peer Review Organization (IPRO) which is a qualified EQR vendor.

3.12.5.2 External Quality Review-Related Activities

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

3.12.5.2.1 ☒ The State assures that the mandatory EQR-related activities described in 42 CFR 438.358(b)(1)(i) through (iv) (relating to the validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy) will be conducted on all MCOs, PIHPs, or PAHPs. (42 CFR 457.1250(a), cross referencing to 42 CFR 438.358(b)(1)).

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

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

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

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

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

3.12.5.3 External Quality Review Report

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

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

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

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

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

457.1250(a), cross referencing to 42 CFR 438.350(b) through (e)).

The Department has a competitive procurement process in place to ensure the EQRO is qualified and meets the above stated conditions.

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)).

The Department assures that the results of the reviews performed by a qualified EQRO of each contracting MCO entity are made available in an annual detailed technical report that summarizes findings on access and quality of care. The report includes all of the above listed item.

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)).

The Department does not substantively revise the content of the final EQR technical report. PA CHIP only reviews for errors.

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)).

The annual EQR technical report is posted at https://www.chipcoverspakids.com.

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)).

The annual EQR technical report does not include protected health information.

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) (42 CFR 457.490(b))

CHIP services are provided through a managed care model, in which enrollees select a primary care physician who is responsible for providing basic primary care services and referrals to other specialty care. For those enrollees in counties with a Gatekeeper PPO, a medical home is assigned in lieu of a primary care physician.

As a means of determining the level of utilization, managed care plans systematically track the utilization of health services to identify patterns of over and under utilization of health services. In addition, each CHIP Contractor is required to submit specific utilization data to the Department on a quarterly and annual basis. The data includes:

- The number of enrollee visits to primary care physicians, medical specialists, as well as visits for vision, hearing, dental, and mental health services.
- The number of prescriptions and the ten most utilized drugs; and
- The number of hospital admissions for medical, surgical, maternity, mental health and substance use disorder and average length of stay, by age group.

The data collected is analyzed by the Department to identify outliers and potential utilization issues. The Department then works with the plans to further evaluate the outliers and correct problems as necessary during its ongoing utilization review and quality improvement programs.

Section 4. Eligibility Standards and Methodology

4.0. ☐ **Medicaid Expansion**

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

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

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

The verification of citizenship requirement includes verifying the identity of the applicant child claiming to be a U.S. citizen or lawfully residing. Citizenship and identity must only be verified once. An electronic match with the SSA will take place to match the child's name, date of birth, gender, and Social Security Number (SSN) in eCIS to the SSA database. If there is a match, citizenship and identity will be considered verified.

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

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

CHIP provides coverage to children from birth through 18. CHIP provides free coverage to children in families with incomes too high for Medicaid and adjusted gross income at or under 208% of FPL. Subsidized CHIP is provided to children in families with adjusted gross income of greater than 208% of FPL, but not greater than 314% of FPL (i.e., up to and including 314% 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):

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):

Must be a resident of the state.

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

4.1.7 ☒ Access to or coverage under other health coverage:

Pennsylvania requires that children be totally uninsured or ineligible for Medicaid to be eligible for CHIP. Contractors have the capacity to compare enrollee families to their own company subscribers to verify whether the family has private or employer sponsored coverage. We currently match new applications against a Medicaid data base to ensure the applicants are not already enrolled in Medicaid. The Commonwealth also runs a match through a Third

Party Liability contract to assist in the determination that the applicants qualifying for low cost CHIP do not currently have private insurance.

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

Enrollment begins the first of the month following the date of application. For a child eligible in a subsidized tier, enrollment will begin after the initial premium is paid,Exceptions to the 12-months of continuous coverage are listed in CS 27.

4.1.9 ☒ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 42 CFR 457.310 and 457.320 that are not addressed above. For instance:

- A child must be a citizen of the United States, a U.S. national, or a qualified alien, consistent with SCHIP regulations defined at 42 CFR 457.320(b)(6). Citizenship of children declaring U.S. citizenship will be verified through a match with the Social Security Administration (SSA). Enrollment of otherwise eligible children will not be delayed pending verification of U.S. citizenship. Children will be conditionally enrolled in CHIP pending final verifications. If citizenship cannot be verified by the SSA, the state will work closely with the family to reconcile any differences for up to 90 days. If the issue cannot be reconciled in the 90-day period, a termination notice will be issued and termination will be effective the first of the next month.

- Citizenship of other applicants may be verified through the Verification Information System – Systematic Alien Verification for Entitlements Program. The commonwealth elects to provide coverage to children who are lawfully residing in the United States and are otherwise eligible for CHIP including optional targeted low-income children described in section 1905(u)(2)(B) without a five-year delay.

- Pennsylvania CHIP simplified the application process by the elimination of the requirement for proof of income in those instances where verification may be obtained through various data exchanges (e.g., Income and Eligibility Verification System – IEVS). If the self-declared income on the application and the information available through IEVS is within tolerance, the income is considered verified. Within tolerance is defined as resulting in no change to the category of CHIP a child is to receive (Free, Subsidized level, or Full Cost). In this case, no further verification is required. If the income cannot be verified through IEVS or if the information in IEVS is out of tolerance, the application will be treated as incomplete and the appropriate notifications will be generated to request the information from the applicant. As with all eligibility determinations, the family retains the right to appeal any determination and provide additional information to show that the correct determination was not made.

- Pennsylvania state law requires the mother's insurance to cover the newborn from the time of birth through 30 or 31 days. If a child is born to a CHIP enrollee, because the mother is covered by CHIP, full CHIP coverage is extended to the child from the time of birth and CHIP would pay for any claims during this period. Based upon the new mother's eligibility status, we would naturally assume the newborn will be eligible for either Medicaid or CHIP.

- Children who are born to individuals eligible under the approved State Plan are considered by Pennsylvania to be targeted low-income children on the date of the child's birth, to have applied and been determined otherwise eligible for Medicaid or CHIP, as appropriate, on the date of birth, and to remain eligible until attaining the age of 1 unless, after a reasonable opportunity period, the agency fails to obtain evidence to satisfy satisfactory documentation of citizenship under 42 CFR 435.407(c)(1) and (2) and identity under 42 CFR 435.407(e) and (f).

    - To ensure no gap in access to health care between the coverage of the child by CHIP under the mother and the coverage of the child by either Medicaid or CHIP under the child's identification number, upon notification of the birth, the insurance contractor will temporarily enroll the newborn in CHIP with an effective date of the first of the month following birth. The child will be assigned its own identification number at that time. Simultaneously, the centralized eligibility system will screen the newborn for potential Medicaid eligibility using the appropriate information on income and family size contained on the mother's existing application.

        - The appropriate information would be directly related to the newborn and the newborn's parent(s) and siblings and their associated income only. The new grandparents and the new mother's siblings and their incomes are not to be counted for the newborn's eligibility determination.
        - In the vast majority of cases, the outcome will be that the newborn is potentially eligible for Medicaid. If potentially eligible for Medicaid, the newborn must be referred to the local county assistance office (CAO) for an eligibility determination.
        - The newborn will remain enrolled in CHIP until an Medicaid eligibility determination is completed. If eligible for Medicaid, the newborn will be terminated from CHIP effective the first day of the following month in which Medicaid determined the newborn eligible. This will ensure no gap in access to health care.
        - If not eligible for Medicaid, the newborn will be screened to determine in which category of CHIP the newborn is placed (Free, Low-cost, or Full-cost).

- The newborn is guaranteed 1 year of eligibility in CHIP or MA, with the exceptions listed in Section 4.1.8 of the State Plan. The normal renewal process will remain in effect for the new mother. After 1 year, the newborn's renewal due date will be synchronized with the new mother's renewal due date. At the next renewal due date, the normal renewal process will be followed.

- Children born to mothers who are not covered by Medicaid or CHIP and are otherwise eligible for CHIP may be enrolled in CHIP with an effective date of the first of the month following the month of birth, if an application is received during the month of birth or the month following. This allows for a newborn to have continuous access to the health care system with no gap in coverage. If the retroactive enrollment causes duplication of coverage with the mother's insurance during the first 30 days of life, CHIP will be the payer of last resort.

- Pennsylvania CHIP chooses to provide coverage to children of employees of a public agency in the state who meet the hardship exception as defined in P.L. 111-148 Section 10203(d)(2)(D)

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

All applicants for CHIP are required to provide Social Security Numbers.

4.1.9.2 ☒ Continuous eligibility

Coverage is provided for 12 consecutive months from the date of enrollment/renewal.Coverage is terminated on the last day of the calendar month in which the child becomes 19 years old.

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.

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

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

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

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

4.1.1-LR ☒ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has

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

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

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

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

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

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

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

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

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

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

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

The state uses the same application for all health care benefits including MA and CHIP. Families have the option to apply online, via the mail, or in person at their County Assistance Office (CAO). CHIP MCOs are able to enter application data into the Commonwealth of Pennsylvania's Access to Social Services (COMPASS) portal from mail in applications and over the phone applications on behalf of families.

Upon receipt of an application for benefits, the CAO will review and process the application to ensure that the application contains all information required to make an eligibility determination. If additional information is needed, the caseworker contacts the applicant to request the required information and explains what, if anything, is needed to verify the information.

The caseworker verifies information such as gross income, household composition, citizenship, identity, and third-party insurance. After verifying all required information, it is determined if the applicant is eligible for Medical Assistance or CHIP.

The applicant has the opportunity to appeal any eligibility decision made by the CAO or to request a reassessment. If additional information is provided by the applicant that allows the CAO to determine the applicant is eligible for a lower cost or the free program (different household size, reduction in income since applying, and the like), eligibility is redetermined and the applicant is enrolled in the appropriate category of CHIP.

Through our past SPA, the Commonwealth initiated the verification of citizenship through a match with the Social Security Administration. Pennsylvania assures that it will continue to follow the process outlined in Section 211 of the Children's Health Insurance Program Reauthorization Act (CHIPRA).

To facilitate cross matches between information technology systems, Social Security numbers will be required on applications. If an applicant does not yet have a Social Security number or fails to include a Social Security number, the CAO will conduct outreach to the applicant to obtain the number. An application will not be delayed nor denied due to the absence of the Social Security number. The demographic information from the application will be forwarded to the Social Security Administration to try to obtain any number that is not provided by using the enumeration process.

Applicants are enrolled on the first of the month following the date of application and after the initial premium payment has been collected.

- The CAOs are provided with the CHIP handbook and other forms of instruction (i.e. CHIP Operations Memos) which prescribe the methods and procedures to be used in the determination of eligibility. The CHIP handbook prescribes: Basic eligibility requirements relating to income,

age, residency, citizenship, and the lawful status of non-citizens;

- Verification requirements (required for income if not verifiable through data exchange matches, U.S. citizenship and proof of qualified alien status only unless, in the judgment of the insurance contractor, other verification is needed to clarify incomplete or inconsistent information provided on the application);
- Application processing standards (a decision on eligibility or ineligibility must be made within forty-five calendar days from the receipt of a complete application); and
- Notification requirements for notices of eligibility, ineligibility, renewal and termination.

In the event of a State or Federally declared disaster, the Commonwealth will notify CMS of the intent to provide temporary adjustments to its eligibility and enrollment policies, the effective dates of such adjustments, and the name of the counties or locations of the areas impacted by the disaster.

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

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

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

The commonwealth will closely monitor expenditures of CHIP funds. If necessary and feasible, we will cap the number of new enrollees in the expanded population (those above 208% of the FPL) and create a waiting list for that population to ensure we do not exceed our CHIP allotment for the year. Prior to implementing a cap and waiting list, the state will provide CMS with appropriate notifications. Other actions at time of decision include:

- Publication in the Pennsylvania Bulletin 60 days prior as public notification
- Inclusion of waiting list information on CHIP and COMPASS web sites

New applications will still be accepted through the normal processes. Screen and enroll procedures for Medicaid will remain unchanged. Eligibility will be run on all applications. The applications of individuals that appear to be eligible for Medicaid will be enrolled in Medicaid. Those applicants not eligible for Medicaid will be put on the waiting list with an effective date of the date when the application is received to enter into eCIS for an eligibility determination. On at least a monthly basis, the commonwealth will make an assessment of the number of enrollees against the appropriated funds for the program. As additional funds

would become available (either through attrition of enrollees or by identified funding) applicants on the waiting list will be notified of the availability of coverage through CHIP. A determination will be made as to the number of new enrollees that can be accommodated with the identified funds. Notifications will go out first to those applicants with the earliest completion date; thus a first come, first served process. To update eligibility, applicants would need to attest that there have not been any changes to their family circumstances (e.g. number in household, income, insurance status, and the like). If changes have occurred, the new information will be added into eCIS and eligibility will be re-determined. The signing of the attestation or the submission of additional information would be the basis for a new eligibility date and the 12 months of eligibility will begin with the enrollment. It is not expected that enrollees will be affected by any caps or waiting lists that may be implemented.

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

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)

4.3.3-EL Express Lane Eligibility

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

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

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

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

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

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

4.4. 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.

During the application process, if a child is found to have or be eligible for state employee health benefits, or other private insurance that meets Minimal Essential Coverage (MEC) requirements, the child is not enrolled in CHIP. CHIP does not enroll pregnant women over age 19 into its program.

There are no waiting periods in CHIP for any applicant.

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

When a child is evaluated in the CHIP eligibility system, if they are below the 133% FPL, they are enrolled in Medicaid.

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))

Medicaid and CHIP eligibility are reviewed in the same electronic Client Information System (eCIS). If a child's household income is found to be over the Medicaid limit, the application is automatically reviewed for CHIP eligibility. A determination of eligibility for the correct program of CHIP (Free, Sub, At Cost) for the child is completed. During the application process, if a child is found to have or be eligible for state employee health benefits, or other private insurance that meets Minimal Essential Coverage (MEC) requirements, the child is not enrolled in CHIP.

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

The state does not provide coverage under a premium assistance program.

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

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

Pennsylvania provides coverage equally to all low-income children regardless of their status as American Indian or Alaska Native.Pennsylvania does not have any registered American Indian tribes within its borders.

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

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

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

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

Section 5. Outreach and Coordination

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

5.1.1. (formerly 2.2.1.) The steps the State is currently takin4g to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

The commonwealth is committed to providing access to quality health care coverage and to improving the health status of its children. Of particular concern are children of low-income families; families with limited access to care; and families having children with special needs due to chronic or disabling conditions. (Special needs programs include spina bifida, diabetes, asthma, hepatitis B, etc.)

To achieve the goal of providing access to health care the office of CHIP meets regularly with the statewide advocacy community dedicated to increasing awareness and enrollment in both CHIP and Medicaid. Senior and management staffs of the Department of Human Services, Health and Education are consulted to complete strategic planning, to monitor progress, collaborate, share resources and to problem solve. The efforts of these meetings and relationships has increased awareness and enrollment with the following efforts which include but are not limited to:

Establishing a single statewide toll-free number (1-800-986-KIDS) to provide access to helpline staff who inform, refer, and assist in applying for CHIP and Medicaid.

Jointly funding a multi-year contract with a media consultant. Developing complementary media messages about the availability of healthcare coverage and the importance of preventative care.

Improving access to enrollment by streamlining eligibility and application practices.

Conducting studies regarding hard-to-reach populations to increase knowledge on how to achieve better results in- outreach to them. Measuring the effectiveness of our efforts by gathering and analyzing available data.

The Department's particular efforts to identify and enroll all uncovered children who may be eligible for CHIP include but are not limited to the following:

Conducting a statewide outreach campaign for CHIP. The campaign includes but is not limited to: paid television, Internet and radio advertisements, posters, brochures, banners and the like.

Monitoring, measuring and evaluating the effectiveness of the statewide outreach campaign as well as other outreach strategies initiated and implemented by the Department.

Engaging in collaborative interagency outreach for the purpose of developing and implementing strategies to enroll children in both CHIP and Medicaid. Agencies include but are not limited to: the Department of Education (school- and library-based enrollment) and, the Department of Health Developing a strategic plan to maximize awareness of CHIP with organizations and associations with existing statewide networks.

Implementing school-based outreach and/or enrollment. Approving and monitoring the outreach and enrollment strategies of CHIP insurance company contractors. Participating in outreach activities initiated by local community organizations.

Conducting studies which improve the Department's understanding of issues relating to hard-to-reach populations and developing outreach strategies recommended by such studies.

As stated above, the commonwealth is committed to assuring that children receive the health care coverage for which they are eligible (either CHIP or Medicaid). The application submitted by the parent or guardian is automatically evaluated at the local County Assistance Office (CAO) for the appropriate health care program. This practice negates the need for the parent or guardian to file separate applications for the two programs and facilitates enrollment of the child. Additionally, the Department is making a concerted effort to have the CHIP MCOs identify children who are potentially eligible for Medicaid due to a serious illness or disabling condition.

