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State/Territory Name: Washington

State Plan Amendments (SPA) #: WA-16-0001-CHIP

This file contains the following documents in the order listed:

1) Approval Letter
2) Final Approved State Plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

JUN 0 1 2016

Mary Wood
CHIP Director
Eligibility Policy & Service Delivery
Washington State Health Care Authority
626 8th Avenue SE
Olympia, WA 98504-5534

Dear Ms. Wood:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number, WA-16-0001, submitted on April 18, 2016. This SPA updates its premium cost sharing amounts to be consistent with the state's approved Modified Adjusted Gross Income conversion plan, and makes technical updates to its CHIP State Plan. This SPA has an effective date of July 1, 2015.

Families are now required to pay monthly premiums according to federal poverty level (FPL) as detailed in the following table:

FPL		Monthly Premium Amount
> 210%	< 260%	$ 20.00 per child/$40.00 family max.
≥ 261%	≤ 312%	$ 30.00 per child/$60.00 family max.

Your title XXI project officer is Ms. Janice Adams. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Adams' contact information is as follows:

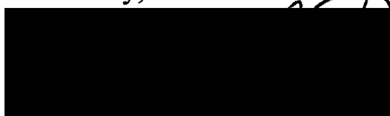
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
Mail Stop: RX-200
701 Fifth Avenue, Suite 1600
Seattle, WA 98104
Telephone: (206) 615-2541
Facsimile: (443) 380-6118
E-mail: Janice.Adams@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Adams and to Mr. David Meacham, Associate Regional Administrator (ARA) in our Seattle Regional Office. Mr. Meacham's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
Mail Stop: RX-200
701 Fifth Avenue, Suite 1600
Seattle, WA 98104

If you have additional questions, please contact Mr. Manning Pellanda, Director, Division of State Coverage Programs, at (410) 786-5143. We look forward to continuing to work with you and your staff on your program.

Sincerely,



Anne Marie Costello
Director

cc:
Mr. David Meacham, ARA, CMS Region X, Seattle

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

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new Title XXI, the State Children's Health Insurance Program (CHIP). Title XXI provides funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR Part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

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

State/Territory: ___________**State of Washington**____________________________
(Name of State/Territory)

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

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

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

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

Name: Dorothy Frost Teeter Position/Title: Director, Health Care Authority

Name: MaryAnne Lindeblad Position/Title: Medicaid Director, Health Care Authority

Name: Mary Wood Position/Title: Assistant Director Medicaid Eligibility and Community Support/Children's Health Insurance Program Director

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this Form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements *(Section 2101)*

1.1 The State will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 ☒ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); or

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); or

1.1.3. ☐ A Combination of both of the above.

Washington's CHIP offers comprehensive healthcare coverage to children through age 18, who reside in households with incomes up to 312% of the federal poverty level (FPL). Healthcare coverage for children in households with incomes up to 250% of FPL is a state mandated entitlement. Coverage for children in households with incomes above 250% of FPL is offered within available state funds appropriated by Washington's legislature. Families are required to pay a modest premium for coverage. CHIP benefits are the same as the state's Medicaid program for children. The program uses the state's Medicaid managed care delivery system and employs Medicaid income eligibility criteria.

1.2 ☒ Please 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))

Washington State assures that expenditures for child health assistance will not be claimed prior to the time the State has legislative authority to operate the State plan or before the State plan amendment is approved by CMS.

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

Washington State assures that the state complies with all applicable civil rights

requirements.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

<u>Amendment 1</u> - This amendment allowed the assignment of eligible children into managed care plans and created eligibility requirements similar to the Washington State Medicaid program.

Submitted: February 8, 2001

Approved: May 7, 2001

Effective date: January 1, 2001

<u>Amendment 2</u> - This amendment removed the co-pay requirement.

Submitted: April 3, 2002

Approved: July 1, 2002

Effective date: January 1, 2002

<u>Amendment 3</u> - This amendment updated the plan to specify the States compliance with the final CHIP regulation.

Submitted: October 3, 2002

Approved: December 19, 2002

Effective date: July 1, 2002

<u>Amendment 4</u> - This amendment allows CHIP coverage for unborn children of women up to 185% of the Federal poverty level who are not eligible for Medicaid.

Submitted: June 25, 2003

Approved: September 22, 2003

Effective date: November 12, 2002

<u>Amendment 5</u> - This amendment changed the eligibility review period from 12 months of continuous coverage to 6 months of non-continuous coverage.

Submitted: January 22, 2004

Approved: une 1 , 2004

E e tive date: De ember 31, 2003

Amendment 6 - This amendment increased the premium amount from $10/mo. per child; $30/mo maximum per family to $15/mo per child; $45/mo maximum per family. The time allowed for non-payment of premiums was decreased from 4-months to 3-months; the waiting period after disenrollment for non-payment was decreased from 4-months to 3-months.

Submitted: August 16, 2004

Approved: November 5, 2004

Effective date: July 1, 2004

Amendment 7 - This amendment restored the certification period back to 12 months continuous coverage; it also updated the State plan to reflect the name and organizational changes that occurred within the agency that administers CHIP.

Submitted: May 2, 2006

Approved: August 1, 2006

Effective date: July 1, 2005

Amendment 8 - This amendment proposed a change in rates and payment methods and a requirement for a SSN for children.

Submitted: November 27, 2006

Withdrawn: December 27, 2006

Amendment 9 - This amendment proposed funding for additional outreach activities.

Submitted: January 23, 2007

Withdrawn: February 3, 2008

Amendment 10 - This amendment increased funding from CHIP for additional outreach activities as a part of the passage of Cover All Kids legislation.

Submitted: April 3, 2008

Approved: December 17, 2008

Effective date: July 1, 2007

Amendment 11 - This amendment proposes increasing the income limit to 300% FPL and creating a two-tiered premium structure for CHIP. The premium amount will also be increased. Good cause for dropping employer sponsored insurance is also amended from a cost of $50 to a cost of 2.5% household income.

Submitted: April 14, 2008

Approved: April 3, 2009

Effective date: January 1, 2009

Amendment 12 - This amendment expanded the delivery of mental health services.

Submitted: May 14, 2008

Approved: January 16, 2009

Effective date: July 1, 2008

Amendment 13 – This amendment is to provide federal funding for the Washington Poison Center (WAPC) under a health services initiative; expand CHIP coverage to lawfully residing alien children under age 19; require verification of citizenship; describe the CHIP dental coverage package; reference FQHC/RHC reimbursement methodology; and eliminate the 3 month sanction for failing to pay required premiums.

Submitted date: June 29, 2010

Approved date: December 9, 2010

Effective date: July 1, 2009 for WAPC funding and lawfully residing alien children.
October 1, 2009 for dental coverage and FQHC/RHC descriptions.
January 1, 2010 for citizenship verification requirement.
April 1, 2010 for elimination of 3 month sanction penalty.

Amendment 14-0001, 14-0002, 14-0003, 14-0004: See Appendix 1 & Table below

Amendment 15-001: Hospital Presumptive Eligibility: See Appendix 2 & Table below

Amendment 16-0001: This amendment is to comply with federal regulation in the

implementation of the Affordable Care Act (ACA) including conversion of the current CHIP effective income limit to a MAGI equivalent and technical corrections to reflect approved CHIP SPA templates referenced in the table below.

Submitted date: April 18, 2016

Approved date: June 1, 2016

Effective date: July 1, 2015.

Superseding Pages of MAGI CHIP State Plan Material

State: Washington

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
WA-14-0001 Effective/ Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3
		CS9	Eligibility – Coverage from Conception to Birth	Supersedes the current section Age 4.1.2.1
		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
WA-14-0002 Effective/ Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
WA-14-0004 Effective/ Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
WA-14-0003 Effective/ Implementation Date: January 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 4.1.9.1
		CS19	Non-Financial – Social Security Number	Supersedes the current section 4.1.9.2
		CS20	Substitution of Coverage	Supersedes the current section 4.4.4
		CS21	Non-Payment of Premiums	Supersedes the current section 8.7.1
		CS27	Continuous Eligibility	Supersedes the current section 4.1.8
WA-15 - 0001		CS28	Hospital presumptive eligibility	See Appendix 2

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

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

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

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

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

Based on the 2008 Washington State Population Survey (WSPS), 95.4% of all children in Washington had health care coverage in April/May 2008. This represents a 2.4% increase in healthcare coverage since the year 2000. 95.3% of children between 200% and 300% of the federal poverty level (FPL) had healthcare coverage. Approximately 13,000 children in this income range remained without healthcare

coverage and are the target population for outreach under Washington's CHIP. 92.7% of children under 200% FPL had coverage at the time of the 2008 WSPS. Approximately 48,000 children in this income range were without healthcare coverage and are included in the target population for outreach as described in 42 CFR 457.90. 97.7% of children above 300% FPL had coverage at the time of the 2008 WSPS. Consistent with national trends, employer- based coverage was the principal source of coverage for higher income children. The rate of employer-sponsored coverage of children above 300% FPL was 85.1%, whereas the rate of employer- sponsored coverage of children below 200% FPL was only 18.8%.

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

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

HCA funds poison treatment advice and prevention for children in Washington State under a health services initiative option as described in 42 CFR 457.10 through a contract with the Washington Poison Center (WAPC). The WAPC provides emergency telephone treatment advice, referral assistance, and information to manage exposure to poisonous and hazardous substances. The WAPC answers poisoning emergency calls from the general public 24 hours a day, 365 days each year at no charge. At all times, a Specialist in Poison Information (SPI) is available to manage cases and Certified Specialists in Poison Information (CSPI) are available to manage cases and direct Poison Information Providers. The service is provided via a toll-free phone number to all communities throughout Washington, including under-served, low-income, and indigent populations. Interpreters are available in over 150

languages and via telecommunications devices for the deaf and hearing impaired (TTY).

