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: Susan N. Dreyfus Position/Title: Secretary/Department of Social and Health Services

Name: Doug Porter Position/Title: Assistant Secretary/Medicaid Purchasing Administration

Name: Kevin Cornell Position/Title: Program Manager/Children's Health Insurance Program

**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 300% 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 household 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. However, the CHIP eligibility process is different due to restrictions about existing insurance. CHIP is administered by DSHS's Medicaid Purchasing Administration (MPA) in coordination with other DSHS administrations and other state agencies including the Department of Health (DOH), the Governor's Office, and the Health Care Authority (HCA).

**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):

Amendment 1 - 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**

Amendment 2 - This amendment removed the co-pay requirement.

**Submitted: April 3, 2002**

**Approved: July 1, 2002**

**Effective date: January 1, 2002**

Amendment 3 - 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**

Amendment 4 - 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

Amendment 5 - 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: June 16, 2004

Effective date: December 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:

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.

## *Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination* ***(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))***

**2.1.** Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (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[1]. 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%.

**2.2.** Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

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[1] Washington State used the biennial Washington State Population Survey (WSPS) to provide a profile of residents between decennial censuses. The WSPS replicates the Bureau of the Census' Current Population Survey (CPS). However, the WSPS employs a greatly enhanced sample size, which allows for statistically reliable analysis for the state and regions within the state. The health status information reported is the household member's status at the time of the interview (April and May 2008).

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

Washington operates several programs to provide healthcare coverage to low-income children. The largest of these programs is Medicaid, which provides coverage to over 680,000 U.S. citizen and legal alien children annually, in households with incomes up to 200% FPL[2]. Since 1988, Washington has operated the Basic Health Program (BHP) providing premium-subsidized health insurance to approximately 60,000 low- income adults and families (including children) with incomes up to 200% FPL. Washington's CHIP program began in 2001 and currently provides coverage to nearly 20,000 children in households with incomes between 200% - 300% FPL. Washington's CHIP coverage also provides coverage for over 9,000 low-income unborn children annually whose mothers do not qualify for Medicaid, but have household income below 185% 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. The Children's Health program mirrors Medicaid and CHIP in its construction. As in the CHIP program, children in households with income between 200% and 300% FPL are required to pay a premium .

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.

[2] Based on 2008 Medicaid Children Title XIX SEDS report.

- Simplified Application – MPA has developed a one-page application for "Apple Health for Kids," which is the State's name for the program that combines all children's medical programs.
- Joint Application - Applications for medical assistance are automatically considered for Medicaid, CHIP, and state-funded programs. In addition, applicants for cash and food assistance benefits may request medical assistance on the same application used for cash and food assistance.
- Extended Medical benefits – Children coming off TANF automatically receive Medicaid for one year after the end of their TANF assistance.
- Application Agents – As funds are available the department contracts with local health jurisdictions and community based organizations to serve as application agents, directly assisting families with completion of a simplified one page Apple Health for Kids application. Application agents are paid a fee for successful enrollments.
- Premium Payment Program – Parents may be reimbursed for the cost of employer- sponsored insurance to cover their Medicaid eligible child.
- Renewal contacts – The department provides the renewal dates to three 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.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

To assist in making health coverage affordable to low-income persons, the Health Care Authority's (HCA) Basic Health Plan (BHP) has adopted a sponsorship program with public and private entities. These entities, including health care providers, but not health care plans, are allowed to pay all or a portion of the sponsored enrollee's premium obligations, but not co-pays. About 27,000 BHP adults and children are receiving coverage through these sponsorship arrangements. Employers can also purchase group coverage for themselves and their employees through BHP. Employers must enroll at least 75% of all eligible employees within the classification

of employees. BHP may charge a minimum financial contribution for each enrolled employee. Employers are required to offer their employees the complete choice of BHP plans available within the employer's county of residence. About 1,000 adults and children are receiving BHP coverage through their employer. Although BHP's financial sponsorship and employer coverage options are not specifically targeted to children, they provide affordable health coverage to families. Through the BHP Plus program, children in these families are able to receive full-scope Medicaid coverage without cost-sharing.[3] Most children are able to receive this coverage through the same health plan and provider network as their family members.