The Department has worked to expand access and simplify the application and renewal process for the CHIP and Medicaid programs through the development of an online application and renewal system called COMPASS (Commonwealth of Pennsylvania Access to Social Services). This web portal allows citizens to screen and apply for CHIP or Medicaid as well as many other social service programs across several Commonwealth agencies with one application. The Department provides administrative funding for toll-free helplines that can answer citizens' questions about CHIP, Medicaid, and various other social service programs, as well as assist callers with completing applications over the phone, utilizing COMPASS.

In 2003, shortly after being sworn into office, Governor Edward G. Rendell created the Governor's Office of Health Care Reform (GOHCR) aimed at improving access, affordability and quality by rejuvenating the state government's approach to health care. In January 2004, Pennsylvania launched a statewide data collection effort to more accurately define the characteristics of the state's uninsured. This effort was repeated in 2008. In July 2004, the GOHCR was given the lead responsibility to apply for a State Planning Grant through the Health Resources and Services Administration (HRSA). The purpose of the grant was to develop a comprehensive plan to provide access to affordable, quality health care coverage for every Pennsylvanian.

In keeping with that goal, in early 2006, the Governor introduced the Cover All Kids expansion that makes CHIP benefits available to all eligible children in the commonwealth. Later that year, eligibility was expanded to cover all children in Pennsylvania through either Medicaid or CHIP. Following federal approval in February 2007, enrollment began in the expanded program in March 2007.

Pennsylvania has added a post application screening process to COMPASS. If a family applies for any of the social services accessed by COMPASS other than Medicaid or CHIP, at the end of the application, the family is made aware of the fact that it appears they are eligible for Medicaid or CHIP and asks if they wish to apply. The information is then pulled from the current application into the application for access to health care. COMPASS then requests any additional information from the family, screens for eligibility and routes the application to the CAO for an eligibility determination.

Upon receipt of an application for benefits, the Medicaid or TANF agency processes the application and ensures that the application contains all information required to make an eligibility determination. If additional information is needed,

the caseworker contacts the applicant to inform the applicant of the required information and explains what, if anything, needed to verify the information. The caseworker verifies information such as gross income, household composition, citizenship, identity, and third party insurance. After verifying all required information, the caseworker determines if the applicant is eligible for Medical Assistance or CHIP. The applicant has the opportunity to appeal any eligibility decision made by the CAO or to request a reassessment. If additional information is provided by the applicant that allows the CAO to determine the applicant is eligible for a lower cost or the free program (different household size, reduction in income since applying, and the like), eligibility is redetermined and the applicant is enrolled in the appropriate category of CHIP.

Other state agencies that have fiscal liability or legal responsibility for the accuracy of data used in eligibility determination findings may be included in the future (i.e. Child Support Enforcement, Child Care Subsidy, School Lunch Program and the like).

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:

CHIP insurance company contractors are mandated by contract to conduct outreach activities.

Each CHIP contractor is required to provide the following outreach information:

- Identification of outreach objectives and activities for the contract period;
- Description of activities to locate potentially eligible children;
- Requirement that outreach materials be linguistically and culturally appropriate, and that outreach services include specific provisions for reaching special populations;
- Indication of whether the contractor will employ a dedicated marketing staff, and if not, submission of a program to assure special efforts are coordinated within overall outreach activities.

Operationally, outreach activities include canvassing local businesses, child care centers, school districts, CAOs, hospitals/providers, legislative offices, religious organizations and churches, social service agencies, unions and civic groups, and numerous other organizations and groups.

All contractors employ bilingual representatives who are capable of responding to CHIP inquiries in either English or Spanish. TDD lines allow for communication with the hearing impaired and access to multiple language translating services are also available.

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42 CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.
See Section 5.1.1.

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

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

The Commonwealth is committed to providing access to quality health care coverage and to improving access to coverage. The achieve this goal, the office of CHIP meets regularly with public advocates from the statewide advocacy community dedicated to increasing awareness and enrollment in both CHIP and Medicaid. Senior and management staffs of the Department of Human Services, Health, and Education are consulted to do strategic planning, to monitor progress, collaborate, share resources, and to problem solve.

The agenda for increasing awareness and enrollment includes but is not limited to:

- Broad based marketing strategies using television, Internet, social media and radio advertising to increase public awareness of the program and to encourage families to enroll their children.
- Targeted marketing to special populations to address cultural diversity and barriers to participation.
- Strong relationships with other public and private agencies to promote outreach and enrollment activities.
- Utilizing (e.g. on-line application) technology to create optional methodologies for enrollment in CHIP.
- Establishing a single statewide toll-free number (1-800-986-KIDS) to provide access to helpline staff who inform, refer, and assist in applying for CHIP and Medicaid.
- Increasing access to coverage by improving eligibility and enrollment practices.
- Conducting market research to improve targeted marketing and outreach.

- Measuring the effectiveness of all efforts by gathering and analyzing available data.

Section 6. Coverage Requirements for Children's Health Insurance

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

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

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

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

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

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.)

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.

6.1.3. ☒ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

A. Benefits Package: See Appendix B, Benefits Chart. Also, note Section 6.2. which denotes benefits provided by Contractors beyond the minimums required by the Act.

B. Administration: CHIP is administered by the Department of Human Services (see Appendix A, Section 2311 (G)(1)). The Department of Human Services is required by statute to:

(1) Review all bids and approve and execute all contracts for the purpose of expanding access to health care services for eligible children (See Appendix A, Section 2311 (G)(2)):

(2) Conduct monitoring and oversight of contracts entered into (See Appendix A, Section 2311 (G)(3)):

(3) Issue an annual report to the Governor, the General Assembly, and the public for each fiscal year outlining primary health services funded for the year, detailing the outreach and enrollment efforts, and reporting by county the number of children receiving health care services from the fund, and the projected number of eligible children (see Appendix A, Section 2311 (G)(4)):

(4) In consultation with other commonwealth agencies , monitor, review and evaluate the adequacy, accessibility and availability of services delivered to enrolled children (see Appendix A, Section 2311 (G)(6)):

(5) Promulgate regulations necessary for the administration of the program (see Appendix A, Section 2311 (H)):

(6) Establish the Children's Health Insurance Advisory Council (see Appendix A, Section 2311 (I)):

(7) Solicit bids and award contracts through a competitive procurement process (see Appendix A, Section 2311 (J)):

(8) In consultation with appropriate commonwealth agencies, review enrollment patterns for the program (see Appendix A, Section 2311 (N)): and

(9) In consultation with appropriate commonwealth agencies, coordinate the development of an outreach plan to inform potential contractors, providers and enrollees regarding eligibility and available benefits (see Appendix A, Section 2312).

C. Program Enactment and Effective Date: The Children's Health Insurance Act, 62 P.S. §§ 5001.101, et seq., was enacted in December 1992 and implemented in May of 1993. The Act was amended on June 17, 1998 by Act 68 of 1998, 40 P.S. §§ 991.2301 et seq., and on November 2, 2006 by Act 136 of 2006 (see Appendix A).

D. Fiscal year 1996 state expenditures for CHIP are as follows:
CHIP expenditures in fiscal year 1996 totaled $31,611,373, including an expenditure of $30,685,814 for its Free Program, and $915,559 for its

Subsidized Program.

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

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

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

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

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage.

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only in New York, Pennsylvania or Florida. (under 42 CFR 457.440)

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).

6.1.4.7. ☐ Other. (Describe)

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

The state assures that no annual, lifetime or other aggregate dollar limitations are imposed on any medical or dental services covered under the CHIP State plan consistent with 42 CFR 457.480(a).

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

Inpatient benefits for medical and mental health hospitalizations, medically related and mental health inpatient rehabilitation, and skilled nursing facilitywhere patients can receive skilled nursing services 24 hours a day are covered. Inpatient hospitalization includes pre-admission testing, semi-private room unless a private room is medically necessary, board general nursing care, intensive or special care facilities, operating room and related facilities, anesthesia, oxygen, therapy services, and any other services normally provided with inpatient care. No day limits apply. Preauthorization is required for non-emergency services. Covered services include inpatient therapy up to 45 visits per calendar year for treatment of

CVA (stroke), head injury, spinal cord injury, or as a resul cord injury, or as

a result of a post-operative brain injury.

Inpatient rehabilitation stays are covered when a member requires skilled rehabilitation services on a daily basis. Requires a physician's prescription. No day limits apply.

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

Outpatient Hospital Services include medical services, counseling or therapeutic treatment or supplies received from an approved health care facility while not an inpatient. Outpatient physical health services related to ambulatory surgery, outpatient hospitalization, specialist office visits, follow up visits or sick child visits with a PCP are included. The are no visit limits.

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

Includes routine and preventive care, sick and urgent care visits, follow-up care after emergency services, blood lead level testing, immunizations and specialist visits. Primary and preventive care includes, but is not limited to, well-child care, health education, TB testing, physical examinations including X-rays as needed for any child exhibiting signs of possible abuse. Also including, but not limited to, injections and medications, wound dressing, casting to immobilize fractures. Physician office visits for the examination, diagnosis and treatment of an illness at the member's PCP office, during or after regular office hours, emergency visits, house-calls in the physician's service area, and telehealth services with a family practitioner, general practitioner, or pediatrician are covered. There are no limits.

Specialist services covers care in any accepted medical specialty or subspecialty. Covers office visits, diagnostic testing, and treatment if medically necessary and the member has an illness or condition outside the scope of practice of the member's PCP. PCP referral is not required. Some services provided by a specialist may require preauthorization. Services must be within the scope of practice of the specialist.

Chiropractic services including spinal manipulations or of other body parts as treatment of diagnosed musculoskeletal conditions. Consultations and X-rays are included. Limited to 20 visits per year. Preauthorization may be required.

Immunizations: coverage is provided for pediatric immunizations, including immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP). No copays apply. Immunizations required for employment or travel are not covered.

Injections and medications including all injections and medications

provided at the time of the office visit or therapy and outpatient surgery performed in the office, a hospital, or freestanding ambulatory service center. Includes immunizations described above and anesthesia services when performed in conjunction with covered services, including emergency services. Must be medically necessary.

Gender transition services includes coverage related to gender affirming services that otherwise fall within the beneficiary's scope of covered services including physician services, inpatient and outpatient hospital services, surgical services, prescribed drugs, therapies, and behavioral health care. Medical necessity is to be determined utilizing the World Professional Association for Transgender Health (WPATH) guidelines and any successor to WPATH guidelines.

Services provided for a sudden onset of a medical condition that is accompanied by rapidly progressing symptoms such that the member would suffer serious impairment or loss of function of a body part or organ, or whose life or life of an unborn child would be in in danger. No limits apply.

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

Surgical services include services provided for treatment of disease or injury. Surgery performed for the treatment of disease is covered on an inpatient or outpatient basis. Cosmetic surgery intended solely to improve appearance, but not to restore bodily function or to correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes (excluding surgery resulting from an accident) is not covered. Includes anesthesia administered by or under the supervision of a specialist other than the surgeon, presence of an assistant surgeon, or other attending specialist. Includes general anesthesia and hospitalization and other expenses normally incurred with administration of general anesthesia. Consultations for a second opinion to determine the medical necessity of elective surgery or when an enrollee's family desires another opinion about medical treatment is covered. No referral is needed for consultation. Surgical services may require preauthorization.

Mastectomy and breast reconstruction benefits are provided for a mastectomy performed on an inpatient or outpatient basis. Benefits include all stages of reconstruction on the breast on which the mastectomy has been performed, surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to, augmentation, mammoplasty, reduction mammoplasty, mastopexy, and surgery on the other breast to produce a symmetrical appearance. Covers surgery for initial and subsequent insertion or removal prosthetic devices to replace a removed breast or portions of the breast, and treatment of physical complications of all stages of mastectomy, including lymphedema. Coverage is also provided for one Home Health Care visit, as determined by the member's physician, received within forty-eight (48) hours after discharge.

Oral surgery may be performed at an inpatient or outpatient facility depending on the nature of the surgery and medical necessity. Examples of covered services include: removal of partially or fully impacted third molars (wisdom teeth), non-dental treatments of the mouth relating to medically diagnosed congenital defects, birth abnormalities, surgical removal of tumors, cysts and infections, surgical correction of dislocated or completely degenerated temporomandibular joints, incision and drainage of abscesses, and baby bottle syndrome. Preauthorization is required. Must be medically necessary.

Reconstructive surgery will only be covered when required to restore function following accidental injury, result of a birth defect, infection, or malignant disease or in relation to gender transition surgery deemed medically necessary in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of 18; or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a mastectomy. Preauthorization required. Must be medically necessary.
Organ transplants includes transplants that are medically necessary and not considered to be experimental or investigative. Also includes immunosuppressants. Preauthorization is required. Must be medically necessary.

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

Covers care at walk-in medical facilities for conditions that do not require emergency care but that need to be treated within 24 hours. Coverage includes medical care at a Retail Health Clinic staffed by a Certified Registered Nurse Practitioner (CRNP) supported by a local physician who is on-call during clinic hours, or at an Urgent Care Center. No visit limits apply.

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

Includes any substance taken by mouth, injected into a muscle, the skin, a blood vessel, or a cavity of the body, or applied topically to treat or prevent a disease or condition, dispensed by order of a health care provider with applicable prescriptive authority. Contractors may use a closed or restrictive formulary provided it meets the minimum clinical needs of CHIP enrollees. A mail order or designated pharmacy process can be used for maintenance prescriptions. A generic drug will be automatically substituted for a brand-name drug whenever a generic formulation is available unless the physician indicates that the brand-name version of the drug is medically necessary.

Pharmacy services for preventive medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin,

smoking deterrents, vitamin D supplements, tamoxifen, and raloxofene are considered preventive medications and are covered at no cost to the member when filled at a participating pharmacy with a valid prescription. Members need to call their insurance provider regarding questions on coverage.

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

Covered when the drug is a part of the formulary, the member has a prescription for the drug, and a documented medical condition that indicates the drug is medically necessary. Copays may apply.

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

Diagnostic services, laboratory and X-ray services, EKGs, EEGs, and other diagnostic services related to the diagnosis and treatment of illness or injury provided on an inpatient or outpatient basis. Requires an order by a PCP, specialist, or facility provider. Some services may require preauthorization.

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

Prenatal and pregnancy family services combined with 6.2.2, 6.2.3, 6.2.4, and 6.2.5 related services are covered. Includes, but is not limited to, birth control pills, injectables, transdermals (patches), and insertion and implantation of contraceptive devices approved by the FDA, voluntary sterilization, and counseling. Abortifacient drugs are not covered. There are no copays when services are provided by a participating provider.

Women's health services covers those services described under the Women's Preventive Services provisions of the Affordable Care Act. Sex-specific services will not be denied or limited based on gender identity which does not align with the sex that generally receives that service. Covered services include, but are not limited to, the following services. There are no copays for preventive services. Routine gynecological exams including a pelvic exam, clinical breast exam, and routine Pap smear. Limited to one annual gynecological exam and one Pap smear per year. Includes counseling, education, and related services to prevent and address the consequences of at-risk behaviors related to sexually transmitted diseases (STDs) and pregnancy. Each Enrollee may utilize her PCP or she may directly choose any participating professional provider delivering gynecological services without referral.

Mammograms: Screening and diagnostic mammograms are covered when performed by a qualified mammography service provider who is certified by the appropriate state of federal agency in accordance with the Mammography Quality Assurance Act of 1992. There are no copays for this service.

Breast feeding: Comprehensive support and counseling from trained providers, access to breastfeeding supplies, including coverage for renting of hospital-grade breast pumps under DME and medical necessity review, and coverage of lactation. support and counseling provided during postpartum hospitalization, mother's options visits, and obstetrician or pediatrician visits for pregnant or nursing mothers with no cost sharing to the member. No copays. Must be medically necessary.

Obstetrical services include prenatal, intrapartum, and postpartum care, including care related to complications of pregnancy and childbirth. Services provided by a participating hospital or birthing center are covered. No copays apply.

Osteoporosis screening is covered for bone mineral density testing using a U.S. FDA approved method. Requires a prescription from a legally licensed provider.

Maternity home care visits are covered for at least one (1) visit provided at the Enrollee's home when the CHIP member is released prior to 48 hours of inpatient care following a vaginal delivery or 96 hours following a Cesarean delivery, or in the case of a newborn, in consultation with the mother or the newborn's representative.

Newborn care includes the provision of benefits for a newborn child of an enrollee for a period of thirty-one (31) days following birth. Includes routine nursery care, prematurity services, preventive/ well-child health care services, newborn hearing screens, and coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. No limits apply.