WAPC public education programs direct attention and resources to at-risk populations living in poverty, including minority and immigrant communities. Consumer-based educational materials have been developed that are culturally relevant, taking into consideration health literacy levels and clearly illustrating and describing WAPC services. In addition to English, materials are available in Spanish, Korean, Vietnamese, Laotian, Chinese, Russian, and Somali.

The WAPC promotes poison awareness through community forums. WAPC's mascot "Mr. Yuk" is a familiar face at presentations in schools, community health fairs, and other local events and gatherings. The WAPC works closely with other community health programs such as Washington State's Safe Kids Program and Safe Kids Coalition groups.

The WAPC advertises their public toll-free number and toll-free TTY number in the white pages and consumer guides of all Washington state telephone directories, as well as on billboards across the state. Advertisements and billboards are in Spanish and English.

The WAPC receives approximately 66,000 calls annually involving a poison or hazardous substance exposure. 63% of all calls received are regarding exposure of child under the age of 19. Over 35% of the total calls relate to exposure of a child in a family whose annual household income is no more than 300% FPL.[1] WAPC intervention resulted in over 94% these exposures calls being handled in the home

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1 The percentage of calls attributed to children in families with incomes no greater than 300% FPL is based on WAPC records for 2009. 66,083 total exposure calls were answered statewide. 41,827 exposure calls were for children ages 0 – 18. 2008 Washington State Population Survey (http://wa-state-ofm.us/SPSOnline/) estimates 55.5% of Washington children are living in households with incomes no more than 300%FPL. This represents 23,214 calls, or 35.1% of the total volume of calls.

so that the child did not have to use an Emergency Department or need a 911 call and response. Each call to the WAPC significantly reduces costs in other medical spending. Cost savings in 1996 dollars were estimated at $175 per call.[2]

The current annual contract is approximately $1.8 million dollars and is based on the WAPC's annual operating budget multiplied by the percentage of phone calls received on behalf of children. The expenditure is within the 10% administrative cap for the CHIP program.

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

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2 *Miller T.R. & Lestina, D.C. (1997). Costs of Poisoning in the United States and Savings from Poison Control Centers: A Benefit-Cost Analysis. Annuals of Emergency Medicine, 29(2), 239-45.*

the frequency, inclusiveness and process for seeking such advice.

The Health Care Authority (HCA) has an extensive tribal consultation and communication policy that promotes a collaborative process between HCA, federally recognized Tribal governments, the Indian Health Service, Urban Indian Health Programs (UIHP), and the American Indian Health Commission for Washington State (AIHC). This process is set forth in Washington's Medicaid State Plan section 1.4 with additional information available on the Tribal Affairs home page at http://www.hca.wa.gov/tribal/Pages/index.aspx

Section 3. Methods of Delivery and Utilization Controls *(Section 2102)(a)(4))*

☐ 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.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

Washington's CHIP uses Washington's Medicaid managed care delivery system. The managed care system contracts with managed care organizations (MCOs) for medical care coverage and a limited mental health benefit for enrollees that do not meet the criteria for primary mental health care services from the Regional Support Networks (RSN's). Other Medicaid services are "carved out" of managed care and provided on a "wrap-around" fee-for-service (FFS) basis. These "wrap around" services include dental coverage, chemical dependency services, eyeglasses, hearing aid devices, pregnancy terminations, and non-emergent transportation. Children also receive services through HCA's FFS program prior to enrollment in managed care.

HCA contracts with MCOs registered with the state's Office of the Insurance Commissioner (OIC) to provide full-scope medical coverage on a full-risk capitation basis. This program is called Healthy Options (HO). If HCA does not contract with at least two MCOs for coverage in a given service area, or if the contracting plan's networks are not able to provide sufficient access throughout the county, enrollees will be allowed to receive coverage through FFS.

In service areas with a choice of at least two MCOs, CHIP enrollees will be required to enroll in an MCO and will receive the same schedule-of-benefits as Medicaid clients.

A CHIP household has the option of selecting a HO plan for their child as part of the application process. However, after approval of the application, if a client does not

voluntarily choose a plan, the client will be assigned to a plan when there are two or more plans in their community.

HCA contracts with Indian Health Services (IHS) and tribal operated health clinics to provide primary care case management (PCCM) coverage to American Indians/Alaska Natives as an alternative to managed care enrollment.

Washington's CHIP program reimburses Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) using the same alternative payment methodology (APM) as the State's Medicaid program. There is no difference between the CHIP rates and the Medicaid rates for reimbursing Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC).

In the State of Washington, FQHCs/RHCs have the choice of reimbursement under the Prospective Payment System (PPS) as outlined in the Benefits Improvement and Protection Act of 2000 (BIPA) statutory language, or an Alternative Payment Methodology (APM).

Prospective Payment System

The facility-specific encounter rates were established in 2002, and they are considered the providers' base encounter rates. The base rates were calculated using cost report data from 1999 and 2000, and in some cases, 2001. The corresponding enhancement rates were also established at this time. Pursuant to the requirements of the PPS, both the FFS encounter rates and managed care enhancement rates for each provider have been increased annually by the percentage change in the MEI.

Alternative Payment Methodology

The APM encounter rates were established by starting with each provider's base PPS rate, and trending forward to 2009 using the APM index. The APM index is a Washington State specific health Care index developed by IHS Global Insight. Rates established under the APM will be inflated each year by the Washington State specific health care index.

Annual reconciliation is a part of the APM. Rates determined under the APM will be periodically rebased.

Supplemental Payments for Managed Care Clients

For clients enrolled with a managed care contractor, the Agency will pay the FQHC/RHC a supplemental payment (called enhancement) in addition to the amount paid by the managed care contractor. These enhancements will pay monthly on a per-member-per-month basis. To ensure that the appropriate amounts are being paid to each FQHC/RHC, the Agency will perform an annual reconciliation and verify that the enhancement payments made in the previous year were in compliance with Section 1902(bb)(5)(A) of the Social Security Act.

An additional description of this methodology can be found on page 3 (RHC) and page 33 (FQHC) of Attachment 4.19-B of the Title XIX state plan, as approved by CMS on June 26, 2009.

HCA contracts with public Regional Support Networks (RSNs) via DSHS' Division of Behavioral Health and Recovery (DBHR) to offer mental health services as prepaid inpatient health plans. To receive mental health care, all Medicaid and CHIP children are enrolled in the RSN providing coverage in their county of residence.

Children enrolled in HO or in the FFS program receive their mental health care through their MCO or FFS provider if they do not meet the criteria for RSN services.

In addition to psychiatrists, the following mental health professionals, when licensed by the Department of Health, may also provide mental health services beginning July 1, 2008:

- Licensed Psychologists
- Licensed Psychiatric Advanced Registered Nurse Practitioners
- Licensed Independent Clinical Social Workers
- Licensed Advanced Social Workers
- Licensed Marriage and Family Therapists
- Licensed Mental Health Counselors

HCA has developed procedures with DBHR to assure coordinated care. HCA sends a monthly tape to DBHR identifying Medicaid clients and their eligibility group and

CHIP clients. DBHR provides services based on clinical need, not insurance coverage. DBHR-contracted and subcontracted outpatient treatment providers who have signed a Core Provider Agreement conduct assessments to determine the extent of the problem and the course of treatment.

Substance abuse treatment services are not included in the HO capitation rates and are paid outside the contracts. HO contracts require that licensed health carriers assure that care is coordinated with non-participating community health and social program providers, including substance abuse providers. In order for the alcohol and drug treatment to be paid through the medical assistance program, patients enrolled in HO must receive substance abuse treatment from state certified treatment agencies who have signed a Core Provider Agreement. One of the DBHR-contracted and subcontracted outpatient treatment providers who have signed a Core Provider Agreement conducts an assessment to determine the extent of the problem and the course of treatment.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

HO plans are required to manage service utilization according to standards in the state's Quality Improvement Program Standards. Before being approved for participation in the program, health plans must have in place utilization review infrastructure and protocols for, but not limited to:

- Determination of medical appropriateness and denial of services;
- Referrals to specialty care;
- Clinician participation and use of clinical practice guidelines;
- Twenty-four hour availability of clinical consultation;
- Availability and profiling of practitioners;
- Identification of members with chronic/high-risk illnesses, hospital discharge

planning, case management, and coordination of special needs;
- Access and timeliness of services; and
- Review of under or over utilization of care.

Internal monitoring reviews will be routinely conducted to assure that medically necessary care is delivered in a cost-effective and efficient manner. External quality reviews, in accordance with federal law (Section 1902 (a) (30) (C) of the Social Security Act), will be conducted annually for selected services by all managed care organizations (MCOs) contracted with the program.

Utilization controls for CHIP children on FFS coverage are consistent with all utilization review requirements of Title XIX. Examples of utilization controls include external review of hospital claims data, exception-to-policy procedures, data audits, pre-authorization for extended coverage utilization, and drug utilization review.

Refer to Section 7 – Quality and Appropriateness of Care – for more information on utilization control.

Section 4. Eligibility Standards and Methodology *(Section 2102(b))*

☐ 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 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☒ Geographic area served by the Plan: The entire state of Washington. **Superseded by CS7**

4.1.2. ☒ Age: Children under the age of nineteen.

4.1.2.1 ☒ Age: Unborn, conception through birth.

4.1.3. ☒ Income: Above 200% FPL up to and including 300% FPL for children under age 19.

4.1.3.1 ☒ Income: 0% of the FPL (and not eligible for Medicaid) through 185% of the FPL for unborn children.

4.1.3.2 ☒ Income: All wages paid by the Census Bureau for temporary employment related to decennial census activities are excluded.

Superseded by CS7.

4.1.4. ☐ Resources (including any standards relating to spenddowns and disposition of resources): There is no resource test.

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): **See CS17**

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility): There is no disability status requirement.

4.1.7. ☒ Access to or coverage under other health coverage: CHIP coverage is not available to children who are otherwise eligible for Medicaid or who have "creditable coverage".

4.1.8. ☒ Duration of eligibility: See **CS27**.