MPA is coordinating its outreach efforts with BHP and private organizations. In Washington, nearly all children receiving free and reduced lunches are also eligible for Medicaid. In 2008, MPA expanded outreach efforts by coordinating with the Office of the Superintendent of Public Instruction (OSPI) to provide a list of potentially eligible children from the Free & Reduced Lunch program to the contracted outreach providers. These lists were used to conduct targeted outreach efforts. This effort continues today as funds are available.

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.

**2.3.** Describe the procedures the state uses to accomplish coordination of CHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

Washington's CHIP program uses the same application as its Medicaid program. Applications for medical assistance are submitted to the local Community Services Office (CSO) for review. Applications have a barcode label that creates an electronic assignment into the Document Management System (DMS) that notifies

[3] This is part of the Health Care Authority's subsidized healthcare program.

local CSO staff that there is an application that needs processing. If the child is determined to be ineligible for Medicaid, the application is then electronically forwarded to Medical Eligibility Determination Services (MEDS) staff at MPA to determine the child's eligibility for the CHIP program.

In addition to this application process, Washington's CHIP program coordinates with the BHP application process. Currently, Washington's Medicaid program has an interagency agreement with the HCA's BHP to cover children under 19 years of age with family incomes at or below 200% FPL. If a family checks a box on their application that states they would like to apply for BHP Plus for their children, HCA automatically forwards the application to MPA. This is permissible under the special rule provision of Title XXI, Section 2110(b)(3). MPA then processes the application, looking first at eligibility for Medicaid. If the children are not Medicaid eligible, then eligibility for CHIP is determined.

For disabled children receiving services under the Title V Children with Special Health Care Needs (CSHCN) program, we identify clients through both self-identification and a data match with the Department of Health (DOH). We coordinate services for these children with representatives from DOH, regional CSHCN representatives, community-based groups and organizations, and CSHCN care coordinators. MPA representatives meet with these groups on a regular basis to discuss and clarify policies, care plans, relevant issues, and complaints. MPA also has a representative on the Medicaid Integration Team whose purpose is to share information and address issues regarding CSHCN that may come up at the regional level.

We also use our outreach contractors to help identify potentially eligible-families, and assist them to apply for all types of benefits. Our statewide toll-free line helps families apply for all types of benefits and connects them with local resources.

Our "Apple Health for Kids" application is available in a broad array of public and community locations, such as physician offices, schools, and community health departments.

## *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 MPA's FFS program prior to enrollment in managed care.

MPA 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 MPA 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.

An CHIP household is not required to select 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.

MPA 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 department 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 department 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.

MPA's Division of Behavioral Health and Recovery (DBHR) contracts with public Regional Support Networks (RSNs) 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

MPA has developed procedures with DBHR to assure coordinated care. MPA 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.

Poison treatment advice and prevention through the Washington Poison Center (WAPC) is supported using CHIP funds available under the 10 percent federal administrative expenditures cap. 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.[4] WAPC intervention resulted in over 94% these exposures calls being handled in the home 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.[5]

**3.2.** Describe the utilization controls under the child health assistance provided

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4 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.

5 *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.*

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.

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.

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): A Washington resident who intends to continue living in the state, or who entered the state looking for a job or entered the state with a job commitment (WAC 388-468-0005).

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: Twelve months of continuous coverage. Eligibility for CHIP may be retro-active up to three months prior to the month of application. In the case of an unborn child, retro-active coverage may begin up to three months prior to the month of application, but no sooner than the month of conception.