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))

Durable medical equipment is covered when medically necessary. Some services may require prior authorization. Includes rental or purchase, delivery and installation of equipment designed to serve a medical purpose for a medical condition, is intended for repeated use, and is not disposable, and is appropriate for home or school use. Replacement or repair is covered for normal wear and tear when medically necessary due to the growth of the child. Orthotic devices includes the purchase, fitting, necessary adjustment, repairs and replacement of rigid or semi-rigid device designed to support, align, or correct bone and muscle injuries or deformities. Replacements are covered when the replacement is deemed medically necessary and appropriate due to the growth of the child.

Prosthetic devices includes the purchase of prosthetic devices and supplies

required as a result of injury or illness to replace part of all of an absent body part or to restore function to a permanently malfunctioning body organs. Includes purchase, fitting, and necessary adjustment of prosthetic devices. Replacements are covered when deemed medically necessary due to the normal growth of the child.

The vision benefit covers one routine examination and refraction every calendar year, including dilation if professionally indicated. The vision benefit covers one frame in any 12-month period unless a second frame is medically necessary. Lenses are limited to once every six months and a prescription change must be documented for a second set of lenses to be covered within a 12 month period of time. Replacement of lost, stolen, or broken frames and lenses is covered once in a calendar year if medically necessary. One prescription for contact lenses is covered per calendar year. Contact lenses are covered in lieu of glasses when medically necessary for vision correction.

Prosthodontic dental devices are covered as a part of a member's dental benefit.

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

Includes ostomy supplies and urological supplies when medically necessary. No limits apply.

Diabetic treatment, equipment, and supplies includes blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, and outpatient management training and education. Physician orders required.

Medical foods include medical foods and prescribed nutritional formulas used to treat PKU and related disorders given orally or by tube feeding. No limits apply.

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

Covered for homebound patients, including nursing care, home health aide services, oxygen, medical and surgical supplies and home infusion therapy. Home infusion therapy does not include blood or blood products. Private duty nursing and custodial services are not covered. No copays apply. No visit limitations.

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

Skilled nursing services: medically necessary skilled nursing and related services are covered on an inpatient basis in semi-private accommodations for patients requiring skilled nursing services, but not requiring confinement in a hospital. No day limits apply

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)

Rape or incest must have been reported to law enforcement authorities or child protective services, unless the treating physician certifies that in his or her professional judgment, the member is physically or psychologically unable to comply with the reporting requirement. Includes only abortions that satisfy the requirements of 18 PA C.S.§3204-3206 and 35 P.S. §§ 10101, 10103-10105. Covered abortions include those that meet the following criteria:

A physician has certified that the abortion is necessary to save the life of the mother or the abortion is performed to terminate a pregnancy resulting from an act of rape or incest reported within 72 hours from the date when the female first learned she was pregnant. Services rendered to treat illness of injury resulting from an elective abortion are covered. The contractor and its subcontractors will respect the conscience rights of individual providers and provider organizations and comply with Pennsylvania law prohibiting discrimination on the basis of the refusal or willingness to participate in certain abortion and sterilization activities as outlined in 43 P.S. §955.2 and 18 PA C.S.A. §3213(d). Elective abortions are not covered.

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)

Services include diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, oral and maxillary surgery, orthodontic, and adjunctive dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions as mandated by law. Cosmetic related services are not covered. Covered services are listed in the CHIP Dental Benefits Plan.

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

Includes the cost of exams, corrective lenses, frames, or contacts in lieu of glasses or when medically necessary. Limited to one exam every 12 months unless an additional exam is medically necessary. Includes dilation if professionally indicated. Covers one pair of prescription eyeglass lenses and one frame, unless a second frame is medically necessary, or contacts every calendar year. Eyeglass lenses may be plastic or glass, single vision, bifocal or trifocal, lenticular lens powers and/or oversize lenses, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses, or polycarbonate prescription lenses with scratch resistant coating. There may be copayments for optional lens types and treatments.

Frames in network are provided at no cost to the member. There is an allowance of $130 in a twelve-month period. Expenses in excess of $130 allowance are payable by the member. A 20% discount applies to any amount over $130.

The replacement of lost, damaged, or stolen corrective lenses, frames, and medically necessary contacts will occur once per year (one original and one replacement). A referral from a PCP is not required to see a vision provider. There is no copayment for routine eye examinations, covered standard eyeglass lenses or contact lenses. If any vision service is provided under the medical benefit for a diagnosis of cataracts, keratoconus, or aphakia, a copayment may apply.

Coverage includes one comprehensive low vision evaluation every five (5) years, with a maximum charge of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for item such as high-power spectacles, magnifiers and telescopes, and follow up care - four visits in any five-year period, with a maximum charge of $100 per visit. Providers will obtain the necessary preauthorization for these services.

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

Hearing aids and devices and the fitting and adjustment of such devices are covered when determined to be medically necessary. Payment limited to one routine hearing examination and one audiometric examination per calendar year.

Includes the cost of examinations and one hearing aid or device per ear every two calendar years.

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

Services may be coordinated through MCO Special Needs Units or Case Management units. Case management provides support to members experiencing complex medical conditions or chronic illnesses through ongoing assessment, care planning, and monitoring.

The primary purpose of Case Management is to ensure that each CHIP member receives access to appropriate primary care, access to specialists trained and skilled in the needs of the member, information about the access to a specialist as PCP if appropriate, information about and access to all covered services appropriate to the member's condition or circumstance, including pharmaceuticals and DME, and access to needed community services.

Services are available to all CHIP members enrolled with the MCO. There

are no requirements for a case management referral. Members are not required to participate in the case management program but may opt out. There is no limit to the member's access to case management.

6.2.23. ☒ Care coordination services (Section 2110(a)(21))

The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

6.2.24. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22)) Speech, occupational, and physical therapy are limited to 60 outpatient visits per year per type of therapy. Members must have a documented diagnosis that indicates the prescribed therapy is medically necessary.

Outpatient habilitation services are health care services that help a person keep, learn, or improve skills and functioning for daily living. Services include physical, occupational, and speech therapy services for people with disabilities in a variety of outpatient settings. Limited to 60 visits per year per each type of therapy for a combined visit limit of 180 days per calendar year.

6.2.25. ☒ Hospice care (Section 2110(a)(23)) Care for a member who is suffering from a terminal illness. Respite care is also included. Requires a certification by a physician stating that the member has a terminal illness. There are no day limits. Members receiving hospice care may still receive care for other illnesses and conditions.

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

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

Outpatient medical therapy services (chemotherapy, radiation therapy, dialysis, and respiratory therapy) are unlimited. Requires a documented diagnosis that necessitates the prescribed service.

Qualifying clinical trials conducted in relations to prevention, detection and treatment of cancer or other life-threatening disease or condition. Covers

items and services consistent with what the plan normally covers. Requires notification of participation in the trial before enrolling in that trial.

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 biologic that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

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

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

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

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

Transportation services by land, air, or water ambulance are covered only in response to an emergency or when determined to be medically necessary.

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

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

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

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

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

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

Pennsylvania Children Health Insurance Program (PA CHIP) has chosen to adopt the American Academy of Pediatrics/Bright Futures periodicity schedule for behavioral health screenings and assessments. There is no difference in coverage within the PA CHIP population.

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

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

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

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

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

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

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

To facilitate the implementation of the use of age-appropriate validated behavioral health screening tools in primary care settings, PA CHIP will be requiring the managed care organizations (MCOs) and their networks to use the approved tools outlined below. PA CHIP will be issuing a policy transmittal requiring the MCOs to implement the requirements of Section 5022 of the SUPPORT Act, including the use of validated behavioral health screening tools in primary care settings. This policy clarification will be distributed to MCO utilizing the standard email distribution method and announced at the appropriate CHIP MCO bi-weekly meeting. The screening tools listed below are from the recommendations of AAP Bright Futures

periodicity schedule and the United States Public Preventative Services Task Force. (USPSTF). PA CHIP will allow the MCOs to choose any tool from the list to administer to the CHIP population.

Validated Behavioral Health Screening Tools:

- A Safe Environment for Every Kid (SEEK) Questionnaire.
- Accountable Health Communities Core Health-Related Social Needs Screening Questions.
- Ages and Stages Questionnaire (ASQ-3).
- Ages and Stages Questionnaire: Social-Emotional (ASQ-SE-2)
- BITSEA.
- Center for Youth Wellness ACE Questionnaire (CYW ACE-Q).
- Communication and Symbolic Behavior Scales - Developmental Profile.
- Early Childhood Screening Assessment (ECSA).
- Edinburgh Postpartum Depression Scale (EPDS).
- Health Leads Screening Tool.
- Hunger Vital Sign.
- Income, Transportation, Housing, Education, Legal Status, Literacy, and Personal Safety (IHELLP).
- Modified Checklist for Autism in Toddlers (M-CHAT-R/F).
- Parents' Evaluation of Developmental Status (PEDS).
- Parents' Evaluation of Developmental Status- Developmental Milestones (PEDS-DM).
- Patient Health Questionnaire-2 (PHQ-2).
- Patient Health Questionnaire-9 (PHQ-9).
- Pediatric Symptom Checklist (Baby & Preschool).
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE).
- Social Communication Questionnaire.
- Strengths & Difficulties Questionnaire.
- Survey of Wellbeing of Young Children.
- Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education Survey Instrument (WE CARE).
- Whole Child Assessment.

PA CHIP Quality Assurance staff will monitor the SUPPORT Act requirements annually via on-site visits and the use of the SMART tool. The CHIP Eligibility and Benefits Handbook outlines all services and benefits available to enrollees through CHIP regardless of their chosen MCO. During the on-site monitoring visit, PA CHIP will assure that an MCO's documents, policies and procedures comply with provisions listed related to:

- Screening and Prevention – ensure MCOs are covering behavioral health related screenings and preventive service and using age appropriate, validated screening tools.
- Treatment and Assessment – reviewing behavioral health benefit

package being offered to CHIP enrollees and that the MCOs are using validated clinical assessment tools and are consistent with 42 CFR 457.495 and section 2103(c)(5).

- Cultural and Linguistic Considerations – review of policies and procedures and any pertinent document as it relates in accordance with 42 CFR 457.110, 457.340 (e), 457.1230. (a) for linguistically appropriate services and following 42 CRF 457.1230(a) for culturally competent care.
- Access to Care – reviewing policies and procedures that don't hinder a member's access to care in accordance with 42 CFR 457.495 and 457.1230.
- Access to covered services.

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

Outpatient mental health services are not limited and include partial hospitalization and intensive outpatient mental health services, psychological testing; visits with outpatient mental health providers, individual, group, and family counseling targeted mental health case management and resource coordination; and prescription drugs. Outpatient mental health services includes behavioral health services. Intensive in-home treatment, day treatment, emergency services, and continuing care are included. No limits on visits per benefit year apply. No copays apply.

Non-hospital residential treatment and outpatient treatment for substance use disorder is covered without limits on number of visits. This includes partial hospitalization patient programs, detoxification, and intensive outpatient programs. Services provided in a facility licensed as an addiction treatment program by the of Department of Drug and Alcohol Program. Covers services of physicians, psychologists, psychiatrists, counselors, trained staff, laboratory and psychological or psychiatric testing, individual and family therapy. No copays apply.

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

Psychosocial treatment is included as part of outpatient services under definition 6.3.2 and inpatient services under definition 6.3.4. Peer Support is included as part of psychosocial treatment (i.e. group counseling). Caregiver Support is part of psychosocial treatment (i.e. group and family counseling).

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

CHIP's tobacco cessation benefit includes counseling sessions, pharmaceutical cessation products including nicotine replacement therapy, and member education and support programs. All FDA approved tobacco cessation products are included in this benefit. This benefit will have no limitations as of 10/24/2019.

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

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

6.3.2.3.1- BH ☒ Opioid Use Disorder

PA CHIP covers medication assisted treatment (MAT) for substance use disorders and opioid use disorders. PA CHIP covers all FDA approved products for treatment of Substance Use Disorder including Opioid Use Disorder.

6.3.2.3.2- BH ☐ Alcohol Use Disorder

6.3.2.3.3- BH ☐ Other

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

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

6.3.2.6- BH ☐ Respite Care
Provided for: ☐ Mental Health ☐ Substance Use Disorder
Children in need of respite care are evaluated for eligibility in Medicaid.

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

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder
Intensive outpatient services are provided as part of outpatient services as defined in 6.3.2.

6.3.2.9- BH ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☒ Substance Use Disorder
Psychosocial rehabilitation are included as part of
Psychosocial rehabilitation is included as part of outpatient services under definition 6.3.2 and inpatient services under definition 6.3.4.

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 is included as part of outpatient services under definition 6.3.2 and inpatient services under definition 6.3.4.

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

Partial hospitalization as part of outpatient services under definition 6.3.2.

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

Covers medical care including psychiatrist visits and consultations, nursing care, group or individual counseling, and therapeutic services, and concurrent care and services normally provided relating to inpatient hospitalization. Members as young as fourteen may self-refer. No day limits apply. Service covers residential treatment, day treatment, emergency services, No copays apply.

Includes services provided in a hospital or an inpatient non-hospital facility that meets the requirements established by the Department of Health and is licensed as an alcohol/drug addiction treatment program by the of Department of Drug and Alcohol Program. Covers detoxification stays, services of physicians, psychologists, psychiatrists, counselors, trained staff, laboratory and psychological/psychiatric testing, individual and family therapy and interventions and medication management and services normally provided to inpatients. No day limits apply. No copays apply.

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
Residential treatment is included as part of inpatient services as defined in 6.3.4. Residential treatment services include psychological testing, visits with outpatient mental health providers, individual, group, and family counseling targeted mental health case management and resource coordination, and prescription drugs are all covered residential treatment services.

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

Detoxification is included as part of outpatient services under definition 6.3.2 and inpatient services under definition 6.3.4.

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
Emergency services are specifically covered under Appendix B, CHIP Benefits Package. Crisis intervention and stabilization are part of these services. There are no limits to this service.

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

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

6.3.7- BH ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder
Care coordination for mental health and substance use disorder is included as part of Care Coordination services under 6.2.23.

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

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

6.3.8- BH ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder
Case management for mental health and substance use disorder is part of case

management definition under 6.2.22. Definition includes care transition services and intensive wraparound.

6.3.9- BH ☒ Other

Provided for: ☒ Mental Health ☐ Substance Use Disorder

In accordance with the Pennsylvania Autism Insurance Act (Act 62), prescription drug coverage and over the counter drug coverage, services of a psychiatrist and/or psychologist, and rehabilitative and therapeutic care including applied behavioral analysis, speech/language, occupational, and physical therapy for the purposes of treating a confirmed diagnosis of autism. Covers evaluations and tests performed to diagnose autism disorder are covered without limits. no limits apply. Members are eligible to use the expedited appeals process defined in Act 62 for Autism related complaints and grievances.

6.4- BH Assessment Tools

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

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

☒ InterQual
☒ Mental Health ☒ Substance Use Disorders

☒ MCG Care Guidelines
☒ Mental Health ☒ Substance Use Disorders

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

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

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

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

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

☐ Other (please describe)

☐ Mental Health ☐ Substance Use Disorders

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

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

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

Because CHIP MCOs are already using age-appropriate validated behavioral health screening tools in primary care settings, PA CHIP intends to issue a policy clarification with a retroactive effective date of October 24, 2019 so the policy aligns with the effective date of the SPACHIP will review the clarification at its earliest MCO biweekly call so all MCOs are aware of the provisions. Monitoring to the provision will begin in March 1, 2021, the start date of the fourth fiscal quarter monitoring.

The MCO must continue to use one or more of the validated clinical assessment tools below for assessment behavioral health conditions. PA CHIP will allow the MCOs to select any assessment tool from the list below to utilize for mental health and substance use disorder conditions.

Validated Clinical Assessment Tools for Behavioral Health Conditions:
- ASAM Criteria (American Society Addiction Medicine).
- InterQual.
- MCG Care Guidelines.
- CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization. System).
- CASII (Child and Adolescent Service Intensity Instrument).
- CANS (Child and Adolescent Needs and Strengths).

PA CHIP Quality Assurance staff will monitor the SUPPORT Act requirements annually via on-site visits and the use of the SMART tool. The CHIP Enrollment and Benefits Handbook outline all services and benefits available to enrollees through CHIP regardless of their chosen MCO. During the on-site monitoring visit, PA CHIP will assure that an MCO's documents, policies and procedures comply with provisions listed related to:

- Screening and Prevention – ensure MCOs are covering behavioral health related screenings and preventive service and using age appropriate, validated screening tools.
- Treatment and Assessment – reviewing behavioral health benefit package being offers to CHIP enrollees and that the MCOs are using validated clinical assessment tools and are consistent with 42 CFR 457.495 and

section 2103(c)(5).