4.1.9. ☒ Other standards (identify and describe):

4.1.9.1 ☒ Citizenship: See **CS18**.

4.1.9.2 ☒ Social Security Number: See **CS19**

4.1.10 ☒Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible children as specified below who are lawfully residing in the United States including the following:

See CS18

☒ The State elects the CHIPRA section 214 option for children up to age 19
☐ The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period

4.1.10.1 ☒The State provides assurance that for individuals whom it enrolls in CHIP under the CHIPRA section 214 option that it has verified, both at the time of the individual's initial eligibility determination and at the time of the eligibility renewal 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.

4.1.11 ☒ The state provides coverage under CHIP for Medicaid children who lose coverage as a result of the elimination of income disregards (§2101f).

See **CS14**.

4.2. The State assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 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.

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

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

Eligibility for CHIP is based on MAGI income methodologies described in **CS15**. The eligibility process is described in **CS24**.

See section 2.3 of this document for a further description of the application process. Families now apply and renew their coverage through Washington states' Health Benefit Exchange at www.wahealthplanfinder.org. They may also use a streamlined paper application submitted to the Exchange for data entry of the information on the application.

Ex Parte renewals are completed using electronic data-matching with the federal hub. If the electronic match confirms eligibility, then CHIP coverage is continued without the need for any further information or forms. If the electronic data match fails, then the family is sent a letter advising them to go to the www.wahealthplanfinder.org to renew their coverage. They also receive a paper renewal form that they may complete and return to the state's Health Benefit Exchange to have renewal data entered into the system.
Data entered into the www.wahealthplanfinder.org web application is transferred to the Automated Client Eligibility System (ACES). ACES transfers eligibility information to the state's Medical Management Information System (MMIS) "ProviderOne". MMIS information is used to enroll clients into managed care.

The application requires the citizenship status and Social Security Number (SSN) of only those children for whom the family is seeking benefits. Adults, and other children listed on the application for whom the family is not applying, are not required to declare their citizenship status or provide an SSN.

When the family applies via www.wahealthplanfinder.org (HPF) web portal, data such as the SSN is transmitted to other available state and federal data exchanges. The

information from these exchanges may then be used as electronic proof of eligibility requirements. One such system is the SVES data match with the Social Security Administration (SSA). SSN information is entered into the HPF system during the application process, and transmitted to the federal hub in real time. Verification of citizenship and enumeration is federally verified and transmitted back to the HPF system and the application is processed in real time.

For continuing enrollment, the Agency will employ an ex parte renewal process that notifies families of their ongoing eligibility every twelve months when the family's circumstances are electronically verified. The renewal letter is generated and mailed to the head of household approximately six weeks prior to the end of the client's 12 month certification period. The family is directed to update their information in the HPF system; call the Agency on a statewide 800#, or complete and return the paper renewal form with current information such as household members, income, and health insurance status. The information is input into the HPF and eligibility is automatically reviewed first for Medicaid, and then reviewed for CHIP eligibility if the recipient is not Medicaid eligible.

CHIP applicants have the same appeal rights as Medicaid applicants. Applicants who are denied eligibility are sent a letter with information on their rights for an Administrative Hearing. Clients may call the Office of Administrative Hearings (OAH) to set up a hearing. OAH notifies the client and the agency's Administrative Hearing Coordinator. The Coordinator prepares the case and sets up a pre-hearing conference as a way to settle the dispute or collect information. Cases that are not resolved in the pre-hearing conference proceed to an Administrative Hearing. At the Administrative Hearing, an Administrative Law Judge gathers information from the client and agency staff. Hearings can be conducted via telephone or in person. The Judge's decision is mailed to the client and the Administrative Hearings Coordinator. Either party may appeal the decision for additional review and if need be, to the courts.

4.3.1 Describe the State's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

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

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))

See **CS24**.

At the time of application and redetermination, the HPF first determines whether an applicant or recipient is eligible for Medicaid. If the child is not Medicaid eligible, the HPF assesses eligibility for CHIP and enrolls them in CHIP, if appropriate. Application information is electronically verified using a variety of data hubs. If income information cannot be electronically verified, the HPF system will allow self-attestation. Eligibility staff will follow up on such cases to obtain verification during the post-eligibility process.

At the time of application and renewal the client is asked to answer questions about the presence of third party insurance. The Coordination of Benefits (COB) section will follow up on cases indicating the family recently stopped third party insurance during the post-eligibility review process. In addition, the COB section will continue to review a monthly report of currently eligible CHIP clients to see whether any clients have health insurance coverage.

At application or review a child applying for, or enrolled in, CHIP will not be eligible for the program if they are covered under a group health plan or health insurance coverage; has access to, or coverage under, a state health benefits plan; or are Medicaid eligible.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

All applications are first reviewed for Medicaid eligibility. Applicants are enrolled in Medicaid if eligible. This process is automated through HPF automated protocols. Eligibility for CHIP is determined only after eligibility for Medicaid is reviewed and the child is found ineligible for Medicaid.

4.4.3. The State is taking steps to assist in the enrollment in CHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2) (42CFR 431.636(b)(4))

The HPF system automatically checks for Medicaid eligibility prior to consideration of eligibility for CHIP. After Medicaid ineligibility is determined, HPF automatically checks for CHIP eligibility based on the applicant's income level.

4.4.4 The insurance provided under the State Child Health Plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☐ Coverage provided to children in families at or below 200% of the FPL: describe the methods of monitoring substitution.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% of the FPL. Describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

See **CS20**

4.4.4.3. ☒ Coverage provided to children in families above 250% of the FPL. Describe how substitution is monitored and identify specific strategies in place to prevent substitution.

See **CS20**

4.4.4.4. ☐ If the State provides coverage under a Premium Assistance Program, describe:
The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.
The minimum employer contribution.

The cost-effectiveness determination.

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))

Targeted low-income children who are American Indian or Alaska Native (AI/AN) will be subject to the same eligibility criteria as other low-income children. HCA has coordinated with and will continue to work with representatives of the Tribes in the state of Washington, urban Indian organizations, and Indian advocacy groups, including the Northwest Portland Area Indian Health Board, the American Indian Health Commission, and the DSHS Indian Policy Advisory Committee, to develop outreach programs and methods that specifically target AI/AN children. CHIP has been, and will continue to be, a regular agenda item at meetings with these groups.

CHIP policy will mirror HCA Medicaid enrollment policy for AI/AN children. AI/AN clients are not required to enroll in HO plans. Instead, AI/AN children may choose a managed care plan, an Indian clinic operating as a primary care case manager (PCCM), or fee-for-service.

Section 5. Outreach and Coordination

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

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

Washington's Governor has outlined two major health goals for Washington's children:

- Improving the quality and efficiency of health care in Washington; and
- Covering all children in Washington with health insurance by 2010.

Washington's legislature appropriated $4.4 million in state funds for state fiscal year (SFY) 2008 and 2009 for outreach activities to accomplish these goals. The following outreach activities have been conducted by Washington State under its "*Apple Health for Kids"* campaign:

1. Develop and implement a proactive statewide marketing campaign to inform low-income families about health care coverage. Included in this campaign are the contracting of a media consultant; the development of outreach and training materials; brochures; program advertising; and a rebranding of the program to "*Apple Health for Kids".*
2. Hire staff to provide program oversight and facilitate local outreach efforts.
3. Contract with 32 local health jurisdictions and 6 community based organizations in all 39 counties in Washington State to conduct outreach with the goal of enrolling uninsured, low-income children as described in 42 CFR 457.90.
4. These contracts involved two elements:
   a. Infrastructure grants to assist contractors to build capacity to conduct local outreach activities to children who do not traditionally access government

assistance programs.

Technical Assistance Payments (TAP) of $75 per approved child as a result of a successful application. HCA has worked with other state agencies to develop lists of children who were likely to be eligible based on available data bases (such as WIC, Food Assistance, Division of Child Support, and Working Connections Child Care programs). Contractors use these lists to conduct outreach/application activities and receive the TAP payment for each child that is subsequently approved for coverage.

5. Implementation of a Media campaign including purchase of advertising in local target markets and a "School-bus" media campaign tour of the state to promote the "*Apple Health for Kids"* program.
6. Conducting 4 renewal pilots to test different retention strategies.
7. Contracting with the Division of Information services for the development and roll-out of the new *"Apple Health for Kids"* website.
8. Increase in contract payments beginning in October 1st, 2008 from $75/per approved child to $150/per approved child. This increase is based on a pilot of a performance based "Application Agent" model where payment is made based on specific application assistance. Applications are barcode labeled to identify and track the agent involved. The contractor will also be responsible for providing a health literacy component to their outreach efforts. The state will only seek federal match for $75/per approved child under this model.

Ongoing Outreach activities:

Washington State will continue the statewide contract to provide:

1. **The external toll-free line.** A dedicated toll-free line for CHIP outreach activities.
2. **Child profile:** This program targets potentially eligible children identified using Washington State's health promotion and immunization registry system,
3. **Washington Coalition of Medicaid Outreach (WCOMO):** To facilitate a statewide stakeholder meeting, WCOMO disseminates pertinent eligibility information and outreach activities for stakeholders.
4. **Application Agents –** As funding is available the State will make payments to application agents for successful enrollments. When funding is not available the

State will continue to provide data matches for community-based outreach organizations.

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

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

Washington operates several programs to provide healthcare coverage to low-income children. The largest of these programs is Medicaid, which provides coverage to approximately 800,000 U.S. citizen and legal alien children annually, in households with incomes up to 210% FPL[3]. Washington's CHIP program began in 2001 and currently provides coverage to approximately 42,000 U.S. citizen and legal alien children annually in households with incomes between 210% - 312% FPL. Washington's CHIP coverage also provides coverage for over 11,000 low-income unborn children annually whose mothers do not qualify for Medicaid, but have household income below 193% FPL. In 2006, Washington reinstated its entirely state funded Children's Health program for low- income children who do not qualify for Medicaid or CHIP based on their citizenship status. Currently the program provides coverage to over 18,000 low-income children annually. The Children's Health program mirrors Medicaid and CHIP in its construction. As in the CHIP program, children in households with income between 210% and 312% FPL are required to pay a premium.