4.1.9. ☒ Other standards (identify and describe):

4.1.9.1 ☒ Citizenship: Proof of U.S. citizenship or legal alien status is required for all new applicants. When proof of citizenship is not readily available a declaration will be accepted, and a reasonable opportunity to present satisfactory documentary evidence of citizenship will be given. The department will utilize available electronic data bases (e.g. Vital Records, EVVE, SVES) whenever possible to establish proof of citizenship on behalf of the applicant. The department will assist the family to obtain proof of citizenship, and when necessary authorize the purchase of a birth certificate from the child's state of birth. In those instances where proof of citizenship status is not available at application it shall be required by the next redetermination.

**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:

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

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

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

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

for prosecution, for deferred inspection or pending removal proceedings;

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

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
(vi) Aliens currently in deferred action status; or
(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

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

**4.2.** 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)

MPA uses two standardized application forms to make eligibility determinations. One form is used for clients applying for the Apple Health for Kids healthcare program (a one-page form). The other form is used for clients applying for cash benefits, food stamps, medical assistance and other benefits. Applicants for CHIP can apply for healthcare coverage by using either form.

Information from the application is entered into the state's Automated Client Eligibility System (ACES), which automatically generates CHIP eligibility notices and reviews. ACES transfers eligibility information to the state's Medical Management Information System (MMIS). MMIS information is used to enroll clients into managed care.

The application asks the citizenship status and Social Security Number (SSN) of only those children for whom the family is seeking benefits. Since disclosure of the Social Security Number is optional, children are enrolled into CHIP without having a Social Security Number. 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 application is screened into the ACES system, 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 ACES system during the screening process, and transmitted to SSA in an overnight batch. Verification of citizenship and enumeration is federally verified and transmitted back to the ACES system where the clients' record is automatically updated even before the application has completed the application process. Wherever possible, department staff utilize electronically available information rather than delaying the application approval process by requesting paper documents from the applicant.

For continuing enrollment, an eligibility review form 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 eligibility review form must be completed and returned with current information such as household members, income, and health insurance status. The eligibility review form is reviewed first for Medicaid, and then reviewed for CHIP eligibility if the recipient is not Medicaid eligible. As an alternative to completing the eligibility review form, the client may call into a statewide 800# and complete the review over the phone with an eligibility specialist .

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))

At the time of application and redetermination, eligibility staff first determines whether an applicant or recipient is eligible for Medicaid. If the child is not Medicaid eligible, staff assesses eligibility for CHIP and enrolls them in CHIP, if appropriate. To assist in this process, eligibility staff uses ACES automated protocols. In addition, there is a series of required questions on the application and eligibility review form that ask about the child's health insurance status. If these questions are not answered at the time of application or review, the applicant is sent an "Insurance Information Request" letter, which must be completed before eligibility can be determined.

The State's MMIS system is also checked at the time of application and re-determination to see if there is any history of a third party insurance. In addition, the Coordination of Benefits section reviews 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 ACES 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 ACES eligibility system automatically checks for Medicaid eligibility prior to consideration of eligibility for CHIP. After Medicaid ineligibility is determined, ACES 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.

In several ways, the State ensures that substitution of coverage does not occur. First,

both the application and the eligibility review form ask a series of questions regarding health insurance status of the applicant's children. If they respond affirmatively to any of these questions, we ask the applicant to list the name of the insurance company or employer providing the insurance. The following individuals are ineligible for CHIP: Anyone who at the time of application or redetermination is covered under a group health plan or health insurance coverage; has access to, or coverage under, a state health benefits plan; or who is Medicaid eligible.

If the client does not respond to the questions, they are sent an "Insurance Information Request" letter that the applicant must respond to in order for CHIP eligibility to be determined. If the client has access to health insurance coverage, they are not enrolled in CHIP.

Also, at the time of application and redetermination the MMIS is checked to see if there is any history showing of insurance coverage for the household. If a history shows, further inquiries can be made.

To monitor substitution of coverage, the State tracks responses on the number of applications and eligibility reviews that show the applicant has insurance coverage. In addition, the State tracks the number of applications and eligibility reviews that are denied due to insurance coverage.