- Cultural and Linguistic Considerations – review of policies and procedures and any pertinent document as it relates in accordance with 42 CFR 457.110, 457.340 (e), 457.1230. (a) for linguistically appropriate services and following 42 CRF 457.1230(a) for culturally competent care.
- Access to Care – reviewing policies and procedures that don't hinder a member's access to care in accordance with 42 CFR 457.495 and 457.1230.
- Access to covered services.

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

6.2.1-DC ☐ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[12]) codes are included in the dental benefits:

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

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

☐ State-developed Medicaid-specific
☒

American Academy of Pediatric Dentistry
☐ Other Nationally recognized periodicity schedule
☐ Other (description attached)

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

6.2.2.1-DC ☒ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[13] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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

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

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

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

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered

benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

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

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☒ International Classification of Disease (ICD) See Mental Health Parity and Addiction Equity Act cover letter, section MH/SUD AND M/S CONDITIONS

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☐ Other (Describe:)

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

☒ Yes

☐ No

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

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

☐ Yes

☒ No

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐ All children covered under the State child health plan.

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

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

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR

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

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

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

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

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

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

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

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

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

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

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

The office of CHIP has defined the four benefit classifications to align with definitions in Pennsylvania's Code:

Inpatient: All covered services or items provided to a beneficiary who has been admitted to a 24-hour facility.

Outpatient: All covered services or items that are provided to a beneficiary that do not otherwise meet the definition of inpatient, prescription drug or emergency care

Emergency Care: All emergency services or items that meet the Commonwealth's definition of emergency services delivered in an Emergency Department setting. Emergency services are those services needed to treat or evaluate an emergency medical condition which is an injury or illness that due to the severity, a reasonable person with no medical training would feel that there is an immediate risk to a person's life or long-term health.

Prescription Drugs: Covered medications, drugs and associated supplies requiring a prescription. Includes drugs claimed using the NCPDP claim forms and adjudicated through a pharmacy benefit manager.

6.2.3.1.1 MHPAEA The State assures that:

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

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

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

☐ Yes

☒ No

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

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

6.2.3.2 MHPAEA The State assures that:

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

Annual and Aggregate Lifetime Dollar Limits

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

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

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☒ No dollar limit is applied

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

☐ Yes (Type(s) of limit:)

☐ No

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

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

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

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

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

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

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

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

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

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

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

Quantitative Treatment Limitations

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

☐ Yes (Specify:)

☒ No

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

☐ Yes

☐ No

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

expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

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

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

☐ Yes

☐ No

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

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

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to

medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Non-Quantitative Treatment Limitations

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

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

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

Please refer to the OCHIP MHPAEA Cover Letter and attached MCO submissions. Each MCO conducted a compliance review and submitted a documentation package based on templates developed by OCHIP.

While the organization of each MCO submission was customized at the discretion of the MCO, generally each submission contains the following pertaining to NQTLs:

- Section 4 details the methodology used by the MCO to identify relevant NQTLs and conduct the analyses
- Appendix B contains an inventory of NQTLs applicable to MH/SUD benefits managed by the MCO
- Appendix D contains the MCO's side by side analyses of the MH/SUD and M/S NQTLs along with a final compliance determination.

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

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

☐ Yes

☒ No

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

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

Availability of Plan Information

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

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

☐ State

☒ Managed Care entities

☐ Both

☐ Other

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

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

☐ State

☒ Managed Care entities

☐ Both

☐ Other

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Yes
☒ No

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

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as

defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

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

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

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

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

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

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

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

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

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

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

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

☐ Yes
☐ No

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

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

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

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

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

6.5-Vaccine coverages

Guidance: States are required to provide coverage for age-appropriate vaccines and their administration, without cost sharing. States that elect to cover children under the State plan (indicated in Section 4.1) should

check box 6.5.1 States that elect to cover pregnant individuals under the State plan should also check box 6.5.2. States that elect to cover the from-conception-to-end-of-pregnancy population (previously referred to as the "unborn") option under the State plan should also check box 6.5.3.

6.5.1. ☒ **Vaccine coverage for targeted-low-income children.**
The State provides coverage for age-appropriate vaccines and their administration in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), without cost sharing. (Section 2103(c)(1)(D)) (42CFR 457.410(b)(2) and 457.520(b)(4)).

6.5.2. ☐ **Vaccine coverage for targeted-low-income pregnant individuals**.
The State provides coverage for approved adult vaccines recommended by the ACIP, and their administration, without cost sharing. (SHO # 23-003, issued June 27, 2023); (Section 2103(c)(12))

6.5.3. ☐ **Vaccine coverage for from-concentption-to-end-of pregnancy population option.**
The state provides coverage for age appropriate (child or adult) vaccines and their administration in accordance with the recommendations of the ACIP, without cost-sharing, to benefit the unborn child.

Section 7. Quality and Appropriateness of Care

☐ 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.

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)) (42 CFR 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.)

CHIP provides services to enrolled children through a managed care model. By state law and regulation, all of the CHIP Contractor delivery systems are state licensed managed care organizations (predominantly HMOs, though one of them uses gatekeeper PPO delivery systems in limited counties) which, as a condition of licensure, must undergo periodic external reviews of their quality assurance systems and the quality of care provided to their members. These reviews are required within one year of licensure and again at three-year intervals or for cause. The reviews are performed by the National Committee for Quality Assurance ("NCQA") with Health Department participation. The

scope of review includes a detailed examination of the plan's quality assurance/improvement program including access, availability, continuity of care, and preventive and health maintenance services to members, including CHIP-enrolled children. NCQA staff also independently assess managed care compliance with current state regulations on a periodic basis. The Department independently identifies opportunities for improvement for the CHIP program and institutes quality improvement performance measures via its contracted external quality review organization, as appropriate.

CHIP enrollees also have access to a complaint and grievance resolution process through their managed care plans. This process is mandated by state law (Act 1998-68) for all managed care organizations and requires members to go through a two-step process at the HMO level, with the second level including one-third member representation in the decision-making process. If the member is still dissatisfied, he or she has the right to appeal the plan's decision to the Department of Health (grievances) or the Department of Human Services (complaints). The Contractor is required to have a data system in place capable of tracking and trending all complaints and grievances. In addition to assuring that appropriate care is accessible to members, this process also enables the Department to track and identify patterns of inappropriate care or service.

7.1.1. ☒ Quality standards

The Department has established Quality Management and Utilization Management requirements to which the insurer is contractually bound. See **Appendix E** (Provided in the original State Plan) which contains requirements as specified in the Department's Request for Procurement.

7.1.2. ☒ Performance measurement

In addition to evaluating contractors based on their overall NCQA accreditation ratings, the program also conducts Healthcare Effectiveness Data Information Set (HEDIS) reviews which compare the CHIP population with the commercial subscribers of the insurer. In addition, the program has been completing direct comparisons of its HEDIS data with Medicaid programs regionally and nationally. The results from HEDIS reviews are used to investigate potential problem areas and institute quality improvement activities, as appropriate.

During FY 2000 the PA CHIP, for the first time, began collecting Earl data and continues to do so annually.

Since these initial efforts, CHIP has joined with the Department of Human Services in its contract with IPRO to develop standardized, clinically relevant, and evidence-based performance measures to facilitate evaluation of care provided by the health plans.

7.1.2 (a) ☐ CHIPRA Quality Core Set

7.1.2 (b) ☐ Other

7.1.3. ☒ Information strategies

All CHIP enrollees receive membership handbooks (see Appendix F (provided with the original State Plan submission), sample handbook which describes the benefits provided to enrollees under the Program). These materials also describe members' rights and responsibilities and the specific steps to appeal any medical or service issue to the plan and to the Department of Health. All service denials or reduction in benefits must also contain information about how to appeal the decision through the member grievance process. Contractors have developed a multitude of member educational materials and informational items that encourage CHIP enrollees to obtain age-appropriate health services and preventive care. These are distributed widely by the plans.

CHIP collects information from all CHIP Contractors on a quarterly and annual basis. This reporting provides information on CHIP enrollment, demographic, and ethnic characteristics, outreach efforts, use of medical and dental services, member grievance information, and data on financial expenditures. Information is used by program managers to document performance and promote adequate program accountability. The data elements are updated on specific needs as identified.

7.1.4. ☒ Quality improvement strategies

Several key initiatives mentioned herein are the basis for individual and collective quality improvement activities.

- Based on the clinical standards adopted and the data obtained from external reviews, each of the nine contractors have been required to identify appropriate mechanisms for improving the provision of preventative and health maintenance services for children enrolled in CHIP.

- The Department and the Contractors work together to implement interventions that will raise the rates of preventative services to conform with established CHIP goals. Such intervention includes:

    - patient information on the availability and necessity of services;
    - parent education;
    - a system of patient reminders;
    - member satisfaction surveys to detect barriers to accessing care;
    - community-based education;

- physician education;
- immunization registries which follow children across providers and insurance programs.

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

State-licensed HMOs are the principal contractor health service provider entities for CHIP enrollees. Under Pennsylvania statute, these entities are subject to oversight and regulation by the Department of Health and the Insurance Department, which also have joint licensing authority of these entities (see 40 P.S. 1551, et seq. and 31 Pa. Code, Chapters 301-303) The Insurance Department is primarily responsible for monitoring initial capitalization and financial solvency. The Department of Health is charged with monitoring quality of care and assuring the availability of and accessibility to health services.

To obtain licensure, certain requirements regarding availability and access must be satisfied by an HMO. These requirements are:

- coverage for basic health services, including emergency services;
- provisions for access to a primary care physician for each subscriber;
- evidence of arrangements for the ten most commonly used specialties;
- policies on obtaining referrals for specialty care;
- professional staff standards (for example, there must be at least one full-time primary care physician per 1600 members);
- physician and provider network capacities.

Many of these requirements are evaluated initially upon licensure; upon request for service area expansion; and periodically through complaint and grievance monitoring, on-site visits by Department of Health staff, external reviews by NCQA, and various quarterly and annual reports addressing the provider delivery systems of the CHIP Contractors.

As part of the annual re-contracting process, Contractor health service delivery system information is assessed to assure an adequate number and distribution of providers and facilities of all types

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

Primary care, including well-child care is provided in accordance with the schedule established by the American Academy of Pediatrics. Services related to those visits, include, but are not limited to, immunizations, health education, tuberculosis testing, and

developmental screening in accordance with routine schedule of well-child visits. Care must also include a comprehensive physical examination, including X-rays if necessary, for any child exhibiting symptoms of possible child neglect or abuse.

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

Contractors must establish and maintain adequate provider networks as determined by the Department of Health to serve all eligible children who are or may be enrolled, to include, but not be limited to: hospitals, children's tertiary care hospitals, specialty clinics, trauma centers, pediatricians, specialists, physicians, pharmacies, dentists, substance abuse treatment facilities, emergency transportation services, rehab facilities, home health agencies and DME suppliers in sufficient numbers and geographic dispersions to make available all services in a timely manner. Covered services must be provided out-of-network if such services are not available in a timely and accessible manner through in-network providers. In accordance with Article XXI Section 2111, of Act 1998-68, and 28 Pa. Code Sections 9.679(D) and 9.679(E), the contractor must have adequate health care available in a timely and accessible manner through its network providers.

Contractors cannot discriminate against CHIP enrollees by offering them access to physician services which differ from the access offered commercial enrollees. For example, a plan may not specifically close a practice to CHIP enrollees if the practice is open to commercial enrollees.

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

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)) (42 CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Decisions related to the prior authorization of health services are made in accordance with state law (Act 1998-68). Contractors must establish and maintain written policies and procedures relating to prior authorization of health services that must be submitted for review and comment by the Department. Contractors must individually identify service(s), medical item(s), and/or therapeutic categories of drugs to be prior authorized. In addition, the list and scope of services to be prior authorized must be approved by the Department.

The policies and procedures must include an expedited review process to address situations when an item or service must be provided in an urgent basis.

Contractors must demonstrate how written policies and procedures for requests for prior authorization comply and are integrated with the enrollee notification requirements and enrollee grievance and appeal procedures.

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? (42 CFR 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.

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)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

Children with a family net income of 208% of the FPL or less are not subject to any cost sharing requirements.

8.2.1. ☒Premiums:

If the family net income is determined to be above 208% of the FPL, the family will be required to share in the cost of the coverage. Premiums are based on a percentage of the negotiated rate with each MCO. The premium percentage bands are captured in the chart

Premium Tier	Federal Poverty Level (FPL)	Percentage of Negotiation Rate
Free	133% - 208%	0%
Low-Cost 1	208% - 262%	25%
Low-Cost 2	262% - 288%	35%
Low-Cost 3	288% - 314%	40%
Full Cost	Greater than 314%	100%

Full cost of coverage as negotiated by the Commonwealth with each of the MCOs.

This (>314% coverage) is a full payment program and is not included in any Title XXI funding.

Premiums are due to the contractors on an established date prior to the first of the month for which premiums are paid. Enrollees will have 30 days from the date when eligibility is determined to pay the initial premium payment or enrollment will be denied.

At the Commonwealth's discretion, premium payment due dates may be temporarily extended for CHIP applicants and existing beneficiaries who reside and/or work in a State or Federally declared disaster area.

8.2.2. ☐ Deductibles:

8.2.3. ☒ Coinsurance or copayments:
Coinsurance is not applicable
Copayments: For children in families with net income greater than 208% of the FPL, but less than 314% of the FPL, the Commonwealth has established reasonable copayments for all services except for the following: well-baby; well-child; immunizations; pregnancy related services; or emergency care that results in admissions.

Copayments are as follows:

Primary Care visits	$5
Specialists	$10
Emergency Care	$25 (waived if admitted)
Prescriptions	$6 for generic and $9 for brand names

Copayments for office visits are limited to physical health and do not include routine preventive and diagnostic dental services or vision services. Emergency care visits for mental health or substance use disorder services may be subject to the $25 emergency care copayment. Copayments will be due at the point of service.

At the Commonwealth's discretion, cost sharing may be temporarily waived for CHIP applicants and existing beneficiaries who reside and/or work in a State or Federally declared disaster area.

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 sections 2103(c)(11)(A) and 2103(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 sections 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 sections 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 sections 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)) (42 CFR 457.505(b))

Notice of the initial premiums and the cost sharing requirements were published in the Pennsylvania Bulletin prior to the requested effective date of the state plan amendment. Premiums, copayments, and the benefit plan were all included in statewide public hearings regarding the Cover All Kids initiative to expand Pennsylvania's CHIP. Adequate time was allotted for anyone to provide comment on any aspect of the expansion. This information was also shared at the following meetings in October 2006:

- **Medical Assistance Advisory Committee (MAAC) Presentation** – The commonwealth presented the plan and program design at a MAAC meeting, which is a monthly meeting conducted by DHS for the purpose of presenting and gaining input from stakeholders on issues of policy development and program administration. MAAC is open to the public and is composed of commonwealth citizens who have experience, knowledge, and interest in the delivery of health care services to low-income citizens and medically vulnerable groups. Members include physicians and other providers, representatives of managed care organizations under contract with the Department, representatives of consumer and provider organizations, current

Medicaid recipients and parents of minor child recipients. The commonwealth provides copies of the SPA it submits to CMS to committee members upon request.

- **Consumer Subcommittee of MAAC** – The commonwealth presented the plan and program design at a Consumer Subcommittee meeting, which is a monthly subcommittee meeting conducted by DHS for the purpose of reviewing and advising the MAAC on policy development and program administration of publicly funded medical assistance (MA) programs. The Consumer Subcommittee's mission is to be a resource to the MAAC, enabling the committee to advise the Department of Human Services on issues regarding access to service and quality of service. A majority of the members of the Consumer Subcommittee are current MA recipients and may also include representatives of: low-income groups whose membership is primarily medical assistance recipients; advisory groups advocating on health care issues for low-income Pennsylvanians; aging or elderly consumer groups advocating on health care issues for low-income Pennsylvanians; disease or health care condition specific groups; Hispanic or other ethnic groups advocating on health care issues for low-income Pennsylvanians; former recipients (within past year); parents of minor child recipients; families of recipients; and others knowledgeable and interested in matters that come before the Subcommittee. At least one, but no more than two, members of the Consumer Subcommittee may serve on other subcommittees.
- **Income Maintenance Advisory Committee (IMAC)** - The commonwealth presented the proposed waiver and program design at an IMAC meeting, which is a bi-monthly meeting conducted by DHS for the purpose of advising the Department on the development and implementation of policies and procedures relating to cash assistance, SNAP, the Low-Income Energy Assistance Program (LIHEAP) and eligibility for Medicaid. The IMAC is composed of 17 members: 12 Medicaid recipients, four advocates and an Executive Director of a County Assistance Office. The Committee Members meet every other month with Department staff in Harrisburg, Pennsylvania. The Commonwealth will provide copies of the SPA to Committee Members upon request.
- **CHIP Advisory Committee Presentation** – The commonwealth presented the plan and general program design at the CHIP Advisory Council meeting. The purpose of the CHIP Advisory Council is to advise the Commonwealth on CHIP outreach activities and to review and evaluate the accessibility and availability of services delivered to children enrolled in CHIP. This meeting is open to the public.