[3] Based on 2015 Medicaid Children Title XIX SEDS report.

To facilitate the success of these programs, Washington has engaged in a number of enrollment and retention strategies to ensure a high penetration rate into Medicaid and CHIP eligible populations. Among our best practices are:

- Continuous Eligibility – Once a child is found eligible for medical assistance, the child remains continuously eligible for a full twelve months, regardless of changes in the household income.
- No asset test - There is no resource test applied to eligibility for children's medical programs.
- No interview requirement – Families do not need a face- to- face interview. Application can be made through the mail or by electronic submission.
- Simplified Application –Families may apply for healthcare coverage including CHIP, through our state-based exchange using a single application. This application may be submitted as a paper application, or by calling the Exchange, or electronically at www.wahealthplanfinder.org .Joint Application - Applications for medical assistance are automatically considered for Medicaid, CHIP, and state-funded programs. Application Assisters –Our state-based Exchange has contracted with 10 lead organizations who subcontract with various community-based organizations to serve as in-person assisters directly assisting families with completion of an electronic application at www.wahealthplanfinder.org , or the streamlined paper application.
- Premium Payment Program – Parents may be reimbursed for the cost of employer- sponsored insurance to cover their Medicaid eligible child.
- Renewal contacts – The Agency provides the renewal dates to managed care organizations (MCO) who have volunteered to assist their enrollees with the renewal process. MCO staff contact the families by phone and assist them with completing the annual renewal form electronically.

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

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

Washington state continues to participate in the national Healthy Kids Now! (HKN!) toll-free 800#. This number provides information on Medicaid and CHIP eligibility for those clients who might qualify for services. Washington also funds a toll-free 800# through WithinReach providing information, application assistance, and referral services. Washington's CHIP eligibility is determined within the structure of our state-based Health Benefit Exchange, www.wahealthplanfinder.org. We continue to work closely with community partner agencies, medical providers, schools, and civic organizations to publicize and promote the Washington Apple Health for Kids program.

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

As of October 1, 2013 Washington employs an electronic application process that will allow families to apply online, over-the-phone, or in-person and receive a "real-time" eligibility decision on their application through our state-based exchange www.wahealthplanfinder.org. Families may also apply by mailing or faxing in a streamlined paper application, but the determination is not made in "real time" when a paper application is used.. The Washington Healthplanfinder system has dramatically improved the delivery of affordable health care by speeding up the

process of receiving an eligibility decision, and reducing the number of administrative barriers. Not only are families able to apply on-line, but the system conducts electronic verifications of identity, citizenship status, enumeration, and income. Self-attestation is allowed in the determination of eligibility, and previously required verifications are followed up on as needed in post-eligibility. When a family applies for coverage, eligibility is determined across the spectrum of Medicaid, CHIP, state-funded, and premium tax-credit programs.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ 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 7.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 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)) (If checked, attach a 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. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

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

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

6.1.4.1. ☒ Coverage the same as Medicaid State Plan

Washington's CHIP will provide the same scope of coverage as provided under its Medicaid program. The chart below lists the general categories of medically necessary services available

to children eligible for Categorically Needy (CN) Medicaid under Title XIX of the Social Security Act (SSA) and CHIP under Title XXI of the SSA.

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 Demonstration Project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or 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

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. (Please provide a sample of how the comparison will be done.)

6.1.4.7. ☒ Other (Describe)

SERVICE	MEDICAID CN	CHIP
Advanced RN Practitioner Services	Yes	Yes
Ambulance/Ground and Air	Yes	Yes
Anesthesia Services	Yes	Yes
Audiology	Yes	Yes
Blood/Blood Administration	Yes	Yes
Case Management – Maternity	L	L
Chiropractic Care	Yes	Yes
Clinic Services	Yes	Yes
Community Mental Health Centers	Yes	Yes
Dental Services	Yes	Yes
Dentures Only	Yes	Yes
Detox (3 days)	Yes	Yes
Drugs and Pharmaceutical Supplies	Yes	Yes
Elective Surgery	Yes	Yes
Emergency Room Services	Yes	Yes
Emergency Surgery	Yes	Yes
Eyeglasses and Exams	Yes	Yes

Family Planning Services	Yes	Yes
Healthy Kids (EPSDT)	Yes	Yes
Hearing Aid	Yes	Yes
Hospice	Yes	Yes
Home Health Services	Yes	Yes
Indian Health Clinics	Yes	Yes
Inpatient Hospital Care	Yes	Yes
Intermediate Care Facility/Services for MR	Yes	Yes
Involuntary Commitment	Yes	Yes
Maternity Support Services	Yes	Yes
Medical Equipment, Durable (DME)	Yes	Yes
Mental Health (Outpatient Services)	Yes	Yes
Midwife Services	Yes	Yes
Neuromuscular Centers	Yes	Yes
Nursing Facility Services	Yes	Yes
Nutrition Therapy	Yes	Yes
Optometry	Yes	Yes
Organ Transplants	Yes	Yes
Out-of-State Care	Yes	Yes
Outpatient Hospital Care	Yes	Yes
Oxygen/Respiratory Therapy	Yes	Yes
Pain Management (Chronic)	Yes	Yes
Personal Care Services	Yes	Yes
Physical/Occupational/Speech Therapy	Yes	Yes
Physical Medicine and Rehabilitation	Yes	Yes
Physician	Yes	Yes
Podiatry	Yes	Yes
Private Duty Nursing	L	L
Prosthetic Devices/Mobility Aids	Yes	Yes
Psychiatric Services	Yes	Yes

Psychological Evaluation	L	L
Rural Health Services & FQHC	Yes	Yes
Substance Abuse/Outpatient	Yes	Yes
Surgical Appliances	Yes	Yes
Total Enteral/Parenteral Nutrition	Yes	Yes
Transportation Other than Ambulance	Yes	Yes
X-Ray and Lab Services	Yes	Yes
Key: Yes: Service is covered (may require prior approval or have other requirements) L: Limited coverage		

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

6.2.1. ☒ Inpatient Services (Section 2110(a)(1))
6.2.2. ☒ Outpatient Services (Section 2110(a)(2))
6.2.3. ☒ Physician Services (Section 2110(a)(3))
6.2.4. ☒ Surgical Services (Section 2110(a)(4))
6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
6.2.6. ☒ Prescription drugs (Section 2110(a)(6))
6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))
6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))
6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structural services. (Section 2110(a)(10))

These services are provided by contract through the Regional Support Services Networks (RSNs).

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

6.2.11.1 ☒ RSN's are the primary mental health care provider for children with substantial mental health needs. RSN's do not have a limitation on the number of hours of treatment they provide.

6.2.11.2 ☒Children enrolled in Healthy Options or in the Fee-For-Service program receive their mental health care through their Healthy Options or FFS provider if they do not meet the criteria for RSN services. CHIP coverage of mental health services is the same as our Medicaid coverage.

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

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

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

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

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

6.2.17.1 ☒ Dental services (Section 2110(a)(17)) State Specific Dental Benefit Package. The state adopted the Washington Medicaid dental benefit package for CHIP. This includes EPSDT coverage. The state assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefit. A comprehensive description of covered services and schedules can be found at http://maa.dshs.wa.gov/Download/Billing_Instructions/Dental_Thru_20/Dental_Program_Through_20_BI.pdf.

1. Diagnostic (i.e., clinical exams, x-rays)(CDT codes: D0100-D0999)(must follow periodicity schedule)
2. Preventative (i.e., dental prophylaxis, topical fluoride treatments)(CDT codes: D1000-D1999)(must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns)(CDT codes: D2000-D2999)
4. Endontic (i.e., root canals)(CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease)(CDT codes: D4000-

4999)

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

6.2.17.2 ☒ Dental Periodicity Schedule. The state has adopted the following periodicity schedule:

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

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

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

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

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

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

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

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

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

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

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

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

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

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

6.3.2. ☐ The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to

provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

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

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

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

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

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

6.4.2. ☐ Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health

insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

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

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

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

The quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and age appropriate immunizations provided under the plan, are addressed for managed care coverage through contract requirements for participating Managed Care Organization (MCOs). Requirements and monitoring criteria are the same as those for the current HO and the fee-for-service (FFS) programs.

The state contracts only with MCOs that are regulated by the Office of the Insurance Commissioner (OIC), which regulates and monitors financial solvency and other consumer protection safeguards.

HCA monitors the quality and appropriateness of care through:

- Monitoring and analysis of quality standards and performance measures for well-baby care, well-child care, and immunizations required through encounter data, chart review, HEDIS reporting, and a variety of other contract monitoring activities listed below;
- Client interviews;
- Biennial client satisfaction/health status surveys for managed care clients;
- Complaint management system;
- Exemption/disenrollment/fair hearing database;
- Standards for health plan internal quality improvement programs;
- Network adequacy standards; and
- On-site contract compliance monitoring and technical assistance.

Contract monitoring is performed through the following actions:

- Requiring the same encounter data reporting (form, format, periodicity) as required under Medicaid HO;
- Generating HEDIS reporting and the above mentioned quality measures with the same criteria as Medicaid HO and similar FFS review;

- Applying utilization controls for FFS coverage that are consistent with all current utilization review requirements under the state's Medicaid plan. Examples of controls include external review of hospital claims data, exception-to-policy procedures, data audits, pre-authorization for extended coverage utilization, and drug utilization review;
- Performing at minimum annual, on-site quality and operational reviews of the MCO contractors;
- Reviewing of the MCOs by an External Quality Review Organization (EQRO), as required by federal law (Section 1902 (a) (30) (C) of the Social Security Act);
- Requiring that MCOs maintain an internal program of quality assurance, as required by federal regulations (42 CFR 434.34);
- Performing biennial client satisfaction surveys;
- Monitoring of actions, grievances and appeals at both the health plan level and the Medicaid state agency level.