Additionally, the State tracks whether the applicant has disenrolled from employer sponsored coverage. If the applicant has lost employer sponsored insurance coverage within the past 4 months, the child must serve a four-month waiting period. However, prior to imposing a waiting period, we look at whether one of nine exceptions applies to the family's situation. Exceptions to the four-month waiting period may be granted when:

1) Parent lost job that has medical coverage for children.
2) Parent with medical insurance died.
3) Child has a medical condition that, without medical care, would cause serious disability, loss of function or death.
4) Employer ended medical coverage for children.

5) Child's medical coverage ended because the child reached the maximum lifetime coverage amount.
6) Coverage under a COBRA extension period ended.
7) Children could not get medical services locally (they have to travel to another city or state to get care for their children).
8) Domestic violence led to loss of coverage.
9) The family's total out-of-pocket maximum for employer-sponsored dependent coverage is 2.5 percent per month or more of family countable income.

If none of the exceptions apply, the child must serve a 4-month waiting period prior to enrollment in CHIP.

Another way we monitor for substitution of coverage is through the review of a monthly report of currently eligible CHIP clients. MPA researches this report for health insurance coverage to ensure there was no substitution of coverage at the time of application or re-determination.

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.

The same strategies that are used to prevent substitution of coverage as described in 4.4.4.2 will be utilized in establishing eligibility for children in the 250%-300%FPL group.

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. MPA 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 MPA 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 (Section 2102(c)*

Describe the procedures used by the State to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

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.
    b. Technical Assistance Payments (TAP) of $75 per approved child as a result of a successful application. MPA 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.

## *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 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)<br>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. Children's mental health outpatient services to include: outpatient psychotherapy; electroconvulsive therapy; and family psychotherapy - in any combination - one hour per day, per client, up to a total of twenty hours per calendar year if medically necessary. Psychiatric diagnostic interview examinations – one per calendar year unless an additional evaluation is medically necessary. Prior authorization is required for additional services that are medically necessary.

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.

MPA 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 MPA. 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 MPA/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. MPA 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, 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 200% FPL, but not above 300% 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 (200%-250%FPL)

Tier 2 (251%-300%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.

If a child is terminated from CHIP for failure to pay premiums for three consecutive months, the household receives a letter outlining their rights and responsibilities. The letter says they will not be able to re-enroll until delinquent premiums are paid. There is no sanction period, however. If the delinquent premiums are paid, the child's eligibility is restored back to the month of termination.

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 or 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))

The department has an established process that continues the child's CHIP coverage even when premiums are not paid. Each month the client is notified in writing of the amount of their current premium, plus the balance of any delinquent premiums that have not been paid. Clients are not disenrolled for non-payment of premiums until they have missed three consecutive months of payment. Once the enrollee is three months in arrears, the enrollee is sent a letter advising them of disenrollment effective the end of the month unless the delinquent premium is paid in full. At any time prior to the end of the certification period the enrollee will be reinstated back to the month of disenrollment if the delinquent premium is paid.

The letter gives them a toll-free number to call to make payment arrangements or to report a change in circumstances that may make them eligible for Medicaid. The letter also advises them of their right to an Administrative Hearing if they disagree with the decision to terminate benefits, and a right to continued benefits pending the outcome of the Administrative Hearing.

☒ 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. 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 State's eligibility section is notified of a change in income, they 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 MPA 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, copays, 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 200% and 300% 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 200% 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 200% and 300% of FPL who have health care coverage.
2. Reduce the percentage of uninsured children between 200% and 300% FPL.
3. Increase the number of children below 200% of FPL who have health coverage.
4. Reduce the percentage of uninsured children below 200% 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))

MPA 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 MPA'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.

MPA has been using HEDIS- and EPSDT related measures to assess the effectiveness of its HO contractors to provide medically appropriate services to Medicaid clients. MPA 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:

MPA 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 200% and 300% FPL will be reported on a biennial basis using WSPS 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.

- MPA 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 MPA's CHIP operational design.

- During the development of the CHIP state plan, MPA 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 MPA and the Children's Alliance – a statewide children's advocacy group.