All of Pennsylvania's CHIP outreach and enrollment materials display the eligibility requirements, coverage types, and cost sharing requirements. The CHIP Contractors include cost sharing requirements in the member handbooks and in letters sent to the applicant that provide notification of eligibility for CHIP. Eligibility letters also clearly indicate the cumulative maximum cost sharing (5% of gross income) expected of the family. Information about cost sharing is also available through 1-800-986-KIDS. Any changes to costs will be included in correspondence to enrollees a minimum of 30 days in advance of the changes.

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

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

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

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

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

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

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

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

☒ Yes (Specify: prescription drugs, emergency room care. For a detailed listing of the financial requirements by MCO, see the Mental Health Parity and Addiction Equity Act cover letter, Table 2)

☐ No

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

☒ Yes

☐ No

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of

financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

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

Please refer to the OCHIP MHPAEA Cover Letter and attached MCO submissions. Each MCO conducted a compliance review and submitted a documentation package based on templates developed by OCHIP.

While the organization of each MCO submission was customized at the discretion of the MCO, generally each submission contains the following pertaining to FRs:

- Section 3 details the methodology used to conduct the FR analyses as well as any results
- Appendix B contains an inventory of applicable FRs

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

☒ Yes (Please refer to the OCHIP MHPAEA Cover Letter and separate MCO submissions as described in 8.4.6, above)

☐ No

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

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

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

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 cost sharing requirement was designed to only include modest premiums and copayments. Only rare circumstances of low-income families combined with very high utilization of non-preventive services by multiple family members would result in families potentially exceeding the 5 percent of family income ceiling. The cost-sharing limit will be calculated annually starting with the date of initial enrollment of any children in the family or the annual re-enrollment date. Premium payments will be required monthly, but the need to continue premium payment for the entire 12-month eligibility period will be taken into account in determining if/when the cost-sharing cap has been exceeded.

The initial letter announcing enrollment in a subsidized program includes notification of the requirements for the cost sharing, the family limitation on cost sharing based upon the reported gross income, the requirement for the family to keep track of the cost sharing amounts paid, and instructions on what to do when the family's cost sharing limits have been exceeded. Families are instructed to contact the state when the cap is met and then to submit copies of the receipts for calculation. Pennsylvania's claims processing is decentralized to each of the nine insurance contractors. Therefore, there is no simple way for the state to track the copayments made. Additionally, all children are enrolled in our eligibility and enrollment system as separate cases and it would be difficult to provide a linkage to get to family output.

Once the limits have been exceeded, a family can apply to the state for a rebate of any cost sharing already paid in excess of the limit. Upon verification that the family exceeded the 5% cost sharing limit, the state will issue a letter to each child in the family to present to the provider that explains that cost sharing is exempt until a specified date (redetermination date) that will be included on the letter. The appropriate contractors will also receive the letter and will then know that premiums will not be required from the enrollees until the next eligibility period begins.

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)) (42 CFR 457.535)

Pennsylvania ensures that American Indian and Alaska Native children will be excluded from cost sharing by collecting information on the application and at the time of redetermination of eligibility regarding a child's status as an American Indian or Alaska Native. The applicant/enrollee will be asked to indicate their tribal membership by stating this on the application. If they are found to be in the American Indian or Alaska Native category, the family will be notified of the exemption and an identification card will be issued with an appropriate group number that excludes cost sharing. All providers are required to verify eligibility by checking the enrollment card which contains a notation regarding copayments, as does the telephone eligibility verification system used by providers.

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

Enrollees will have 30 days from the date eligibility is determined to pay the initial premium payment or enrollment will be denied.

For Low-Cost CHIP, once an enrollee pays the initial premium, they cannot be disenrolled for failure to pay ongoing premiums during the continuous eligibility period.

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

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

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

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

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

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

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

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and

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

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

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

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

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

Section 9. Strategic Objectives and Performance Goals and Plan Administration

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)) (42 CFR 457.710(b)).

- Increase public awareness of CHIP and other state programs aimed at providing health care assistance.
- Increase overall access to coverage relative to estimated number of uninsured children in Pennsylvania.
- Increase access to coverage for racial, ethnic, minority, and special needs children eligible for CHIP.
- Increase access to coverage for children in rural areas, specifically central and northeast Pennsylvania.
- Increase the percentage of children receiving age-appropriate well child care, immunizations, and preventive health services.

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

- Continue to increase access to coverage (increased use of FQHCs, insurance contractors include Certified Registered Nurse Practitioners and Physician Assistants in provider networks, increase number of practices with after-hours appointments, and the like).
- Increase enrollment in rural counties by at least 5% each of the next three years.
- Reduce the unnecessary overutilization of Ambulatory Care, Emergency Department visits by 2.2% each of the next three years.
- Increase frequency of adolescent well-care visits by 3% per year for the next 3

years.

- Increase the percentage of eligible children receiving all vaccinations in HEDIS combination 2 by 0.7% per year for the next 3 years.
- Continue to increase the number of children who are tested for blood lead levels as specified in the Performance Improvement Project (PIP)

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)) (42 CFR 457.710(d))

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

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

9.3.7. ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. ☒ Immunizations
9.3.7.2. ☒ Well childcare
9.3.7.3. ☒ Adolescent well visits
9.3.7.4. ☒ Satisfaction with care
9.3.7.5. ☒ Mental health
9.3.7.6. ☒ Dental care
9.3.7.7. ☒ Other, list:
Lead testing, body mass index, and asthma.

9.3.8. ☐ Performance measures for special targeted populations.

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

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

CHIP requires the submission of annual reports containing information on enrollments, demographics, utilization of services, etc.

CHIP requires monitoring and evaluation of quality and access to health care services.

The Department of Health contracts with an external review organization to conduct this evaluation.

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

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

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

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

PA CHIP has sought input from the public through a variety of methods. One such way is the Children's Health Advisory Council which was created by state statute. The Children's Advisory Council is now under jurisdiction of the Department of Human Services as a result of amendments to the CHIP law (see **Appendix A**, Act 84 of 2015). The Children's Advisory Council is chaired by the Secretary of Human Services and consists of three ex-officio members from the Insurance Department, the Department of Health, and the Department of Human Services, respectively and 16 voting members ranging from legislators to a parent with a child enrolled in CHIP.

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 onproposed pregnant women expansions. (Section 2107(c)) (42 CFR 457.120(c))

Pennsylvania does not have any American Indian Tribes recognized by the federal or state government. Any Pennsylvania resident, including those who are American Indians or Alaska Natives, may participate, through the process described in Section 9.9, in the design and implementation of the program, including those policies that would ensure the provisions of child health assistance to American Indian and Alaska Native children.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

Pennsylvania Bulletin Notice – The Pennsylvania Bulletin is the commonwealth's official method of communicating information and rulemaking. The Commonwealth posted a notice on June 23, 2016 announcing the upcoming Advisory Council meeting

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

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

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

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

CHIP Budget

STATE: Pennsylvania	FFY Budget	FFY Budget	FFY Projected Budget
Federal Fiscal Year	**2024**	**2025**	**2026**
State's Enhanced FMAP Rate	**67.88%**	**68.56%**	**69.24%**
Benefit Costs			
Insurance Payments	$ -	$ -	$ -
Managed Care	$ 439,701,157	$ 441,161,596	$ 463,219,675
Per Member/ Per Month Rate	172	213	223
Fee for Service	$ -	$ -	$ -
Total Benefit Costs	$ 439,701,329	$ 441,161,809	$ 463,219,675
(Offsetting beneficiary cost sharing payments)	$ -	$ -	$ -
Net Benefit Costs	$ 439,701,329	$ 441,161,809	$ 463,219,675
Cost of Proposed SPA Changes - Benefit			
Administration Costs			
Personnel	$3,009,015.98	$3,047,179.00	$3,138,594.37
General Admnistration	$281,771.59	$89,714.41	$92,405.84
Contractors/Brokers	$4,525,909.51	$5,425,033.59	$5,587,784.60
Claims Processing	$0.00		
Outreach/Marketing Costs	$3,135,397.00	$3,115,468.00	$3,208,932.04
Health Services Initiatives	$1,057,271.00	$446,363.00	$459,753.89
Other			
Total Administration Costs	$10,952,094.08	$12,123,758.00	$12,487,470.74
10% Administrative Cap	$29,384,355.65	$29,770,925.10	$31,487,685.15
Cost of Proposed SPA Changes			
Federal Share	$306,621,219.14	$310,772,584.74	$329,379,627.71
State Share	$145,089,474.94	$142,512,982.26	$146,327,518.03
Total Costs of Approved CHIP Plan	**$451,710,694.08**	**$453,285,567.00**	**$475,707,145.74**

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: State appropriation and Tobacco settlement funds are the sources for the majority of CHIP funds.

Section 10. Annual Reports and Evaluations

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

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

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

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

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

Section 11. Program Integrity (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)) (42 CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42 CFR 457.935(b))

(The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)

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

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

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

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

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

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

Section 12. Applicant and Enrollee Protections (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.

Pennsylvania implemented an Eligibility Review Process on July 1, 2001. An eligibility review may be requested when:

- an applicant is denied coverage
- an enrollee's coverage is to be terminated
- an enrollee's coverage is to change from Free Health Care Insurance to Subsidized Health Care Insurance
- an enrollee's coverage is to move from a lower premium rate to a higher premium rate within the subsidized program or coverage is moved to the at cost program
- an enrollee's coverage is to move from a higher premium rate to a lower premium rate, but the enrollee disagrees with the determination (mistake in calculating income or family size) or states that they should be in the free program or Medicaid
- there is a failure to make a timely determination of eligibility

The parent or guardian of an applicant or an enrollee may request a review within 30 days of the date of the notice of ineligibility, termination or change in coverage. A request for a review is sent to the appropriate MCO.

Notices to the parent or guardian must include information concerning the

impartial eligibility review process. Whenever possible, disputes related to eligibility are resolved prior to the conduct of the review by the Department.

When a request for an impartial review is received, the CAO:

- Logs in the request for a review
- Determines the need for expedited review (i.e. the parent or guardian has indicated that the child has an immediate need for medical attention)
- Informs the Department's Review Officer that a request for review has been received
- Continues coverage or reinstates coverage of an enrollee until the review process has been concluded

- The Department Review Officer will:
-
- When the need for an expedited review is identified, an interview is scheduled consistent with 42 CFR 457.1160(a)
- Conducts an eligibility review of the decision of ineligibility within two working days of the receipt of the appeal request.
- The purpose of the eligibility review is to assure that the decision made regarding ineligibility was appropriate.
- A written record of the eligibility review is prepared.
-
- If the eligibility review results in a determination that the eligibility decision was not appropriate, the Review Officer:
- Informs the parent or guardian and CAO in writing that an error occurred, and the child is eligible
- Enrolls the applicant child retroactively to the date that the child should have been enrolled
- Re-enrolls an enrollee who has been terminated retroactively to the date the child was terminated
- If the eligibility review results in a determination that the decision was appropriate, the Department's Review Officer conducts an interview with the appellant and the MCOs representative.
- The review is an informal process and is not an administrative hearing.
- The Review Officer:
- Informs the parent or guardian in writing of the:
- Date, time and location of the interview
- Right to review records maintained by the MCO regarding the eligibility determination
- Right to receive a copy of the relevant portions of the CHIP Procedures Manual and State or Federal law upon which the decision of ineligibility was based
- Right to have a representative during the interview

- Right to have appropriate interpretative service available during the interview if needed
- Opportunity for continuation of coverage for an enrolled child (with the payment of premium, if required)
- Provides the parent or guardian with a copy of the application and verification received from the CAO
- Reviews the application document and verification and the letter of request prior to the conference call in order to become familiar with the case circumstances. Additional documents that may have an impact on the outcome may be submitted by the parent or guardian or their representative.
-
- Conducting the review interview
- The primary objectives of the review are, where possible, to facilitate resolution of the matter at issue and to enroll the child, when appropriate.
- The Review Officer may ask for additional documentation, as needed.
-
- Issues a written decision within a reasonable time consistent with 42 CFR 457. 1180. A written decision in the form of letter is prepared and sent to the parent or guardian, the representative (if appropriate) and to the CAO. The CAO implements the decision of the review officer upon receipt of the letter.
- If anytime during the process, the appellant sends confirmation that a request for a review has been withdrawn, a written confirmation of the request and the resulting action(s) is explained. (Withdrawal of a request may occur if the CAO, applicant or enrollee informs the Department that the request for review has been withdrawn for any reason. Example: MCO has resolved the matter at issue prior to the date of the scheduled review interview.)
-
- A parent or guardian or representative may request reconsideration of the decision of the review officer if they are dissatisfied with the outcome of the review. A parent or guardian must file a written request for reconsideration with the Secretary of Human Services within 15 calendar days from the date of the Review Officer's decision. The request for reconsideration must describe the reason(s) upon which the request is made. Requests for reconsideration will stay the action proposed in the decision of the Review Officer (e.g. that coverage should be terminated).
-
- The Secretary may affirm, amend, or reverse the decision of the review officer. After a review of the factors considered by the review officer and the request for reconsideration, the Secretary of Human Services issues a written reconsideration decision. A copy of the reconsideration decision

- will be sent to the parent or guardian, the representative (if appropriate) and to the MCO.
-
- A parent or guardian or representative may appeal the decision of the Pennsylvania Department of Human Services to the Commonwealth Court within 30 days from the date that the Secretary responds to the request for reconsideration.
    - 2D0Right to have appropriate interpretative service available during the interview if needed
    - Opportunity for continuation of coverage for an enrolled child (with the payment of premium, if required)
  - Provides the parent or guardian with a copy of the application and verification received from the Contractor
- Informs the Contractor that the interview has been scheduled
- Reviews the application document and verification and the letter of request prior to the conference call in order to become familiar with the case circumstances. Additional documents that may have an impact on the outcome may be submitted by the parent or guardian or their representative.

- Conducts the review interview
  - The primary objectives of the review are, where possible, to facilitate resolution of the matter at issue and to enroll the child, when appropriate.
  - The Review Officer may ask either or both parties for additional documentation, as needed.

- Issues a written decision within a reasonable time consistent with 42 CFR 457. 1180. A written decision in the form of letter is prepared and sent to the parent or guardian, the representative (if appropriate) and to the Contractor. The Contractor implements the decision of the review officer upon receipt of the letter.
- If anytime during the process, the appellant sends confirmation that a request for a review has been withdrawn, a written confirmation of the request and the resulting action(s) is explained. (Withdrawal of a request may occur if the contractor, applicant or enrollee informs the Department that the request for review has been withdrawn for any reason. Example: contractor has resolved the matter at issue prior to the date of the scheduled review interview.)

A parent or guardian or representative may request reconsideration of the decision of the review officer if they are dissatisfied with the outcome of the review. A parent or guardian must file a written request for reconsideration with the Secretary of Human Services within 15 calendar days from the date of the Review Officer's decision. The request for reconsideration must describe the reason(s) upon which the request is made. Requests for

reconsideration will stay the action proposed in the decision of the Review Officer (e.g. that coverage should be terminated).

The Secretary may affirm, amend, or reverse the decision of the review officer. After a review of the factors considered by the review officer and the request for reconsideration, the Secretary of Human Services issues a written reconsideration decision. A copy of the reconsideration decision

will be sent to the parent or guardian, the representative (if appropriate) and to the Contractor.

A parent or guardian or representative may appeal the decision of the Pennsylvania Department of Human Services to the Commonwealth Court within 30 days from the date that the Secretary responds to the request for reconsideration.

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

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.