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

In addition to the utilization controls described in Section 3.2, National Committee for Quality Assurance (NCQA) standards are the guidelines for contract requirements and monitoring. Generally, the NCQA standards address the following:

- Quality Management and Improvement – program structure, program operations, health services contracting, availability of practitioners;
- Accessibility of services, member satisfaction, health management systems, primary care provider role, scope and content of clinical quality improvement (QI) activities, clinical measurement activities, effectiveness of the QI program, and delegation of QI activity;
- Utilization Management;
- Credentialing and Re-credentialing;
- Members' Rights and Responsibilities; and
- Preventative Health Services and Medical Records.

Quality standards for FFS will be consistent with all quality utilization review requirements under the state's Medicaid plan, and the additional quality activities listed in Section 7.1

7.1.2. ☒ Performance measurement

Health Plan Employer Data and Information Set (HEDIS) performance measures will be reported and preventive health services relevant to the program such as EPSDT and child immunizations will be evaluated with the same criteria as the current HO program and similar FFS review. See further performance criteria in Section 7.1.4.

7.1.3. ☒ Information strategies

Encounter data, HEDIS measures, provider network adequacy standards, and health care experience data will be reported by health plans. The current complaint management system will be maintained at both the health plan level and the State level to assure timely resolution of client complaints and grievances. FFS information strategies will be consistent with all information requirements under the state's Medicaid plan.

7.1.4. ☒ Quality improvement strategies

The following strategies and activities have been implemented and are consistent with the HO and FFS programs:

- Monitoring and analysis of quality standards and performance measures for well-baby care, well-child and adolescent care, and childhood immunizations required through encounter data, chart review, HEDIS reporting, and a variety of other contract monitoring activities listed below;
- Client interviews;
- Biennial client satisfaction/health status surveys for managed care clients;
- Complaint management system;
- Exemption/disenrollment/fair hearing database;
- Standards for health plan internal quality improvement programs;
- Network adequacy standards; and
- On-site contract compliance monitoring and technical assistance.

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

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

The methods used to assure access to covered services, including well-baby care, well-child care, well-adolescent care, and childhood and adolescent immunizations, are based on the Healthy Options program. The methods, including monitoring, will be the following:

Availability of Practitioners

MCOs must have a written access plan describing the mechanisms used to assure the availability of primary care providers (PCPs) and physician specialists, hospitals, and pharmacies. Standards for the number and geographic distribution of PCPs and specialty care practitioners are established in the procurement requirements. MCOs submit their provider networks to HCA. MCOs must collect and analyze data to measure performance against these standards and implement corrective action when necessary.

As part of the procurement process, HO bidders are required to submit GeoNetwork analysis that describes how its network compares to HCA access guidelines for distribution (travel distance) and capacity of primary care providers (PCPs), obstetrical providers, hospitals and pharmacies. This information is compared to BHP and Public Employee Benefit Board (PEBB) networks to judge whether there is sufficient capacity. HO, BHP and PEBB plans are required to submit monthly updates of provider network changes.

Accessibility of Services

- Covered services for managed care enrollees, such as types of practitioners and providers, location of practitioners and providers, and timeliness, must be made at least as accessible as for members enrolled under the MCO's other state, federal, or private contracts.
- Coverage for medical advice through a toll-free telephone number on a 24 hours per day, 7 days per week basis must be made available to members for the purpose of rendering medical advice concerning the emergency, urgent or routine

nature of a medical condition, and authorizing care at other facilities when the use of participating facilities is not practical. This advice and authorization must be made by a licensed health care professional.

- Mechanisms must be established to assure the accessibility of primary care services, urgent care services and member services.
- Standards (which apply to HO, BHP, PEBB and CHIP) must be established that are no longer than the following:
  - Non-symptomatic (i.e., preventive care) office visit – within 30 calendar days;
  - Non-urgent, symptomatic (i.e., routine care) office visit – within 10 days;
  - Urgent, symptomatic (i.e., presentation of medical conditions requiring immediate attention, not life-threatening) office visit within 48 hours; and
  - Emergency medical care within 24 hours per day, 7 days per week.
- MCOs must collect and analyze data to measure their performance against the above standards. FFS quality standards and utilization controls are consistent with all quality and utilization review requirements under the state's Medicaid plan.
- Washington State Well-Child Exam Forms, developed collaboratively with the Washington Chapter of the American Academy of Pediatrics, the Department of Health, Head Start/ECEAP staff, health plan staff and many other stakeholder groups as part of a statewide focus on improving well-child care. Historical EPSDT chart review studies consistently demonstrated that providers using a structured charting or screening tool were significantly more likely to meet the minimum documentation requirements for a qualifying well-child visit.
  - These forms are free of charge to providers who deliver well-child care to Medicaid clients. The forms are unique to each age category and include the ages listed below:
  - Infancy – 2-4 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, and 2 years
  - Early childhood – 3 years, 4 years, 5 years, 6 years, 8 years, and 10 years
  - Late childhood – 12 years

  - Adolescence – 14 years, 16 years, 18 years
  - Each age-specific document is a two-page, NCR form. The first sheet is for the child's medical record. On the back of the first page includes information about different components of the exam. The second page is given to the family after the exam. The back of the second page provides the family with both parent education and some information about the child's growth and development between the current visit and the next anticipated visit. The forms are available in hard copy and can be ordered through MAA. The forms can also be downloaded at the DSHS website: http://www1.dshs.wa.gov/msa/forms/eforms.html (beginning at form # 13-683).

- Pay for Performance incentives for 2 year old immunizations and well-child care have been part of the Healthy Options/CHIP contract since 2004. DSHS set aside $1,000,000 each to be paid for improved performance on 2 year old immunizations and well-child care. Calculations are based on a point system that rewards health plans for both their current year performance relative to other plans and for their improvement from previous year to current year relative to other plans. The four highest performing plans share in the reward.

- EPSDT Rate Increase for Foster Care Children as a result of several studies that suggested that children in foster care were not receiving adequate health care services. HCA increased the rate of reimbursement for well-child care (for this population only) in late fall, 2001.

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

Please see response to Section 7.2.1 regarding access to covered services. The same criteria apply to all covered services.

For emergency services, the definition of emergency in the plan will be based on the current definition addressing need as defined by the "prudent layperson". As noted

above, standards assuring access and network adequacy must be written by MCOs specifying how to access emergency medical care within 24 hours per day, 7 days per week. In addition, emergency care services for medical emergencies must be provided in non-participating facilities when a member:

- Has a medical emergency meeting the contract definition and is not able to use a participating hospital (42 CFR 434.30), or
- Presents at a non-participating hospital emergency department and the member's condition is determined to be non-emergency. In such instances, the MCO must cover facility and professional services for medical screening examinations as defined in the contract.

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

The State's contract with MCOs requires the MCO to provide all medically necessary specialty care for enrollees. If an enrollee needs specialty care from a specialist who is not available within the MCO's provider network, the MCO must provide the necessary services with a qualified specialist outside of the MCO's provider network.

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

Washington follows Washington Administrative Code 388-501-0165 related to the prior authorization of services.

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

☐ 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)

8.1.1. ☒ YES, except for American Indians/Alaska Natives and Unborn children, who are exempt from this requirement.

8.1.2. ☐ 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 and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

Households with income above 210% FPL, but not above 312% FPL, are required to pay a monthly premium for each enrolled child; up to a family maximum premium amount for two children. The premium amount will be based on the household's income as indicated by the following Tiers:

Tier 1 (210%-260%FPL)

Tier 2 (261%-312%FPL)

In January, 2009 these premiums will be:

Tier 1 - $20/mo. per child; up to a family maximum of $40/mo.

Tier 2 - $30/mo. per child; up to a family maximum of $60/mo.

Payments can be made for periods greater than one month. Eligibility will end if premiums are not paid for three consecutive months.

Households with enrolled children will receive monthly billing statements. These monthly statements include the current amount as well as any overdue amount. The statement includes a note that informs the client that accounts over 90 days past due may result in loss of medical coverage. A phone number is provided with a notation

to call if their income goes down, a family member moves in or out of their home, or a child under age 19 becomes pregnant or disabled, as their children may be eligible for a medical program with no premiums. There is also an additional warning on the statement of clients who are 30 or 60 days overdue.

8.2.2. Deductibles: None.

8.2.3. Coinsurance or copayments: None.

8.2.4. Other: None.

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)(B))(42CFR 457.505(b))

State-published CHIP brochures and summary documents contain information about enrollee cost-sharing requirements. The CHIP application packet includes detailed information about cost-sharing requirements. CHIP enrollment and health plan enrollment documents also include all cost-sharing requirements.

If there is a change to cost-sharing requirements, the State sends each client a letter detailing the changes with a toll-free number to call if they have any questions about the changes. The information is relayed to the public through our outreach workers, advocates, and notification to providers.

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

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

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

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

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

The only cost sharing requirement is the premium payment.

For Tier 1 families, the monthly premium amount of $20 per child per month up to a maximum premium amount of $40 per month per family will not exceed 1.4 percent of the family income.

For Tier 2 families the monthly premium amount of $30 per child per month up to a maximum premium amount of $60 per month per family will not exceed 1.5 percent of the family income.

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

American Indian and Alaska Native (AI/AN) children are self-identified at the time of application. This information is put into MMIS, which codes them appropriately so that no premium billing statement is sent to the household for those children.

If a child is not self-identified at the time of application, client materials, as well as the billing invoice, provide information on excluding AI/AN children from the cost-sharing requirement. If premiums were inadvertently paid for an AI/AN child, a refund is issued.

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

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

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

See **CS21**

☒ The disenrollment process affords the enrollee an opportunity to

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

Prior to disenrollment, clients are notified in a letter that they can call a toll-free number to report any changes in income or household. They may also update their record by logging in to the HPF system and updating their case information. This allows their eligibility to be determined for Medicaid or any programs for which they may be eligible.