- MPA 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.

- MPA 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.

- MPA also provided an opportunity for all interested parties to review and comment on the original State Plan application through MPA'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))

MPA consulted with the American Indian Health commission of Washington State and the Northwest Portland Area Indian Health Board on the design of CHIP. MPA 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 (less than 500), 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.

| Washington State SCHIP Budget Plan | Federal Fiscal Year Costs | Federal Fiscal Year Costs |
|---|---|---|
| Enhanced FMAP rate | 65.08% | 65.00% |
| **Benefit Costs** | **FFY 2010** | **FFY 2011** |
| **Insurance Payments** | **-** | **-** |
| Managed Care – Children (200-300%FPL) PM/PM | $106 | $119 |
| • 17,293 FFY10 eligibles; 19,188 FFY11 eligibles | $22,015,372 | $27,508,684 |
| • 179 FFY10 eligibles; 181 FFY11 eligibles **[Section 214, Title XXI]** (1) | $227,881 | $259,489 |
| • 3,876 FFY10 eligibles; 4,564 FFY11 eligibles **[Section 214, Title XIX]**(1) (2) | $4,934,458 | $6,543,133 |
| Fee for Service - Children (200-300%FPL) PM/PM | $155 | $156 |
| • 3,023 FFY10 eligibles; 3,349 FFY11 eligibles | $5,622,054 | $6,282,188 |
| • 31 FFY10 eligibles; 32 FFY11 eligibles **[Section 214, Title XXI]**(1) | $57,653 | $60,027 |
| • 677 FFY10 eligibles; 797 FFY11 eligibles **[Section 214, Title XIX]** (1) (2) | $1,259,058 | $1,495,044 |
| Fee for Service - Unborn Child (185%FPL) PM/PM | $188 | $190 |
| • 7,377 FFY10 eligibles; 7,378 FFY11 eligibles | $16,601,616 | $16,814,763 |
| 133% Medicaid Children (FMAP to EFMAP Federal Only)(3) | $10,450,000 | $24,575,000 |
| **Total Benefit Costs** | **$61,168,093** | **$83,540,205** |
| **(Total offsetting beneficiary cost sharing payments)** | ($3,811,611) | ($4,297,723) |
| **Net Benefit Costs** | **$57,356,482** | **$79,242,482** |
| **Administration Costs**(4) | | |

| | | |
|---|---|---|
| Personnel | $427,219 | $448,580 |
| General Administration | $313,982 | $329,681 |
| Contractors/Brokers (e.g., Within Reach) | $162,194 | $170,304 |
| Claims Processing | $47,403 | $49,773 |
| Outreach/Marketing Costs[5] | $1,215,000 | 0 |
| Health Services Initiative – Washington Poison Center[6] | $921,210 | $945,714 |
| **Total Administration Costs** | **$3,087,008** | **$1,944,052** |
| | | |
| 10% Administrative Cost Ceiling | $6,372,942 | $8,804,720 |
| Federal Share (multiplied by enhanced-FMAP rate) | $32,535,763 | $36,797,497 |
| 133% Medicaid Children (FMAP to EFMAP Federal Only) | $10,450,000 | $24,575,000 |
| State Share | $17,457,727 | $19,814,037 |
| TOTAL PROGRAM COSTS* | **$60,443,490** | **$81,186,534** |

***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 eligibility expansion**

(1) Upon approval of this SPA Washington estimates that 32,456 children will be eligible for FFP under its CHIP State Plan in FFY2010, including an additional 4,763 children as a result of CHIPRA, Section 214 eligibility expansion in CHIP and Medicaid. Washington estimates that 35,490 children will be eligible for FFP under its CHIP State Plan in FFY11, including an additional 5,574 children as a result of CHIPRA, Section 214 eligibility expansion in both CHIP and Medicaid. The total projected costs for CHIPRA, Section 214 eligibility expansion is estimated at $6.48 million dollars in FY10, the federal share is estimated at $4.22 million dollars in FY10. The total projected costs for CHIPRA, Section 214 eligibility expansion is estimated at $8.36 million dollars in FY11, the federal share is estimated at $5.43 million dollars in FY11.