Appendix B
CHIP BENEFITS PACKAGE SUMMARY

Service	Description	Limitations
Primary and Preventive Care	Well-child care, including but not limited to immunizations, health education, TB testing, developmental screening. Physical examinations including x-rays as need for any child exhibiting signs of possible abuse. Also including, but not limited to, injections and medications, wound dressing, casting to immobilize fractures.	None.
Specialist Care	Covers care in any accepted medical specialty or subspecialty.	PCP referral is not required. Some services provided by a specialist may require preauthorization.
Case management services	Services may be coordinated through MCO Special Needs Units or Care Management units. Case management provides support to members experiencing complex medical issues or chronic illnesses through ongoing assessment, care planning, and monitoring.	None.
Chiropractic Care	Including spinal manipulation or other body parts as treatment of diagnosed musculoskeletal conditions. Consultations and x-rays are included.	Limited to 20 visits per year. Preauthorization may be required
Dental Benefits	See CHIP Dental Benefits Plan.	See CHIP Dental Benefits Plan.
Diabetic treatment, equipment, and supplies	Includes blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, orthotics, and outpatient management training and education.	Physician orders required

Service	Description	Limitations
Diagnostic services	Laboratory and X-ray services and other diagnostic services related to the diagnosis and treatment of illness or injury.	Requires an order by a PCP, specialist, or facility provider. Some services may require preauthorization.
Disposable medical equipment	Includes ostomy supplies and urological supplies.	Must be medically necessary. No limits apply.
Durable Medical Equipment	Equipment designed to serve a medical purpose for a medical condition, is intended for repeated use, and is not disposable, and is appropriate for home or school use.	May require prior authorization.
Emergency Services	Services provided for a sudden onset of a medical condition that is accompanied by rapidly progressing symptoms such that the member would suffer serious impairment or loss of function of a body part or organ, or whose life or life of an unborn child would be in in danger.	None.
Emergency Transportation	Transportation by land, air, or water ambulance rendered in response to an emergency	Must be medically necessary.
Hearing Care Services	Covers routine and audiometric testing.	One routine hearing and audiometric examination per year. One hearing aid or device per ear
Hospice	Care for a member who is suffering from a terminal illness. Respite care is also included.	No day limits apply. Requires physician certification of terminal illness and prior authorization.
Home Health Services	Services intended for a homebound member including nursing care, home health aide services, oxygen, medical and surgical supplies and home infusion therapy (not including blood and blood products).	No copays No visit limitations Private duty nursing and custodial care are not covered.

Service	Description	Limitations
Immunizations	Coverage is provided for pediatric immunizations, including immunizing agents, which conform to the standards of the Advisory Committee on Immunization Practices (ACIP).	No copays Immunizations required for travel or employment are not covered.
Injections	Includes all injections and medications provided at the time of the office visit or therapy and outpatient surgery performed in the office, a hospital, or freestanding ambulatory service center. Includes immunizations as described in this benefits package and anesthesia services when performed in conjunction with covered services, including emergency services.	Must be medically necessary
Inpatient Hospital Stays	Includes pre-admission testing, semi-private room unless private room is medically necessary, board, general nursing care, intensive or special care facilities, OR and related facilities, anesthesia, oxygen, therapy services, and any other services normally provided with inpatient care. Covered services include inpatient therapy up to 45 visits per calendar year for treatment of CVA, head injury, spinal cord injury, or as a result of a post-operative brain surgery.	No day limits apply. Preauthorization required for non-emergency services.
Inpatient Rehabilitation Stays	Covered when a member requires skilled rehabilitation services on a daily basis.	Require a physician's prescription. No day limits apply.
Medical Foods	Includes medical foods and prescribed nutritional formulas used to treat PKU and related disorders given orally or by tube feeding.	None.

Service	Description	Limitations
Mental Health Services Autism Related Services	Covers evaluations and tests performed to diagnose autism disorder, services of a psychiatrist/psychologist, rehabilitative care including applied behavioral analysis, speech/language, occupational, and physical therapy, prescription and over-the-counter drug coverage. Members are eligible to use the expedited appeals process defined in Act 62 for autism related complaints and grievances.	None
Inpatient mental health services	Includes services furnished in a state-operated mental hospital, residential facility, or other 24-hour therapeutically structured services. Covers medical care including psychiatric visits and consultations, nursing care, group and individual counseling, and therapeutic services, and concurrent care and services normally provided relating to inpatient hospitalization. Members may self-refer.	No day limits apply.
Outpatient mental health services	Includes partial hospitalization and intensive outpatient mental health services, psychological testing, visits with outpatient mental health providers, individual, group, and family counseling, targeted mental health case management and medication management.	No day limits apply.

Service	Description	Limitations
Inpatient substance abuse services	Services provided in a hospital or an inpatient non-hospital facility that meets the requirements established by the Department of Health and is licensed as an alcohol/drug addiction treatment program. Covers detoxification stays, services of physicians, psychologists, psychiatrists, counselors, trained staff, laboratory and psychological/psychiatric testing, individual and family therapy and interventions and medication management and services normally provided to inpatients.	No day limits apply. **Treatment for tobacco use cessation is included.**
Outpatient substance abuse services	Services provided in a facility licensed by the Department of Health as an alcohol/drug addiction treatment program. Covers services of physicians, psychologists, psychiatrists, counselors, trained staff, laboratory and psychological/psychiatric testing, individual and family therapy.	No limit on number of visits **Treatment for tobacco use cessation is covered.**
Oral Surgery	For removal of partially or fully impacted third molars (wisdom teeth), non-dental treatments of the mouth related to medically diagnosed congenital defects, birth abnormalities, surgical removal of tumors, surgical corrections of dislocated or completely degenerated temporomandibular joints and incision and drainage of abscesses.	Preauthorization required. Must be medically necessary.
Organ Transplants	Includes transplants that are medically necessary and not considered to be experimental of investigative. Also includes immunosuppressants	Preauthorization required. Must be medically necessary.

Service	Description	Limitations
Orthotic devices	Includes the purchase, fitting, necessary adjustment, repairs, and replacement of rigid or semi-rigid device designed to support, align, or correct bone and muscle injuries or deformities.	Replacements are covered when the replacement is deemed medically necessary and appropriate du to the normal growth of the child.
Outpatient Hospital Services	Included medical services, nursing, counseling or therapeutic treatment or supplies received from an approved health care facility while not an inpatient. Outpatient physical health services related to ambulatory surgery, outpatient hospitalization, specialist office visits, follow up visits or sick child visits with as PCP are included.	No visit limits
Outpatient Medical Services	Includes chemotherapy, Dialysis, Radiation Treatment, and Respiratory Therapy.	No visit limits. Requires a documented diagnosis that necessitates the prescribed service
Outpatient Rehabilitation Services	Physical, Occupational, and Speech Therapy.	60 visits per year per each type of therapy.
Outpatient Habilitation Services	Health care services that help a person keep, learn, or improve skills and functioning for daily living. Services include Physical, Occupational, and Speech Therapy services for people with disabilities in a variety of outpatient settings.	30 visits per year per each type of therapy.
Prosthetic Devices	Includes the purchase of prosthetic devices and supplies required as a result of injury or illness to replace part or all of an absent body part or to restore function to permanently malfunctioning body organs. Includes purchase, fitting, and necessary adjustments of prosthetic devices	Replacements are covered when deemed medically necessary and appropriate due to the normal growth of the child.
Skilled nursing services	Medically necessary skilled nursing and related services are covered on an inpatient basis in semi=private accommodations for patients requiring skilled nursing services, but not requiring confinement in a hospital.	No day limits apply.

Service	Description	Limitations
Surgical Services	Surgery performed for the treatment of disease or injury is covered on an inpatient or outpatient basis. Cosmetic surgery intended solely to improve appearance, but not to restore bodily function or to correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes (excluding surgery resulting from an accident) is not covered. Includes anesthesia administered by or under the supervision of a specialist other than the surgeon, assistant surgeon, or other attending specialist. Includes general anesthesia and hospitalization and other expenses normally incurred with administration of general anesthesia. Consultations for a second opinion consultations to determine the medical necessity of elective surgery or when an enrollee's family desires another opinion about medical treatment. No referral is needed.	Services may require preauthorization
Surgical services Mastectomy and breast reconstruction	Benefits are provided for a mastectomy performed on an inpatient of outpatient basis. Benefits include all stages of reconstruction on the breast on which the mastectomy has been performed, surgery to reestablish symmetry or alleviate functional impairment, including, but not limited to, augmentation, mammoplasty, reduction mammoplasty, mastopexy, and surgery on the other breast to produce a symmetrical appearance. Covers surgery for initial and subsequent insertion or removal of prosthetic devices to replace a removed breasts or portions of the breast, and treatment of physical complications of all stages of mastectomy, including lymphedema. Coverage is also provided for one Home Health Care visit, as determined by the member's physician, received within forty-eight (48) hours after discharge.	Preauthorization required Must be medically necessary

Service	Description	Limitations
Surgical services Reconstructive surgery	Reconstructive surgery will only be covered when required to restore function following accidental injury, result of a birth defect, infection, or malignant disease or in relation to gender reassignment surgery deemed medically necessary in order to achieve reasonable physical or bodily function; in connection with congenital disease or anomaly through the age of 18; or in connection with the treatment of malignant tumors or other destructive pathology which causes functional impairment; or breast reconstruction following a mastectomy.	Preauthorization required. Must be medically necessary.
Telehealth Visit	Visit with family practitioner, general practitioner, or pediatrician.	None.
Transgender Services	Coverage related to gender affirming services that otherwise fall within the beneficiary's scope of covered services, including physician services, inpatient and outpatient hospital services, surgical services, prescribed drugs, therapies and behavioral health care.	Medical necessity is to be determined utilizing the World Professional Association for Transgender Health (WPATH) Standard of Care guidelines and any successor WPATH guidelines.
Qualifying Clinical Trials	Clinical trial conducted in relation to prevention, detection and treatment of cancer of other life-threatening disease or condition. Covers items and services consistent with what the plan normally covers.	Notification of participation in the trial must be giving before enrolling in the trial.
Urgent Care Services	Covers care at walk-in medical facilities for conditions that do not require emergency care but that needs to be treated within 24 hours.	None.
Vision Care	Covers eye exams and refractive services, eyeglass lenses and frames, contact lenses, and low vision services.	One eye exam per year, one pair of lenses and frames plus one replacement per year. One prescription for contacts per year. Limits apply to low vision evaluations, follow up and equipment.

Service	Description	Limitations
Women's Health Services	Women's Health Services covers those services described under the Women's Preventive Services provisions of the Affordable Care Act. Sex- specific services will not be denied or limited based on gender identity which does not align with the sex that generally receives that service. Covered services include but are not limited to the following services.	There are no copayments for preventive services.
Women's Health Services: Routine gynecological services	Gynecological exam including a pelvic exam, clinical breast exam and routine Pap-smear. Counseling, education and related services to prevent and address the consequences of at-risk behaviors related to STD and pregnancy. Each enrollee may utilize her PCP or she may directly choose any participating professional provider delivering gynecological services without referral.	One annual gynecological exam and one Pap-smear per year
Women's Health Services: Mammograms	Screening and diagnostic mammograms are covered when performed by a qualified mammography service certified by the appropriate State or Federal agency in accordance with the Mammography Quality Assurance Act of 1992. There are no copays for this service.	None.
Women's Health Services: Breastfeeding	Comprehensive support and counseling from trained providers, access to breastfeeding supplies, including coverage for renting of hospital-grade breast pumps under DME and medical necessity review, and coverage of lactation support and counseling provided during postpartum hospitalization, mother's options visits, and obstetrician or pediatrician visits for pregnant or nursing mothers with no cost sharing to the member.	No co-pay. Must be medically necessary.

Service	Description	Limitations
Women's Health Services: Obstetrical services	Includes prenatal, intrapartum, and postpartum care, including care related to complications of pregnancy and childbirth. Services provided by a participating hospital or birthing center are covered.	No co-pay.
Women's Health Services: Osteoporosis screening	Coverage is provided for bone mineral density testing using a U.S. FDA approved method.	Requires a prescription from a legally licensed provider
Women's Health Services: Family Planning	Included, but is not limited to, birth control pills, injectibles, transdermals (patches) and insertion and implantation of contraceptive devices approved by the FDA, voluntary sterilization and counseling.	Abortifacient drugs are not covered
Women's Health Services: Maternity home care visit	Included at least one (1) visit provided at their home when the CHIP member is released prior to 48 hours of inpatient care following a vaginal delivery or 96 hours following a Cesarean delivery, or in the case of a newborn, in consultation with the mother or the newborn's representative.	At least one (1) visit provided.
Women's Health Services: Newborn care	Includes the provision of benefits for a newborn child of an enrollee for a period of thirty-one (31) days following birth. Includes routine nursery care, prematurity services, preventive/ well-child health care services, newborn hearing screens, and coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.	None.
Pharmacy Services for Prescription Drugs	Includes any substance taken by mouth, injected into a muscle, the skin, a blood vessel, or a cavity of the body, or applied topically to treat or prevent a disease or condition, dispensed by order of a health care provider with applicable prescriptive authority. Contractors may use a closed or restrictive formulary provided it meets the minimum clinical needs of CHIP enrollees. A mail order or designated pharmacy process can be used for maintenance prescriptions. Generic drugs will be automatically substituted for a brand-name drug whenever a generic formulation is available unless the physician indicated the brand-name version is medically necessary.	Copays may apply.

Service	Description	Limitations
Pharmacy Services for Over-the –Counter Medications	Covered when the drug is a part of the formulary, the member has a prescription for the drug, and a documented medical condition that indicates the drug is medically necessary.	Copays may apply
Pharmacy Services for Preventive Medications	Select medications such as contraceptives, iron supplements, sodium fluoride, folic acid supplements, vitamins, aspirin, smoking deterrents, vitamin D supplements, tamoxifen, and raloxifene are considered preventive medications and are covered at no cost to the member when filled at a participating pharmacy with a valid prescription.	Members need to call their insurance provider regarding questions on coverage.

Appendix C
Revised PA CHIP Dental Benefit Package – Effective 1/1/2012

The PA CHIP's core dental benefits will cover all the dental procedure codes covered by the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan. However, all deductibles, copayments, or coinsurance for PA CHIP covered dental benefits are waived. The "least expensive alternative treatment" policy remains in effect as well as the medical necessity restrictions, including the appropriate use of prior authorization. Please refer to the Orthodontic Services section for more information on limits related to comprehensive orthodontic services.

Least Expensive Alternative Treatment

Pennsylvania CHIP provides a benefit package to children covered by the CHIP program. In addition, a CHIP insurance contractor may elect to provide benefits in addition to the Pennsylvania CHIP benefit package, so long as the CHIP program is not directly or indirectly required to pay for the additional benefits. Consequently, this Pennsylvania CHIP benefit package is broad but it is not all inclusive. If a child's family wishes to have the child receive a service that is not covered by the CHIP benefit package, the family and a health care or dental health provider are free to make appropriate arrangements between themselves, as explained below.

Specifically, the Pennsylvania CHIP program pays for the "least expensive alternative treatment" ("LEAT") for a CHIP covered service that, based on clinical practice standards, will adequately treat a child's
condition. However, a dentist may elect to provide a clinically appropriate service that is more costly than the least expensive alternative treatment if that dentist is willing to accept the reimbursement that would otherwise be paid for providing the least expensive alternative treatment
service. Likewise, a CHIP insurance contractor may decide to pay the dentist more than the normal reimbursement for the least expensive alternative treatment when that dentist provides a treatment that is reimbursed at a higher rate than the least expensive alternative treatment; however, such higher reimbursement should not be included in the CHIP cost experience for future CHIP rates. In both cases, the actual services provided to a child should be reported to the CHIP program.

Another situation that may arise is that a family may wish to obtain a clinically appropriate service for a child that is more costly than the least expensive alternative treatment required for that child, but neither the dentist nor the insurer is willing to absorb the difference in cost between the least expensive alternative treatment required and the treatment desired by the family. In this situation, the incremental cost is not a

Pennsylvania CHIP covered service.

A family should be free to obtain services that are not services or benefits covered by the Pennsylvania CHIP program, as long as the family understands in advance the amount that the dentist will bill the family of the difference between the charge of the actual service rendered and the amount received from the CHIP insurer or subcontractor for the least expensive alternative treatment service. For example, a child may need a cap on a tooth. If the least expensive alternative treatment service that is appropriate is a porcelain cap but the family would prefer a gold cap, the family could make an informed decision and agree to pay the dentist some or all of the difference between the charge for the gold cap and the amount the CHIP program will pay for a porcelain cap.

Contractors are expected to develop internal guidelines including, but not limited to prior authorization policies, that will be used to facilitate the administration of the PA CHIP dental benefit package and to assist in determining medical necessity for certain services. In addition to non-emergent oral and maxillofacial surgical services, prior authorization policies should apply, at a minimum, to any services that are categorized as being endodontic, prosthodontic, or orthodontic in nature using the most recently published version of the American Dental Association's Current Dental Terminology classification system. Members who are denied services will have the right to appeal the denial using the appeals and grievances process as defined by Act 68.

The following is a list of services and their corresponding limits that are payable under the FEDVIP Dental Plan. Cost-sharing is waived for CHIP enrollees, but the periodicity schedule remains. The list includes those services most commonly provided to covered individuals, but other services may be covered for an individual member if it is determined that the requested service is medically necessary and one of the services identified below is insufficient to meet their dental needs.