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

Once the HPF system is updated for a change in income, it will automatically review eligibility for Medicaid.

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

Enrollees are sent a letter informing them of disenrollment from CHIP. The letter contains information on their rights for an Administrative Hearing. Clients can call the Office of Administrative Hearings (OAH) to set up a hearing, or they may contact HCA staff directly and request a hearing. OAH notifies the client and the agency's Administrative Hearing Coordinator of the request. If the enrollee requests an Administrative Hearing prior to their disenrollment, the enrollee will receive continued benefits pending the outcome of the Administrative Hearing. The Coordinator prepares the case and sets up a pre-hearing conference as a way to settle the dispute or collect information. Cases that are not resolved in the pre-hearing conference proceed to an Administrative Hearing. The Administrative Law Judge conducts the hearing. The Judge's decision is mailed to the client and the Administrative Hearing Coordinator. Either party may appeal the decision for additional review and to the courts, if need be.

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

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

8.8.2. ☒ No cost-sharing (including premiums, deductibles, co pays,

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

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

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

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

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

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

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

Washington's CHIP strategic objective is to increase the number of children in households between 210% and 312% of FPL who have health insurance coverage. In addition, CHIP will assist the Medicaid program to increase the number of low-income children in households below 210% of FPL who have health insurance coverage.

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

The following performance goals have been identified:

1. Increase the number of children between 210% and 312% of FPL who have health care coverage.
2. Reduce the percentage of uninsured children between 210% and 312% FPL.
3. Increase the number of children below 210% of FPL who have health coverage.
4. Reduce the percentage of uninsured children below 210% of FPL.
5. Track the satisfaction and health care of CHIP children compared to Medicaid children and non-Medicaid children.

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

HCA and the Governor's Office of Financial Management (OFM) Forecast Section will analyze WSPS data to measure the number and percentage of children who are uninsured. The WSPS is a comprehensive survey conducted under contract with Washington State University's Social and Economic Sciences Research Center. The survey is modeled after U.S. Bureau of the Census's Current Population Survey

(CPS). However, the survey is a statewide survey with a greatly enhanced sample size (6,950 households in 1998) to allow for statistically reliable analyses for the state and regions within the state. There are expanded samples of racial and ethnic minorities to be able to compare socio-economic characteristics of people of different racial and ethnic backgrounds. The WSPS is conducted biennially. Therefore, the CHIP uninsured performance measures will be reported every two years.

The assessment of CHIP enrollees' satisfaction with their health care and services is based on HCA's work with the Consumer Assessment of Health Plans (CAHPS). These surveys are conducted every other year in accordance with CAHPS Consortium (A group of national survey experts associated with the Harvard Medical School, RAND, and the Research Triangle Institute protocols). The last survey was conducted in 2007, and 78% of respondents indicated there was no problem getting access to care. The survey included both HO enrollees and Medicaid FFS clients.

HCA has been using HEDIS- and EPSDT related measures to assess the effectiveness of its HO contractors to provide medically appropriate services to Medicaid clients. HCA contracts with its external review organization to generate a set of similar, child appropriate measures for CHIP enrollees.

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, please list:

HCA will track and compare CHIP dental access and usage with Medicaid children.

9.3.8. ☐ Performance measures for special targeted populations.

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

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

Washington State will report on the number of CHIP enrolled children on an annual basis. The number and percentage of uninsured children between 210% and 312% FPL will be reported on a biennial basis using available population data.

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

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

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

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

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

Over the past decade of expanding services to children, Washington State has relied on several strategies to assure high levels of community involvement:

- The public had an opportunity to testify on the Governor's proposed CHIP during both the 1998 and 1999 legislative sessions. The public also had an opportunity to comment on an alternative CHIP program that was being offered by House Republicans. Stakeholders and advocacy groups met throughout the 1999 session to comment on and ask legislators to pass the Governor's proposal, which was enacted on a bipartisan basis during the 1999 session.

- HCA also worked with the Seattle Campaign for Kids 2001 and a potential CHIP demonstration project prior to the 1999 session. Input in that project was reflected in the Governor's proposal and HCA's CHIP operational design.

- During the development of the CHIP state plan, HCA involved representatives of various stakeholder groups including the state medical association, the state hospital association, provider groups, representatives of the Legislature, health care plans, client rights organizations and client advocacy groups. The public meetings held to review the plan submittal were jointly sponsored by HCA and the Children's Alliance – a statewide children's advocacy group.

- HCA sponsored fourteen local community groups to provide feedback on the Healthy Options program. The Healthy Options Committees were asked to provide input, as well as feedback throughout implementation.

- HCA consulted with the American Indian Health Commission of Washington State and the Northwest Portland Area Indian Health Board on the design of CHIP. CHIP had been an item of discussion for over a year with these groups.

- HCA also provided an opportunity for all interested parties to review and comment on the original State Plan application through HCA's CHIP website.

- Public testimony during the 2007 session in which the state legislature passed SSSB 5093 "Cover All Kids" with bipartisan support, approving an increase in the CHIP program to 300%FPL.

The combination of statewide and local input provided a robust mechanism for assuring broad input into the planning, implementation, and ongoing development of 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. (Section 2107(c)) (42CFR 457.120(c))

HCA consulted with the American Indian Health commission of Washington State and the Northwest Portland Area Indian Health Board on the design of CHIP. HCA has coordinated with and will continue to work with representatives of the Tribes in the state of Washington, urban Indian organizations, and Indian advocacy groups, including the Northwest Portland Area Indian Health Board, the American Indian Health Commission, and the DSHS Indian Policy Advisory Committee. Although the total number of Indian children served by CHIP continues to be small (just over 1,000), the ongoing commitment by the State to Indian health issues is viewed by the Tribes as an important move.

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

The CHIP expansion to 300% of FPL was authorized by Second Substitute Senate Bill (2SSB 5093) which was signed into law by the Governor on March 13, 2007, and which became effective July 22, 2007. The legislation has been codified under Section 74.09.470 of the Revised Code of Washington (RCW). The expansion provisions are found in RCW.74.09.470(1).

2SSB 5093 was subject to public comment in the House Health Care & Wellness Committee, House Appropriations Committee, Senate Health & Long-Term Care Committee and Senate Ways & Means Committee. The bill was also subject to debate and vote by the House and Senate.

9.10. Provide a 1- year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
    - Projected amount to be spent on health services;
    - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
    - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Section 10. Annual Reports and Evaluations ***(Section 2108)***

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

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

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

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

10.3.1 ☒ The State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website.

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

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

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

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX. (Section 2107(e)) (42CFR 457.935(b))

The items below were moved from section 9.8. (Previously items 9.8.6-9.8.9)

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

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

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

12.1. Eligibility and Enrollment Matters

Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

All CHIP clients have an opportunity for review of eligibility and enrollment matters. Clients may contact HCA's Medical Eligibility Determination Services (MEDS) section or the Office of Administrative Hearings (OAH) to begin the review process. The HCA Administrative Hearing Coordinator is notified of the request for review. The Coordinator prepares the case and sets up a pre-hearing conference as a way to settle the dispute or collect information. Cases that are not resolved through a pre-hearing conference proceed to an Administrative Hearing. At the Administrative Hearing, an Administrative Law Judge gathers information from the client and agency staff. Hearings can be conducted via telephone or in person. The Judge's decision is mailed to the client and the Administrative Hearing Coordinator. Either party may appeal the decision for additional review and to the courts if need be.

12.2. Health Services Matters

Please describe the review process for health services matters that comply with 42 CFR 457.1120.

All CHIP clients also have an opportunity for review of health services matters. The process as described in section 12.1 is the same process used for review of health services matters.

12.3. Premium Assistance Programs

If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the Group Health Plan at initial enrollment and at each redetermination of eligibility.

Not applicable to Washington State's CHIP.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Eligibility - Targeted Low-Income Children CS7

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.310, 315 and 320

■ **Targeted Low-Income Children** - Uninsured children under age 19 whose household income is within standards established by the state.

☑ The CHIP Agency operates this covered group in accordance with the following provisions:

Age

Must be under age 19.

Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standards

Begin with lowest age range first.

Please note that the lower bound for CHIP eligibility should be the highest standard used for Medicaid poverty-level children for the same age group or groups entered here.

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	0	19	210	312	X

Age ranges may overlap. If there is an overlap, provide an explanation. Include the age ranges for each income standard that has overlapping ages and the reason for having different income standards.

Special Program for Children with Disabilities

Does the state have a special program for children with disabilities? No

PRA Disclosure Statement

CHIP Eligibility

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V.20130709

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
MAGI-Based Income Methodologies **CS15**

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.315

☑ The CHIP Agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups, as described below, and consistent with 42 CFR 457.315 and 435.603(b) through (i).

In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility, whichever is later.

If the state covers pregnant women, in determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

○ The pregnant woman is counted just as herself.

○ The pregnant woman is counted just as herself, plus one.

◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

◉ Current monthly household income and family size.

○ Projected annual household income for the remaining months of the current calendar year and family size.

In determining current monthly or projected annual household income, the state will use reasonable methods to:

☒ Include a prorated portion of the reasonably predictable increase in future income and/or family size.

☒ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 457.315 and 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent. Yes

☑ The CHIP Agency certifies that it has submitted and received approval for the conversion for all separate CHIP covered group income standards to MAGI-equivalent standards.

An attachment is submitted.

PRA Disclosure Statement

CHIP Eligibility

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CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Eligibility - Coverage From Conception to Birth — CS9

42 CFR 457.10

■ **Coverage From Conception to Birth -** Coverage from conception to birth when the mother is not eligible for Medicaid.

☑ The CHIP Agency operates this covered group in accordance with the following provisions:

Age Standard

From conception through birth.

Does the state have an additional age definition or other age-related conditions? No

Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standard

The statewide income standard is: From zero up to 193 % FPL

■ Exempted from requirement of providing or applying for a Social Security Number.

■ Exempted from requirement of verifying citizenship status.