**[2] Section 214 Medicaid Children**

Children added to Medicaid as a result of CHIPRA, Section 214 eligibility expansion are exempt from cost-sharing premiums.

**[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 2010 the federal share is estimated at $10.45 million dollars; in FFY 2011 the federal share is estimated at $24.58 million dollars.

| (4)Calculation of Unused Administration Funding | FFY2010 | FFY2011 |
|---|---|---|
| Current Program Costs | $57,356,482 | $79,242,482 |
| 10% Administrative Cap | $6,372,942 | $8,804,720 |
| Federal Share | $4,147,511 | $5,723,068 |
| Administrative Costs - Current Plan | $3,087,008 | $1,944,052 |
| Federal Share | $2,009,025 | $1,263,634 |
| **Unused Administration Funding Available** | **$3,285,934** | **$6,860,668** |
| Federal Share | $2,138,486 | $4,459,434 |

| (5)Calculation of Children's Outreach Funding | FFY2010 | FFY2011 |
|---|---|---|
| Statewide Application Agent Program | $500,000 | $0 |
| Media Campaign & Other Outreach Contracts | $715,000 | $0 |
| Total Benefit Costs | $1,215,000 | $0 |
| Federal Share | $790,722 | $0 |
| State Share | $424,278 | $0 |

Outreach costs including Application Agent fees, media campaigns, publications, and other outreach efforts are suspended in 2011 because of state budget constraints. As funding becomes available, these services 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 | FFY2010 | FFY2011 |
|---|---|---|
| State Appropriation | $321,687 | $331,000 |
| Federal Title XXI Share | $599,523 | $614,714 |
| Total Federal/State Share | $921,210 | $945,714 |

The WAPC's total operating budget is calculated at just over $2.6 million in FY2010, and just over $2.9 million in FY2011. Based on call demographics the cost to the WAPC

operating budget attributed to providing services for low-income children was $921,210 dollars in FY2010 and just over $1 million dollars in FY 2011. The legislature appropriated $331,000 dollars in state funding from the State General Fund for FY 2010 and $331,000 dollars in state funding from the State General Fund for FY 2011. This appropriations are intended to match federal dollars under Title XXI to support an HSI to fund the WAPC as provided under Section 2105(a)(1)(D)(ii). In FY 2010 the actual state expenditure was $321,687 dollars. In FY 2011 the total state and federal match is estimated at no more than $945,714 based on the limit of appropriated state funds.

**Summary of projected costs for SPA 13**

In FFY2010 the total projected costs for this SPA will increase the budget by $7,400,259 dollars. The increased federal share in FFY2010 is calculated at $4,816,089 dollars. In FFY 2011 the total projected costs for this SPA will increase the budget by $9,303,407 dollars. The increased federal share in FFY2011 is calculated at $6,047,215 dollars.

| Expenditure | FFY2010 | FFY2011 |
|---|---|---|
| **Sec. 214 children in Title XXI** | | |
| State share | $99,708 | $111,831 |
| Federal share | $185,826 | $207,685 |
| subtotal | $285,534 | $319,516 |
| **Sec. 214 children in Title XIX** | | |
| State share | $2,162,776 | $2,813,362 |
| Federal share | $4,030,740 | $5,224,815 |
| subtotal | $6,193,516 | $8,038,177 |
| **Washington Poison Center** | | |
| State share | $321,687 | $331,000 |
| Federal share | $599,523 | $614,714 |
| Subtotal | $921,210 | $945,714 |
| Expenditure total | $7,400,259 | $9,303,407 |
| Federal share total | $4,816,089 | $6,047,215 |

## *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 MPA's Medical Eligibility Determination Services (MEDS) section or the Office of Administrative Hearings (OAH) to begin the review process. The MPA AdministrativeHearing 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.