- Members must have a fully erupted set of permanent teeth to be eligible for comprehensive orthodontic services.
- **All orthodontic services require prior approval,** a written plan of care, and must be rendered by a participating provider.
- Orthodontic treatment must be considered medically necessary and be the only method considered capable of:
    - Preventing irreversible damage to the member's teeth or their supporting structures.
    - Restoring the member's oral structure to health and function.
- A medically necessary orthodontic service is an orthodontic procedure that occurs as a part of an approved orthodontic treatment plan that is intended to treat a severe dentofacial abnormality or serious handicapping

malocclusion. Orthodontic services for cosmetic purposes are not covered.

- Orthodontia procedures will only be approved for dentofacial abnormalities that severely compromise the member's physical health or for serious handicapping malocclusions. Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, open bite, and crossbite.
    - Dentofacial abnormalities that severely compromise the member's physical health may be manifested by:
        - Markedly protruding upper jaw and teeth, protruding lower jaw and teeth, or the protrusion of upper and lower teeth so that the lips cannot be brought together.
        - Under-developed lower jaw and receding chin.
        - Marked asymmetry of the lower face.
    - A "handicapping" malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the recipient by causing:
        - Obvious difficulty in eating <u>because of the malocclusion,</u> so as to require a liquid or semisoft diet, cause pain in jaw joints during eating, or extreme grimacing or excessive motions of the orofacial muscles during eating because of necessary compensation for anatomic deviations.
        - Obvious severe breathing difficulties <u>related to the malocclusion,</u> such as unusually long lower face with downward rotation of the mandible in which lips cannot be brought together, or chronic mouth breathing and postural abnormalities relating to breathing difficulties.
        - Lisping or other speech articulation errors that are <u>directly related to orofacial abnormalities</u> and cannot be corrected by means other than orthodontic intervention.

o Members who score 25 or higher on the Salzmann Evaluation Index upon examination and evaluation by an orthodontist are considered to meet the criteria required to substantiate the medical necessity for orthodontic treatment of a serious handicapping malocclusion.

CHIP DENTAL BENEFITS PLAN

GENERAL INFORMATION
All benefits are subject to the definitions, limitations, and exclusions given below and are payable only when the service is necessary for the prevention, diagnosis, care, or treatment of a covered condition and meet generally accepted dental protocols.
The following is a list of services most commonly provided to covered individuals. It is not an all-inclusive list. Benefits for ADA codes not listed below will be provided, subject to exclusions and limitations shown in this plan.
Some services may be subject to dental review. The dentist should submit a pre-determination/pre-certification request prior to start of service.
There is no deductible if you use an in-network provider. There is no annual limit for dental services or medically necessary orthodontic dental services. There are no deductibles, copayments or coinsurance for PA CHIP covered dental benefits.
All exams, oral evaluations and treatments, such as fluorides and some images are combined under one limitation under the plan. Periodic oral exam (D0120) oral evaluations (D0145), and comprehensive oral exam (D0150, D0180) are combined and limited to one exam every 6 months from the date services were last rendered. There must be a 6 month separation between services, even if the separation of services enters a new benefit year.
All services requiring more than one visit are payable once all visits are completed.
All major prosthodontic services are combined under one replacement limitation under the plan. Benefits for prosthodontic services are combined and limited to one every 60 months. For example, if benefits for a partial denture are paid, this includes benefits to replace all missing teeth in the arch.
The periodicity scheduled used for the CHIP dental package is the American Academy of Pediatric Dentistry and the American Academy of Pediatrics.

BASIC SERVICES		
Diagnostic Services		
Code	**Service**	**Limits**
D0120	Oral Evaluation	One every six months
D0140	Limited Evaluation – problem focused	As medically necessary w/review
D0145	Oral Evaluation	One oral evaluation for a patient under three years of age and counseling with primary caregiver every six months.
D0150	Oral Evaluation	One oral evaluation is eligible during a six-month period.
D0160	Oral Evaluation	One oral evaluation is eligible during a six-month period. Detailed and Extensive oral

		evaluations problem focused are only eligible by report when not related to non-covered medical, dental or adjunctive dental services including Temporomandibular Joint Dysfunction.
D0170	Re-evaluation	One re-evaluation is eligible during a 30-day period.
D0180	Comprehensive periodontal Evaluations	One every six months
D0210	Full Mouth Radiographic Series	One Full Mouth Radiographic Series (**D0210**) or Panoramic Radiograph (**D0330**) is eligible in a 60 month period
D0220	Periapical film (first)	One per visit, Ten in any 12- month period unless additional film is medically necessary
D0230	Periapical film (each additional film)	Ten in any 12-month period
D0240	Occlusal radiographic image	By report as medically necessary
D0270	Bitewing Radiographs – single image	One radiograph every 6 months
D0272	Bitewing radiographs – two images	One set every 6 months
D0274	Bitewing radiographs – four images	One set every 6 months
D0277	Vertical bitewings 7-8 images	One set every 6 months
D0290	Skull X-Ray	Once in a 12-month period
D0330	Panoramic Radiograph	One Full Mouth Radiographic Series (D0210) or Panoramic Radiograph (D0330) is eligible in a 60 month period.
D0340	Cephalometric radiographic image	By report demonstrating medical necessity
D0350	2D Oral Facial Photographic Images obtained intraorally or extraorally	limit removed
D0351	3D photographic image	By report demonstrating medical necessity
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image	Interpretation of diagnostic image and report only

D0415	Collection of microorganism for culture and sensitivity	As medically necessary as a program exception
D0422	Collect and prep genetic sample	One per lifetime
D0423	Genetic test -- specimen analysis	One per lifetime
D0460	Pulp vitality test	One per 30 day period
D0470	Diagnostic models	Substantiation of medical necessity
Services Not Covered		
D0320	TMJ Arthrogram	
D0321	Temporomandibular Joint films	
D0322	Tomographic survey	
D0360 D0362 D0363	Cone Beam	
D0415	Collection of microorganism for culture and sensitivity	Program exception
D0416	Viral Culture	
D0417	Collection and preparation of saliva for laboratory diagnostic testing	
D0418	Analysis Of Saliva Sample – Chemical Or Biological Analysis Of Saliva Sample For Diagnostic Purposes	
D0421	Genetic Test For Susceptibility To Oral Diseases	
D0425	Caries Susceptibility Tests	
D0431	Adjunctive Pre-Diagnostic Test	
D0472 **D0473, D0474**	Accession Of Tissue	By report with substantiation of medical necessity. May be covered as a medical benefit
D0475	Decalcification Procedure	
D0476	Special stains for microorganisms	
D0477	Special stains, not for microorganisms	
D0478	Immunohistochemical Stains	
D0479	Tissue In-Situ Hybridization, Including Interpretation	
D0480	Accession Of Exfoliative Cytologic Smears	

D0481	Electron Microscopy – Diagnostic	
D0482 D0483	Immunofluorescence	
D0484	Consultation on slides prepared elsewhere	
D0485	Consultation including preparation of slides	
D0486	Laboratory Accession Of Transepithelial Cytologic Sample	
D0502	Oral Pathology Procedure	
D9950	Occlusion Analysis	
D0210, D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0273, D0274, D0277, D0290, D0330	Diagnostic Dental X-Rays Performed In Conjunction With Temporomandibular Joint Dysfunction Are Not Covered	
Preventive Services		
D1110, D1120	Routine cleaning	One every 6 months
D1206	Topical application of fluoride varnish	Two every 12 months
D1208	Topical application of fluoride (excluding prophylaxis)	Two every 12 months
D1351	Sealants	one sealant per tooth every 36 months
D1352	Preventive resin restorations on a moderate to high caries risk patient – permanent teeth	One preventive resin per tooth every 36 months
D1353	Sealant repair – permanent tooth	One per tooth every 36 months
D1354	Interim caries medicament – permanent teeth	I per tooth every 36 months, molars/bicuspids, excluding wisdom teeth. Per arch two times per calendar year.
D1510, D1515, D1520, D1525	Space maintainers that replace prematurely lost teeth – fixed or removable space maintainers	Limited to children under age 19
D1550	Re-cementation or re-bond of space maintainers	Limited to children under age 19
D1555	Removal of fixed space	Only eligible for children under

	maintainers	age 19
D9110	Palliative treatment of dental pain – minor procedure	By report. As medically necessary.
Services Not Covered		
D1310	Nutritional counseling	
D1320	Tobacco Counseling	
D1330	Oral Hygiene Instruction	
D5986	Fluoride Gel Carrier	
D5991	Topical Medicament Carrier	

INTERMEDIATE SERVICES		
Minor Restorative Services: Eligible amalgam and composite fillings are limited to once in a 24 month period.		
Code	**Service**	**Limits**
D2140	Amalgam, one surface- primary or permanent	
D2150	Amalgam – two surfaces, primary or permanent	
D2160	Amalgam – three surfaces, primary or permanent	
D2161	Amalgam – four surfaces, primary or permanent	
D2330	Resin-based composite – one surface, anterior	
D2331	Resin-based composite – two surfaces, anterior	
D2332	Resin-based composite – three surfaces, anterior	
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	
D2910	Re-cement inlay or re-bond inlay, onlay veneer or partial coverage restoration	
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	
D2920	Re-cement or re-bond crown	
D2929	Prefabricated porcelain crown - - primary	Under age 15 where no permanent successor exists
D2930	Prefabricated stainless steel	Under age 15 – limited to 1 per

	crown – primary tooth	tooth every 60 months
D2931	Prefabricated stainless steel crown- permanent tooth	Under age 15 – limited to 1 per tooth every 60 months
D2940	Protective Restoration	
D2951	Pin retention	Per tooth – in addition to restoration
Endodontic Services		
D3220	Therapeutic pulpotomy (excluding final restoration)	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to one tooth per lifetime
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	Incomplete endodontic treatment when you discontinue treatment. limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to one tooth per lifetime
Periodontal Services		
D4341	Periodontal scaling and root planning – four or more teeth per quadrant	limited to 1 per quadrant every 24 months
D4342	Periodontal scaling and planning – one to three teeth per quadrant	limited to 1 every 24 months
D7921	Collect – apply autologous product	limited to 1 in 36 months
Prosthodontic Services		
D5410, D5411	Adjust complete denture	Limit removed
D5421, D5422	Adjust partial denture	Limit removed
D5510	Repair broken complete denture base	Limit removed
D5520	Replace missing or broken	Limit removed

	teeth – complete denture (each tooth)	
D5610	Repair resin denture base	Limit removed
D5620	Repair cast framework	Limit removed
D5630	Repair or replace broken clasp	Limit removed
D5640	Repair or replace broken tooth – per tooth	Limit removed
D5650	Add tooth to existing partial denture	Limit removed
D5660	Add clasp to existing partial denture	Limit removed
D5710, D5711	Rebase complete denture	limited to 1 in 36 month period 6 months after initial installation
D5720, D5721	Rebase partial denture	limited to 1 in 36 month period 6 months after initial installation
D5730, D5731	Reline complete denture	limited to 1 in 36 month period 6 months after initial installation
D5740, D5741	Reline partial denture	limited to 1 in 36 month period 6 months after initial installation
D5750, D5751	Reline complete denture (laboratory)	limited to 1 in 36 month period 6 months after initial installation
D5760, D5761	Reline partial denture (laboratory)	limited to 1 in 36 month period 6 months after initial installation
D5850, D5851	Tissue conditioning	Limit removed
D6930	Re-cement fixed partial dentures	None
D6980	Fixed partial denture repairs	By report
Oral Surgery		
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	Medical necessity
D7210	Removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Medical necessity
D7220	Removal of impacted tooth – soft tissue	Medical necessity
D7230, D7240, D7241	Removal of impacted tooth	Medical necessity
D7250	Removal of residual tooth roots (cutting procedure)	Medical necessity
D7251	Coronectomy – intentional partial tooth removal	Medical necessity
D7270	Tooth reimplantation and/or	does not need to be a bundled

	stabilization of accidentally evulsed or displaced tooth	service
D7280	Surgical access of an unerupted tooth	Medical necessity
D7310, D7311	Alveoloplasty in conjunction with extractions	One per tooth per lifetime
D7320, D7321	Alveoloplasty not in conjunction with extractions	One per tooth per lifetime
D7471	Removal of exostosis	Limited to once per lifetime
D7510	Incision and drainage of abscess – intraoral soft tissue	Does not need to be a bundled service
D7910	Suture of recent small wounds up to 5 cm	Medical necessity
D7953	Bone replacement graft for ridge preservation – per site	Medical necessity. May be covered as a medical benefit
D7971	Excision of pericoronal gingiva	Medical necessity
Services Not Covered		
D7292	Surgical replacement of screw retained plate	
D7293	Surgical replacement with surgical flap	
D7294	Surgical replacement without surgical flap	
D7880	TMJ appliance	
D7881	Occlusal orthotic device adjustment	
D7899	TMJ therapy	
D7951	Sinus augmentation – lateral	
D7952	Sinus augmentation of vertical	
D7997	Appliance removal	
D7998	Intraoral placement of a fixation device	

Major Services		
Restorative Services		
Note: When dental services that are subject to a frequency limitation were performed prior to your effective date of coverage the date of the prior service may be counted toward the time, frequency limitations and/or replacement limitations under this dental insurance. (For example, even if a crown, partial bridge, etc. was not placed while covered by a CHIP plan, or paid by a CHIP plan, the frequency limitations may apply.) inlays, onlays, and crowns require preauthorization.		
Code	**Service**	**Limits**

D0160	Detailed and extensive oral evaluation – problem focused	By report
D2510, D2520, D2530	Inlay – metallic	an alternate benefit will be provided
D2542, D2543, D2544	Onlay – metallic	1 per tooth every 60 months
D2740	Crown – porcelain/ceramic substrate	limited to 1 per tooth every 60 months
D2750	Crown – porcelain fused to high noble metal	limited to 1 per tooth every 60 months
D2751	Crown- porcelain fused to predominantly base metal	limited to 1 per tooth every 60 months
D2752	Crown – porcelain fused to noble metal	limited to 1per tooth every 60 months
D2780	Crown ¾ cast high noble metal	limited to 1per tooth every 60 months
D2781	Crown -3/4 cast predominantly base metal	limited to 1per tooth every 60 months
D2783	Crown – ¾ porcelain/ceramic	limited to 1per tooth every 60 months
D2790	Crown – full cast high noble metal	limited to 1per tooth every 60 months
D2791	Crown – full cast predominantly base metal	limited to 1per tooth every 60 months
D2792	Crown – full cast noble metal	limited to 1per tooth every 60 months
D2794	Crown – titanium	limited to 1per tooth every 60 months
D2950	Core buildup, including any pins	limited to 1per tooth every 60 months
D2954	Prefabricated post and core, in addition to crown	Limited to once per tooth per lifetime
D2980	Crown repair	By report one per tooth per 12 month period
D2981	Inlay repair	
D2983	Veneer repair	By report
D2990	Resin infiltration/smooth surface	limited to 1 tooth every 36months
Endodontic Services		
D3310, D3320, D3330	endodontic therapy	Excluding final restoration
D3346, D3347, D3348	Retreatment of previous endodontic therapy	
D3351, D3352, D3353	Apexification/recalcification	

D3354	Pulpal regeneration	Does not include final restoration
D3410, D3421, D3425, D3426	Apicoectomy/periadicular surgery	
D3450	Root amputation – per root	
D3920	Hemisection (including any root removal) not including root canal therapy	
Periodontal Services		
D4210, D4211	Gingivectomy or gingivoplasty	Limited to 1 every 36 months Per quadrant
D4212	Gingivectomy or gingivoplasty	With restorative procedures, per tooth, limited to 1 every 36 months
D4240	Gingival flap procedure, 4 or more teeth	Limited to 1 every 36 months Per quadrant
D4241	Gingival flap procedure, including root planning – one to three contiguous teeth or bounded teeth spaces per quadrant	Limited to 1 every 36 months Per quadrant or site
D4249	Clinical crown lengthening - hard tissue	Per tooth per lifetime
D4260, D4261	Osseous surgery (including flap entry and closure	Limited to 1 every 36 months Per quadrant
D4263	Bone replacement graft – first site in quadrant	Limited to 1 every 36 months Per quadrant
D4270	Pedicle soft tissue graft procedure	Limited to 1 every 36 months per quadrant
D4273	Autogenous connective tissue graft procedures (including donor site surgery)	Limited to 1 every 36 months per quadrant
D4275	Non-autogenous connective tissue graft	Limited to 1 every 36 months per quadrant
D4277, D4278	Free soft tissue graft	
D4283	Subepithelial tissue graft/each additional contiguous tooth, implant, or edentulous tooth position in same graft site	
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical	Limited to 1 every 36 months

	site and donor material) – each additional contiguous tooth, implant, or edentulous tooth position in the same graft site	
D4355	Full mouth debridement	Limited to 1 per lifetime
Prosthodontic Services		
D5110, D5120	Complete denture	Limited to 1 every 60 months
D5130, D5140	Immediate denture	Limited to 1 every 60 months
D5211, D5212	Partial denture – resin base (including any conventional clasps, rests, and teeth)	Limited to 1 every 60 months
D5213, D5214	Partial denture –resin base (including any conventional clasps, rests, and teeth)	Limited to 1 every 60 months
D5221, D5222	Immediate partial denture - resin base (including any conventional clasps, rests, and teeth)	Limited to 1 every 60 months
D5223, D5224	Immediate partial denture – cast metal framework with resin denture base (including any conventional clasps, rests and teeth)	Limited to 1 every 60 months
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	Limited to 1 every 60 months
Note: an implant is a covered procedure of the plan only if determined to be a dental necessity. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthesis phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan.		
D6010	Endosteal implant	Limited to 1 every 60 months
D6012	Surgical placement of interim implant body	Limited to 1 every 60 months
D6040	Eposteal implant	Limited to 1 every 60 months
D6050	Transosteal implant including hardware	Limited to 1 every 60 months
D6055	Connecting bar – implant or abutment supported	Limited to 1 every 60 months
D6056	Prefabricated abutment	Limited to 1 every 60 months
D6057	Custom abutment	Limited to 1 every 60 months
D6058	Abutment supported porcelain ceramic crown	Limited to 1 every 60 months