PRA Disclosure Statement

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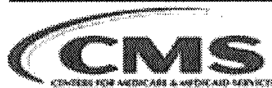
Washington State CHIP Budget Plan	Federal Fiscal Year Costs	Federal Fiscal Year Costs
Enhanced FMAP Rate	65.00%	65.00%
Benefit Costs	**FFY 2014**	**FFY 2015**
Insurance Payments		
Managed Care – Children (211-312%FPL) PM/PM	$116	$116
24,093 FFY14 eligibles; 25,497 FFY15 eligibles	$33,890,058	$35,605,100
5,730 FFY14 eligibles; 5,829 FFY15 eligibles; [Section 214, Title XIX][1]	$7,988,312	$8,139,360
9,742 FFY14 eligibles; 15,917 FFY15 eligibles [Welcome Mat][2]	$13,582,131	$22,227,650
Fee for Service - Children (211-312%FPL) PM/PM	$245	$265
3,526 FFY14 eligibles; 3,698 FFY15 eligibles	$10,369,378	$11,778,054
831 FFY14 eligibles; 845 FFY15 eligibles [Section 214, Title XIX][1]	$2,444,193	$2,692,520
1,413 FFY14 eligibles; 2,309 FFY15 eligibles [Welcome Mat][2]	$4,155,740	$7,352,981
Fee for Service - Unborn Child (193%FPL) PM/PM	$520	$518
5,558 FFY14 eligibles; 5,498 FFY15 eligibles	$34,672,500	$34,208,632
133% Medicaid Children (FMAP to EFMAP Federal Only)[3]	$27,503,427	$29,393,306
Total Benefit Costs	**$134,605,739**	**$151,397,603**
(Total offsetting beneficiary cost sharing payments)	($5,931,468)	($6,221,312)
Net Benefit Costs	**$128,674,271**	**$145,176,291**
Administration Costs[4]		
Personnel	$1,155,368	$1,213,136
General Administration	$406,230	$426,542
Contractors/Brokers (e.g., Within Reach)	$967,280	$1,015,644
Claims Processing	$98,111	$103,017
Outreach/Marketing Costs[5]	$0	$0
Health Services Initiative – Washington Poison Center[6]	$1,089,070	$1,089,070
Total Administration Costs	**$3,716,059**	**$3,847,409**
10% Administrative Cost Ceiling	$14,297,141	$16,130,699
Federal Share (multiplied by enhanced-FMAP rate)	$95,679,914	$107,153,062
State Share	$36,710,416	$41,870,638
Total Program Costs*	**$132,390,330**	**$149,023,700**
*No new sources of state funds are being used to fund the measures in this budget. The source of state matching funds remains appropriations by the state legislature.		
[1] Section 214 Medicaid Children		
Children added to Medicaid as a result of CHIPRA, Section 214 eligibility expansion are exempt from cost-sharing premiums.		
[2] Welcome Mat	**FFY2014**	**FFY2015**
ACA Expansion - Welcome Mat Impact for Children Between 211-312% FPL		
Total Welcome Mat	$17,737,871	$29,580,631
Federal share	$11,529,616	$19,227,410
State share	$6,208,255	$10,353,221
[3] 133% Medicaid Children (FMAP to EFMAP Federal Only)		
Washington is a qualified state under §2105(g) to claim an "uncapped" portion of expenditures for Medicaid children at or above 133%FPL. The amount of the claim for these expenditures is based on the difference between the EFMAP for CHIP and the current FMAP rate for Medicaid. In FFY 2014 the federal share is estimated at $27.50 million dollars; in FFY 2015 the federal share is estimated at $29.39 million dollars.		

Washington State CHIP Budget Plan	Federal Fiscal Year Costs	Federal Fiscal Year Costs
Enhanced FMAP Rate	65.00%	65.00%
[4] Calculation of Unused Administration Funding	**FFY2014**	**FFY2015**
Current Program Costs	$132,390,330	$149,023,700
10% Administrative Cap	$14,297,141	$16,130,699
Federal Share	$9,293,142	$10,484,954
Administrative Costs - Current Plan	$3,716,059	$3,847,409
Federal Share	$2,415,438	$2,500,816
Unused Administration Funding Available	$10,581,082	$12,283,290
Federal Share	$6,877,703	$7,984,139
[5] Calculation of Children's Outreach Funding	**FFY2014**	**FFY2015**
Statewide Application Agent Program	$0	$0
Media Campaign & Other Outreach Contracts	$0	$0
Total Benefit Costs	$0	$0
Federal Share	$0	$0
State Share	$0	$0
Outreach costs are not currently being charged to the CHIP grant. As state funding becomes available, outreach efforts including media campaigns, application agents, etc. will be restored. If state appropriations are restored for outreach, Washington assures that administrative expenditures will not exceed the 10% cap.		
[6] WAPC Health Services Initiative Funding (Contract #1012-95481-02)	**FFY2014**	**FFY2015**
Total WAPC Health Services Initiative Funding	$1,089,070	$1,089,070
Federal Share	$707,896	$707,896
State Share	$381,175	$381,175
Summary of Projected Costs for SPA 14		
In FFY2014 the total projected costs for this SPA will increase the budget by $17,737,871 dollars. The increased federal share in FFY2014 is calculated at $11,529,616 dollars. In FFY 2015 the total projected costs for this SPA will increase the budget by $29,580,631 dollars. The increased federal share in FFY2015 is calculated at $19,227,410 dollars.		



CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Child Health Insurance Program
Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards **CS14**

Section 2101(f) of the ACA and 42 CFR 457.310(d)

[■] Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

( ) The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

(●) The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

( ) The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.

(●) The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.

( ) The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

[ ] % FPL

( ) The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.

( ) Other.

Describe the benefits provided to this population:

( ) This population will be provided the same benefits as are provided to children in the state's Medicaid program.

(●) This population will be provided the same benefits as are provided to children in the state's separate CHIP.

( ) Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

( ) Cost sharing is the same as for children in the Medicaid program.

CHIP Eligibility

- (●) Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- ( ) No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- ( ) Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

PRA Disclosure Statement

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CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Eligibility Processing **CS24**

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

☑ The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.

☒ An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

☐ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

☑ The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

☒ Other electronic means:

	Name of method	Description	
+	FAX	The applicant may fax a copy of their paper application to a published fax number.	X

Screen and Enroll Process

☑ The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:

CHIP Eligibility

■ Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and

■ Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and

■ Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA. Yes

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:

- ■ Once every 12 months.
- ■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.
- ■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

☐ The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.

☒ The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

Check all types of agencies that apply:

- ☒ The Exchange
- ☒ Medicaid
- ☒ Other agency administering insurance affordability programs

	Name of Agency	
+	Department of Social and Health Services staff assisting an applicant or a recipient of Medicaid with an online application through the Washington Healthplanfinder.	X

☑ The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

CHIP Eligibility

PRA Disclosure Statement

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V.20130709

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER: WA-14-0004-MC4	**STATE:** Washington

Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION ☒Paper Application ☐Online Application	
TRANSMITTAL NUMBER: WA-14-0004-MC4	**STATE:** Washington
Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.	

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Residency CS17

42 CFR 457.320

Residency

☑ The CHIP Agency provides CHIP to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

A child is considered to be a resident of the state under the following conditions:

■ A non-institutionalized child, if capable of indicating intent and who is emancipated or married, if the child is living in the state and:

1. Intends to reside in the state, including without a fixed address, or
2. Has entered the state with a job commitment or seeking employment, whether or not currently employed.

■ A non-institutionalized child not described above and a child who is not a ward of the state:

1. Residing in the state, with or without a fixed address, or
2. The state of residency of the parent or caretaker, in accordance with 42 CFR.435.403(h)(1), with whom the individual resides.

■ An institutionalized child, who is not a ward of the state, if the state is the state of residence of the child's custodial parent or caretaker at the time of placement, or

■ A child who is a ward of the state regardless of where the child lives, or

■ A child physically located in the state when there is a dispute with one or more states as to the child's actual state of residence.

If the state covers pregnant women, a pregnant woman is considered to be a resident under the following conditions:

■ A non-institutionalized pregnant woman who is living in the state and:

1. Intends to reside in the state, including without a fixed address, or if incapable of indicating intent, is living in the state, or
2. Entered with a job commitment or seeking employment, whether or not currently employed.

■ An institutionalized pregnant woman placed in an out-of-state-institution, as defined in 42 CFR 435.1010, including foster care homes, by an agency of the state, or

■ An institutionalized pregnant woman residing in an in-state-institution, as defined in 42 CFR 435.1010, whether or not the individual established residency in the state prior to entering the institution, or

■ A pregnant woman physically located in the state when there is a dispute with one or more states as to the pregnant woman's actual state of residence.

The state has in place related to the residency of children and pregnant women (if covered by the state):

CHIP Eligibility

One or more interstate agreement(s). No

A policy related to individuals in the state only for educational purposes. Yes

Provide a description of the policy:

Individuals who are living in the state solely for the purposes of attending an educational institution are not considered residents of the state.

PRA Disclosure Statement

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CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Citizenship **CS18**

Sections 2105(c)(9) and 2107(e)(1)(J) of the SSA and 42 CFR 457.320(b)(6), (c) and (d)

Citizenship

☑ The CHIP Agency provides CHIP eligibility to otherwise eligible citizens and nationals of the United States and certain non-citizens, including the time period during which they are provided with reasonable opportunity to submit verification of their citizenship, national status or satisfactory immigration status.

■ The CHIP Agency provides eligibility under the Plan to otherwise eligible individuals:

Who are citizens or nationals of the United States; or

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), and 1902(ee) of the Act, and 42 CFR 435.406, 407, 956 and 457.380.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process. Yes

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual. Yes

The date benefits are furnished is:

◉ The date of application containing the declaration of citizenship or immigration status.

○ The date the reasonable opportunity notice is sent.

○ Other date, as described:

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3). Yes

Otherwise eligible children means children meeting the eligibility requirements of targeted low-income children with the exception of non-citizen status.

☑ The CHIP Agency provides assurance that lawfully residing children are also covered under the state's Medicaid program.

CHIP Eligibility

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible pregnant women, lawfully residing in the United States, as provided in Section 214 of CHIPRA 2009, P.L. 111-3. The state may not select this option unless the state also elects to cover lawfully residing children. A state may not select this option unless the state also covers Targeted Low-Income Pregnant Women.	No

■ An individual is considered to be lawfully residing in the United States if he or she is lawfully present and meets state residency requirements.

■ An individual is considered to be lawfully present in the United States if he or she is:

1. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);
2. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));
3. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;
4. A non-citizen who belongs to one of the following classes:

   (i) Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively;

   (ii) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

   (iii) Granted employment authorization under 8 CFR 274a.12(c);

   (iv) Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

   (v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

   (vi) Granted Deferred Action status;

   (vii) Granted an administrative stay of removal under 8 CFR 241;

   (viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231,or under the Convention Against Torture, who:

   (i) Has been granted employment authorization; or

   (ii) Is under the age of 14 and has had an application pending for at least 180 days;

6. Has been granted withholding of removal under the Convention Against Torture;
7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C.1101(a)(27)(J);
8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or
9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).

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10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Social Security Number **CS19**

42 CFR 457.340(b)

Social Security Number

As a condition of eligibility, the CHIP Agency must require individuals who have a social security number or are eligible for one as determined by the Social Security Administration, to furnish their social security number, or numbers if they have more than one number.

☑ The CHIP Agency requires individuals, as a condition of eligibility, to furnish their social security number(s), with the following exceptions:

Individuals refusing to obtain a social security number (SSN) because of well established religious objections, or

Individuals who are not eligible for an SSN, or

Individuals who are issued an SSN only for a valid non-work purpose.

■ The CHIP Agency assists individuals, who are required to provide their SSN, to apply for or obtain an SSN from the Social Security Administration if the individual does not have or forgot their SSN.

■ The CHIP Agency informs individuals required to provide their SSN:

By what statutory authority the number is solicited; and

How the state will use the SSN.

☑ The CHIP Agency provides assurance that it will verify each SSN furnished by an applicant or beneficiary with the Social Security Administration, not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by the Social Security Administration and that the state's utilization of the SSNs is consistent with sections 205 and 1137 of the Social Security Act and the Privacy Act of 1974.

The state may request non-applicant household members to voluntarily provide their SSN, if the state meets the requirements below.

The state requests non-applicant household members to voluntarily provide their SSN. Yes

☑ When requesting an SSN for non-applicant household members, the state assures that:

■ At the time such SSN is requested, the state informs the non-applicant that this information is voluntary and provides information regarding how the SSN will be used; and

■ The state only uses the SSN for determination of eligibility for CHIP or other insurance affordability programs, or for a purpose directly connected with the administration of the state plan.

PRA Disclosure Statement

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CHIP Eligibility

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CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Substitution of Coverage **CS20**

457.310(b)(2) and (b)(3), 457.320(a)(9) and 2110(b)(1)(C) of the SSA

Substitution of Coverage

☑ The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

■ Substitution of coverage prevention strategy:

	Name of policy	Description	
+	Tracking of the number of applicants who drop group health insurance	Each applicant will be asked if they have dropped group health insurance coverage in the 4 months preceding their application. If the incidence of dropped coverage exceeds 5% of approved applications, the Agency will conduct a survey to see if one of nine "good cause" reasons apply. The outcome of the survey will determine if substitution of coverage is a substantial enough issue to require implementation of a waiting period not to exceed the statutory maximum.	X

A waiting period during which an individual is ineligible due to having dropped group health coverage. No

☑ If the state covers pregnant women, the waiting period does not apply to pregnant women.

If the state elects to offer dental only supplemental coverage, the following assurances apply:

☐ The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(5) of the SSA.

☐ The waiting period does not apply to children eligible for dental only supplemental coverage.

PRA Disclosure Statement
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V.20130718

MAR 1 8 2015

CHIP Eligibility

State Name: Washington

OMB Control Number: 0938-1148

Transmittal Number: WA - 14 - 0005

Expiration date: 10/31/2014

Separate Child Health Insurance Program Non-Financial Eligibility - Non-Payment of Premiums

CS21

42 CFR 457.570

Non-Payment of Premiums

Does the state impose premiums or enrollment fees? Yes

Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility? Yes

Does the state have a premium lock out period? Yes

Please describe the lock-out period:

When a family fails to pay the required premium for 3 consecutive months, coverage is suspended for CHIP for a period not to exceed 90 days. The family may resolve this suspension at any time by paying the delinquent premium or reporting a change in their circumstances resulting in eligibility for Medicaid. If the family pays the delinquent premium at any time during the initial certification period, eligibility will be restored to the first day of the lock-out period and no new application will be necessary. If the family does not pay the delinquent premium, they will need to reapply at the end of the 90 days and will have their eligibility for CHIP redetermined.

What is the length of the time premium lock-out period?

Select a length of time:

- ◯ One month
- ◯ Two months
- ◉ 90 days
- ◯ Other (not to exceed 90 days)

Are there exceptions to the required lock-out period? Yes

- ☐ Individual's income decreased to a level where no premium is required or within Medicaid standards
- ☐ Other financial hardship
- ☒ Other

	Describe	
+	The debt is written off after twelve months	X
+	The family pays the delinquent premium during the lock-out period	X

☑ The state assures that:

It does not require the collection of past due premiums or enrollment fees as a condition of eligibility for enrollment once the lock-out period has expired; and

CHIP Eligibility

It provides enrollees with an opportunity for an impartial review to address disenrollment from the program in accordance with section 457.1130(a)(3); and

The child will be reenrolled in CHIP during the lock-out period upon payment of past due premiums or enrollment fees.

PRA Disclosure Statement

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V.20140415

MAR 1 8 2015

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Continuous Eligibility **CS27**

2105(a)(4)(A) of the SSA and 42 CFR 457.342 and 435.926

The CHIP Agency may provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, during a continuous eligibility period up to 12 months, or until the time the child reaches an age specified by the state (not to exceed age 19), whichever is earlier.

The CHIP Agency elects to provide continuous eligibility to children under this provision. Yes

(●) For children up to age 19

( ) For children up to age [ ]

The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends:

■ At the end of the 12 months continuous eligibility period.

Exceptions to the continuous eligibility period:

■ The child attains the age specified by the state Agency or age 19.

■ The child or child's representative requests voluntary disenrollment.

■ The child is no longer a resident of the state.

■ The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to child or child's representative.

■ The child dies.

■ There is a failure to pay required premiums or enrollment fees on behalf of a child, as provided for in the state plan.

☒ Other

	Describe	
+	a child who becomes an inmate of a public institution, as defined in WAC 388-500-0005. If the child is released during the certification period, eligibility is restored from the date of release through the continuous eligibility period.	X

PRA Disclosure Statement

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CHIP Eligibility

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V.20130717

MAR 1 8 2015

CHIP Eligibility

State Name: Washington

OMB Control Number: 0938-1148

Transmittal Number: WA - 15 - 0001

Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Presumptive Eligibility for Children

CS28

42 CFR 457.355 and 435.1102, 2107(e)(1)(L) and 1920A of the SSA

The CHIP Agency covers children when determined presumptively eligible by a qualified entity. Yes

■ Describe the population of children to whom presumptive eligibility applies:

Children from birth to age of 19 with income no more than 312%FPL.
Unborn children from conception to birth, whose mothers are ineligible for Medicaid, with income no more than 193%FPL.

■ Describe the duration of the presumptive eligibility period and any limitations:

The presumptive period begins on the date the determination is made, and continues through the date the eligibility determination for regular CHIP is made; but no longer than the end of the month following the month of the PE determination if no CHIP application is filed.
Limitations -
Individuals will only be approved for one PE period within twenty four months.
For unborn children from conception to birth there is one PE period per pregnancy.

■ Describe the application process and eligibility determination factors used:

Qualified entities will first attempt an application for CHIP through our state-based exchange portal at www.wahealthplanfinder.org which provides a real-time determination of eligibility. If the entity is unable to submit an application through the portal because it is unavailable, malfunctions, posts an error message, or the individual lacks the information to complete the application, then the entity will complete a PE worksheet.

The PE worksheet requires the individual to attest to only the following minimum information to identify their eligibility:
1. Full name, date of birth, and address.
2. Basis of eligibility (child < 19, or pregnant woman).
3. Washington residency and citizenship or immigration status.
4. Household size and income.

The qualified entity will make a determination of PE based on the individuals' declaration and issue a notice of approval or denial at the time the determination is made. The PE determination will be transmitted to the Health Care Authority(HCA) within 5 days.

The qualified entity will not be required to determine whether the pregnant woman is eligible for Medicaid, or for CHIP under the unborn provision. Designated staff at HCA will use the information on the PE worksheet to establish the appropriate program eligibility segment within our MMIS system and follow up on obtaining any missing information needed to complete a full application through the state-based exchange at www.wahealthplanfinder.org.

CHIP Eligibility

■ The CHIP Agency uses qualified entities, as defined in section 1920A, to determine eligibility presumptively for children.

Separate Child Health Insurance Program
General Eligibility - List of Qualified Entities **CS30**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select the types of entities used to determine presumptive eligibility:

☐ Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan

☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants, and Children (WIC) under section 17 of the Child Nutrition Act of 1966

☐ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)

☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)

☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs

☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act

☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act

☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act

☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*)

☒ Any other entity the state so deems, as approved by the Secretary

	Name of entity	Description	
+	Qualified hospitals that elect to determine presumptive eligibility	A qualified hospital is a contracted provider who has signed a PE agreement with HCA. They must have staff who have successfully completed training and background checks required to establish access as an application assister in the state-based exchange, in addition to completion of the PE training.	X

☑ The CHIP Agency assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

CHIP Eligibility

	An attachment is submitted.	

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