D6059	Abutment supported porcelain fused to high noble metal	Limited to 1 every 60 months
D6060	Abutment supported porcelain fused to predominantly base metal crown	Limited to 1 every 60 months
D6061	Abutment supported porcelain fused to noble metal crown	Limited to 1 every 60 months
D6062	Abutment supported cast high noble metal crown	Limited to 1 every 60 months
D6063	Abutment supported cast predominantly base metal crown	Limited to 1 every 60 months
D6064	Abutment supported cast noble metal crown	Limited to 1 every 60 months
D6065	Implant supported porcelain/ceramic crown	Limited to 1 every 60 months
D6066	Implant supported porcelain fused to high metal crown	Limited to 1 every 60 months
D6067	Implant supported metal crown	Limited to 1 every 60 months
D6068	Abutment supported retainer for porcelain/ceramic fixed partial denture	Limited to 1 every 60 months
D6069	Abutment supported retainer for porcelain fused to high noble metal fixed partial denture	Limited to 1 every 60 months
D6070	Abutment supported retainer for porcelain fused to predominantly base metal fixed partial denture	Limited to 1 every 60 months
D6071	Abutment supported retainer for porcelain fused to noble metal fixed partial denture	Limited to 1 every 60 months
D6072	Abutment supported retainer for cast high noble metal fixed partial denture	Limited to 1 every 60 months
D6073	Abutment supported retainer for cast noble metal fixed partial denture	Limited to 1 every 60 months
D6074	Abutment supported retainer for cast noble metal fixed partial denture	Limited to 1 every 60 months

D6075	Implant supported retainer for ceramic fixed partial denture	Limited to 1 every 60 months
D6076	Implant supported retainer for porcelain fused to high noble metal fixed partial denture	Limited to 1 every 60 months
D6077	Implant supported retainer for cast metal fixed partial denture	Limited to 1 every 60 months
D6080	Implant maintenance	Limited to 1 every 60 months
D6090	Repair implant prosthesis	Limited to 1 every 60 months
D6091	Replacement of semi- precision or precision attachment	Limited to 1 every 60 months
D6095	Repair implant abutment	Limited to 1 every 60 months
D6100	Implant removal	Limited to 1 every 60 months
D6101	Debridement periimplant defect	Limited to 1 every 60 months Covered if implants are covered
D6102	Debridement and osseous peiimplant defect	Limited to 1 every 60 months Covered if implants are covered
D6103	Bone graft periimplant defect	Covered if implants are covered
D6104	Bone graft implant replacement	Covered if implants are covered
D6110, D6111	Implant/abutment supported removable denture for edentulous arch	Limited to 1 every 60 months
D6112, D6113	Implant/abutment supported removable partial denture for partially edentulous arch	Limited to 1 every 60 months
D6114, D6115	Implant/abutment supported fixed denture for edentulous arch	Limited to 1 every 60 months
D6116, D6117	Implant/abutment supported fixed denture for partially edentulous arch	Limited to 1 every 60 months
D6190	Implant index	Limited to 1 every 60 months
D6210	Pontic –cast high noble metal	Limited to 1 every 60 months
D6211	Pontic – cast predominantly base metal	Limited to 1 every 60 months
D6212	Pontic – cast noble metal	Limited to 1 every 60 months
D6214	Pontic – titanium	Limited to 1 every 60 months
D6240	Pontic – porcelain fused to high noble metal	Limited to 1 every 60 months
D6241	Pontic – porcelain fused to	Limited to 1 every 60 months

	predominantly base metal	
D6242	Pontic – porcelain fused to noble metal	Limited to 1 every 60 months
D6245	Pontic – porcelain/ceramic	Limited to 1 every 60 months
D6519	Inlay/onlay – porcelain/ceramic	Limited to 1 every 60 months
D6520, D6530	Inlay – metallic	Limited to 1 every 60 months
D6543, D6544	Onlay – metallic	Limited to 1 every 60 months
D6545	Retainer – cast metal for resin bonded fixed prosthesis	Limited to 1 every 60 months
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	Limited to 1 every 60 months
D6549	Retainer –for resin bonded fixed prosthesis	Limited to 1 every 60 months
D6740	Crown – porcelain/ceramic	Limited to 1 every 60 months
D6750	Crown – porcelain fused to high noble metal	Limited to 1 every 60 months
D6751	Crown – porcelain fused to predominantly base metal	Limited to 1 every 60 months
D6752	Crown – porcelain fused to noble metal	Limited to 1 every 60 months
D6780	Crown – ¾ cast high noble metal	Limited to 1 every 60 months
D6781	Crown – ¾ cast predominantly base metal	Limited to 1 every 60 months
D6781	Crown – ¾ cast noble metal	Limited to 1 every 60 months
D6783	Crown – ¾ porcelain/ceramic	Limited to 1 every 60 months
D6790	Crown – full cast high noble metal	Limited to 1 every 60 months
D6791	Crown – full cast predominantly base metal	Limited to 1 every 60 months
D6792	Crown – full cast noble metal	Limited to 1 every 60 months
D9932, D9933	Cleaning and inspection of removable complete denture	Limited to 1 every 60 months
D9934, D9935	Cleaning and inspection of removable partial denture	Limited to 1 every 60 months
D9940	Occlusal guard, by report	I in 12 months for patients 13 and older
D9943	Occlusal guard	In every 24 months
Services Not Covered		
D0171	Reevaluation-post-operative office visit	

D2410, D2420, D2430	Gold foil	
D2799	Provisional crown	
D2955	Post removal	
D2975	Coping	
D3460	Endodontic implant	
D3470	Intentional reimplantation	
D3910	Surgical procedure for isolation of tooth	
D3950	Canal preparation	
D4230, D4231	Anatomical crown exposure	
D4320	Splinting intracoronal	
D4321	Splinting extracoronal	
D5810, D5811	Complete denture – interim	
D5820, D5821	Partial denture - interim	
D5862	Precision attachment	
D5867	Replacement precision attachment	
D5986	Fluoride gel carrier	
D6051	Interim abutment	
D6199	Unspecified implant procedure, by report	
D6253	Provisional pontic	
D6793	Provisional retainer crown	
D6920	Connector bar	
D6940	Stress breaker	
D6950	Precision attachment	
D9219	Evaluation for deep sedation or general anesthesia	
D9986	Missed appointment	
D9987	Cancelled appointment	

Orthodontia		
Prior authorization required for orthodontic services		
D8010	Limited orthodontic treatment of the primary dentition	
D8020	Limited orthodontic treatment of the transitional dentition	
D8030	Limited orthodontic treatment of the adolescent dentition	
D8040	Limited orthodontic treatment of the adult dentition	
D8050	Interceptive orthodontic	

	treatment of the primary dentition	
D8060	Interceptive orthodontic treatment of the transitional dentition	
D8070	Comprehensive orthodontic treatment of the transitional dentition	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	
D8090	Comprehensive orthodontic treatment of the adult dentition	
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment examination to monitor growth and development	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
Services Not Covered		
Repair of damaged orthodontic appliances		
Removable orthodontic retainer adjustment		
Replacement of lost or missing appliance		
Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.		

General Services		
Anesthesia		
D9230	Nitrous oxide	No age limit for CHIP enrollees
D9223	Deep sedation/general anesthesia	Each 15 minute increment
D9241	Intravenous moderate (conscious) sedation/analgesia	First 30 minutes
D9243	Intravenous moderate (conscious) sedation/analgesia	Each 15 minute increment

D9248	Non-intravenous conscious sedation	
D9310	Consultation (diagnostic service provided by dentist or physician other than the practitioner providing treatment	
D9610	Therapeutic drug injection	By report
D9930	Treatment of complications (post-surgical) – unusual circumstances	By report
Services Not Covered		
D0310	Sialography	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	
D9211	Regional block anesthesia	
D9212	Trigeminal division block anesthesia	
D9215	Local anesthesia	
D9248	Non-intravenous conscious sedation	
D9410	House/extended care facility call	
D9420	Hospital call	
D9450	Case presentation	
D9630	other drugs and medicaments	
D9920	Behavior management	
D9941	Fabrication of athletic mouthguard	
D9950	Occlusion analysis – mounted case	
D9951, D9952	Occlusal adjustment	
D9970	Enamel microabrasion	
D9971	Odontoplasty 1-2 teeth	
D9972, D9973	External bleaching	
D9974	Internal bleaching	
D0472, D0473, D0474, D0480, D0502	Oral pathology lab	
The following services may be covered under medical benefits. Preauthorization required		
D5911, D5912	Facial moulage	
D5913	Nasal prosthesis	

D5914	Auricular prosthesis	
D5915	Orbital prosthesis	
D5915	Ocular prosthesis	
D5919	Facial prosthesis	
D5922	Nasal septal prosthesis	
D5923	Ocular prosthesis (interim)	
D5924	Cranial prosthesis	
D5925	Facial augmentation implant	
D5926	Nasal prosthesis (replacement)	
D5927	Auricular prosthesis (replacement)	
D5928	Orbital prosthesis (replacement)	
D5929	Facial prosthesis (replacement)	
D5931, D5932, D5933	Obturator prosthesis	
D5934	Mandibular resection prosthesis w/guide flange	
D5935	Mandibular resection prosthesis w/o guide flange	
D5936	Obturator prosthesis (interim)	
D5937	Trismus appliance	
D5951	Feeding aid	
D5952, D5953	Speed aid prosthesis	
D5954	Palatal augmentation prosthesis	
D5955	Palatal lift prosthesis (definitive)	
D5958	Palatal lift prosthesis (interim)	
D5959	Palatal lift prosthesis (modification)	
D5960	Speech aid prosthesis (modification)	
D5982	Surgical stent	
D5983	Radiation carrier	
D5984	Radiation shield	
D5985	Radiation cone locator	
D5987	Commissure splint	
D5988	Surgical splint	
D5992	Adjust maxillofacial prosthetic appliance, by	

	report	
D7285	Biopsy oral tissue (hard)	
D7286	Biopsy oral tissue (soft)	
D7295	Harvest bone for autogenous grafting procedure	
D7410, D7411	Surgical excision lesion (benign) soft tissue	
D7412	Surgical excision Complicated lesion (benign)	
D7413, D7414	Surgical excision Lesion (malignant) soft tissue	
D7415	Surgical excision Complicated lesion (malignant)	
D7440, D7441	Surgical excision Lesion (malignant) intra-osseous	
D7460, D7461	Surgical excision Removal of benign lesion (nonodontogenic)	
D7465	Destruction of lesion (by report)	
D7490	Radical resection of maxilla or mandible	
D7530	Removal of foreign body	
D7540	Removal of reaction producing foreign body	
D7550	Partial ostectomy	
D7560	Maxillary sinusotomy	
D7610	Upper open reduction	
D7620	Upper closed reduction	
D7630	Lower open reduction (simple)	
D7640	Lower closed reduction (simple)	
D7650	Open reduction (simple)	
D7660	Closed reduction (simple)	
D7670	Alveolus closed reduction (simple)	
D7671	Alveolus open reduction (simple)	
D7680	Facial bones (simple)	
D7710	Upper open reduction (compound)	
D7720	Upper closed reduction (compound)	

D7730	Lower open reduction (compound)	
D7740	Lower closed reduction (compound)	
D7750	Malar and/or zygomatic arch open reduction (compound)	
D7760	Malar and/or zygomatic arch closed reduction (compound)	
D7770	Alveolus open reduction (compound - stabilization of teeth)	
D7771	Alveolus closed reduction (compound – stabilization of teeth)	
D7780	Facial bones (compound)	
D7810	TMJ open reduction	
D7820	TMJ closed reduction	
D7830	TMJ manipulation	
D7840	Condylectomy	
D7850	Surgical discectomy	
D7852	Disc repair	
D7854	Synovectomy	
D7856	Myotomy	
D7858	Joint reconstruction	
D7860	Arthrotomy	
D7865	Arthroplasty	
D7870	Arthrocentesis	
D7871	Non-arthroscopic lysis and lavage	
D7872	Arthroscopy with or without a biopsy	
D7873	Arthroscopy surgical adhesions	
D7874	Arthroscopy disc repositioning and stabilization	
D7875	Arthroscopy synovectomy	
D7876	Arthroscopy surgical discectomy	
D7877	Arthroscopy surgical debridement	
D7911, 7912	Complicated sutures	
D7920	Skin graft	
D7940	Osteoplasty for orthognatic deformities	

D7941	Osteotomy lower rami	
D7943	Osteotomy – lower rami with bone graft	
D7944	Osteotomy – segmented	
D7945	Osteotomy – body of mandible	
D7946	Lefort I upper total	
D7947	Lefort I upper segmented	
D7948	Lefort II or Lefort III without bone graft	
D7949	Lefort II or Lefort III with bone graft	
D7950	Bone graft – mandible or face	
D7955	Repair of maxillofacial soft or hard tissue	
D7980	Sialolithotomy	
D7981	Excision of a salivary gland	
D7982	sialodochoplasty	
D7983	Closure of a salivary fistula	
D7990	Emergency tracheotomy	
D7991	Coronoidectomy	
D7995	Synthetic graft	
D7996	Implant lower for augmentation purposes	
D9975	External bleaching per arch	

General Exclusions
Services and treatment not prescribed by or under the direct supervision of a dentist, except where a dental hygienist is permitted to practice without supervision by a dentist.
Services or treatment which are experimental or investigational
Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation.
Services and treatment received from a dental or medical department maintained by on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group.
Services and treatment performed prior to your effective date of coverage.
Services and treatment incurred after termination date of your coverage unless

otherwise indicated.
Services and treatment which are not dentally necessary of which do not meet generally accepted standards of dental practice.
Services and treatment resulting from your failure to comply with professionally prescribed treatment.
Telephone consultations.
Any charge for failure to keep a scheduled appointment.
Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances.
Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ).
Services or treatment provided as a result of intentionally self-inflicted injury or illness.
Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging is an illegal occupation, or participating in a riot, rebellion, or insurrection.
Office infection control charges.
Charges for copies of your records, charts, or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays.
State or territorial taxes on dental services performed.
Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist.
Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law.
Those for which the member would have no obligation to pay in the absence of this or any similar coverage.
Those which are for specialized procedures and techniques.
Those performed by a dentist who is compensated by a facility for similar covered services performed for members.
Duplicate, provisional and temporary devices, appliances, and services.
Plaque control programs, oral hygiene instruction, and dietary instructions.
Services to alter vertical dimensions and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration from misalignment of teeth.
Gold foil restorations.
Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
Treatment or services for injuries resulting from war or an act of war, whether declared or undeclared, for from police or military service for any country or organization.
Hospital costs or any additional fees that the dentist or hospital charges for treatment as the hospital (inpatient of outpatient).
Charges by the provider for completing dental forms.
Adjustment of a denture or bridgework which is made within 6 months after

installation by the same dentist who installed it.
Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss, and teeth whiteners.
Cone beam imaging and cone beam MRI procedures.
Precision attachments, personalization, precious metal bases and other specialized techniques.
Repair of damaged orthodontic appliances.
Replacement of lost or missing appliances.
Fabrication of athletic mouthguard.
Internal and external bleaching.
Oral sedation.
Topical medicament center.
Bone grafts when done in connection with extractions, apicoectomies, or non- covered/non-eligible implants
When two or more services are submitted and the services are considered part of the same service to one another, the plan will pay the most comprehensive service (the service that includes the other non-benefitted service) as determined by the plan.
When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service) the plan will pay for the service that represents the final treatment
All out of network services covered are subject to the usual and customary maximum allowable fee charges as defined by the CHIP plan. The member is responsible for all remaining charges that exceed the allowable amount.